

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0045823</u></p> <p>Facility Name: <u>ASTA CARE CENTER - FORD COUNTY</u></p> <p>Address: <u>1240 NORTH MARKET STREET</u> <u>PAXTON</u> <u>60957</u> Number City Zip Code</p> <p>County: <u>FORD</u></p> <p>Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u></p> <p>HFS ID Number: <u>36-4493674</u></p> <p>Date of Initial License for Current Owners: <u>07/01/02</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MICHAEL GILLMAN</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MICHAEL GILLMAN</u>			(Title) <u>MEMBER</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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<p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																									

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	69	Skilled (SNF)	69	25,254	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	25,254	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,997	1,467	2,136	7,600	8
9	SNF/PED					9
10	ICF	13,770	1,563	84	15,417	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,767	3,030	2,220	23,017	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.14%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 07/01/02

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/02/02 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 17 and days of care provided 2,136

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	206,974	13,295	5,976	226,245		226,245		226,245		1
2	Food Purchase		138,907		138,907		138,907	(1,639)	137,268		2
3	Housekeeping	139,444	27,022		166,466		166,466		166,466		3
4	Laundry	5,868	6,536		12,404		12,404		12,404		4
5	Heat and Other Utilities			91,496	91,496		91,496		91,496		5
6	Maintenance	34,591	13,519	25,713	73,823		73,823	565	74,388		6
7	Other (specify):*			5,436	5,436		5,436		5,436		7
8	TOTAL General Services	386,877	199,279	128,621	714,777		714,777	(1,074)	713,703		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	924,879	122,897	54,318	1,102,094		1,102,094	5,300	1,107,394		10
10a	Therapy		803	848	1,651		1,651		1,651		10a
11	Activities	61,868	12,440	576	74,884		74,884		74,884		11
12	Social Services	1,133		1,548	2,681		2,681		2,681		12
13	CNA Training										13
14	Program Transportation			166	166		166		166		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	987,880	136,140	59,856	1,183,876		1,183,876	5,300	1,189,176		16
	C. General Administration										
17	Administrative	111,047			111,047		111,047	89,449	200,496		17
18	Directors Fees										18
19	Professional Services			31,253	31,253		31,253	692	31,945		19
20	Dues, Fees, Subscriptions & Promotions			24,722	24,722		24,722	(10,697)	14,025		20
21	Clerical & General Office Expenses	96,573	17,574	46,462	160,609		160,609	(10,163)	150,446		21
22	Employee Benefits & Payroll Taxes			236,448	236,448		236,448		236,448		22
23	Inservice Training & Education										23
24	Travel and Seminar			124	124		124	435	559		24
25	Other Admin. Staff Transportation			18,530	18,530		18,530	(10,415)	8,115		25
26	Insurance-Prop.Liab.Malpractice			40,749	40,749		40,749	1,362	42,111		26
27	Other (specify):*			37,747	37,747		37,747	(31,319)	6,428		27
28	TOTAL General Administration	207,620	17,574	436,035	661,229		661,229	29,344	690,573		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,582,377	352,993	624,512	2,559,882		2,559,882	33,570	2,593,452		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,181
	REPAIRS & MAINTENANCE	795
		0
		5,976
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	26,799
	ELECTRICITY	36,502
	WATER	28,115
	CABLE TV - LOBBY	80
		0
		91,496
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,107
	PAINTING & DECORATING	0
	BUILDING REPAIRS	2,672
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,696
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,200
	FIRE SERVICE	10,038
		0
		0
		0
		0
		25,713
7	OTHER	
	SCAVENGER	5,436
	SECURITY SERVICE	0
		0
		0
		5,436
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,400
		2,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	41,480
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 47-2	384
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	840
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B 46-2	4,414
	PSYCHIATRIC XVIII B 48-2	7,200
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		54,318
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	848
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		848
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	576
		0
		576
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,548
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,548
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	166
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,389
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	23,864
		0
		31,253
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,108
	EMPLOYEE WANT ADS XIX F	4,412
	CONTRIBUTIONS VI 20 XIX F	3,000
	DUES & SUBSCRIPTIONS XIX F	4,424
	LICENSES & PERMITS XIX F	3,033
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	355
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	700
	PATIENT BACKGROUND CHECKS XIX F	690
		24,722
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,671
	EQUIPMENT REPAIR & MAINTENANCE	9,499
	OUTSIDE CLERICAL SERVICES	1,680
	PENALTIES / OVERDRAFT CHARGES VI 18	13,803
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	183
	TELEPHONE	15,626
	MESSENGER SERVICE	0
		0
		46,462

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	118,763
	UNEMPLOYMENT COMPENSATION XIX D	17,414
	WORKERS COMPENSATION INSURANC XIX D	95,081
	HOSPITALIZATION INSURANCE XIX D	3,292
	EMPLOYEE BENEFITS - OTHER XIX D	1,898
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		236,448
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	124
	TRAVEL XIX G	0
		124
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	18,530
		18,530
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	40,749
		40,749
27	OTHER	
	BAD DEBTS VI 24	37,747
		37,747

GRAND TOTAL COLUMN 3 OTHER

624,512

**ASTA CARE CENTER - FORD COUNTY
SCHEDULES
12/31/2008**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	138,907
LESS SALES TAX	<u>(1,639)</u>
NET FOOD	137,268

TOTAL PATIENT CENSUS	23,017
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	69,051

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	69,051
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	69,051

NET FOOD	137,268
DIVIDE TOTAL MEALS/YEAR	<u>69,051</u>

COST PER MEAL	1.99
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			23,082	23,082		23,082	14,853	37,935		30
31	Amortization of Pre-Op. & Org.			21,562	21,562		21,562		21,562		31
32	Interest			36,074	36,074		36,074	24,712	60,786		32
33	Real Estate Taxes			31,154	31,154		31,154		31,154		33
34	Rent-Facility & Grounds			144,000	144,000		144,000	56,000	200,000		34
35	Rent-Equipment & Vehicles			6,505	6,505		6,505	377	6,882		35
36	Other (specify):*										36
37	TOTAL Ownership			262,377	262,377		262,377	95,942	358,319		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		71,882	302,266	374,148		374,148		374,148		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			37,881	37,881		37,881		37,881		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		71,882	340,147	412,029		412,029		412,029		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,582,377	424,875	1,227,036	3,234,288		3,234,288	129,512	3,363,800		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,811)	30		9
10	Interest and Other Investment Income	(292)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,639)	2		13
14	Non-Care Related Interest	(5,217)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(13,803)	21		18
19	Entertainment		20		19
20	Contributions	(3,355)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(607)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,747)	27		24
25	Fund Raising, Advertising and Promotional	(8,108)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(21,979)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (101,558)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	231,070		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 231,070		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 129,512		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ASTA CARE CENTER - FORD COUNTY

ID# 0045823

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3	MARKETING SALARY	(6,504)	21	3
4	TRAVEL	(15,475)	25	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(21,979)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY# 0045823

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,639)	0	0	0	0	0	0	0	0	0	0	(1,639)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	565	0	0	0	0	0	0	0	0	0	565	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,639)	565	0	(1,074)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,300	0	0	0	0	0	0	0	0	0	5,300	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	5,300	0	5,300	16								
	C. General Administration													
17	Administrative	0	89,449	0	0	0	0	0	0	0	0	0	89,449	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(607)	1,299	0	0	0	0	0	0	0	0	0	692	19
20	Fees, Subscriptions & Promotions	(11,463)	766	0	0	0	0	0	0	0	0	0	(10,697)	20
21	Clerical & General Office Expenses	(20,307)	10,144	0	0	0	0	0	0	0	0	0	(10,163)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	435	0	0	0	0	0	0	0	0	0	435	24
25	Other Admin. Staff Transportation	(15,475)	5,060	0	0	0	0	0	0	0	0	0	(10,415)	25
26	Insurance-Prop.Liab.Malpractice	0	1,362	0	0	0	0	0	0	0	0	0	1,362	26
27	Other (specify):*	(37,747)	6,428	0	0	0	0	0	0	0	0	0	(31,319)	27
28	TOTAL General Administration	(85,599)	114,943	0	29,344	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,238)	120,808	0	33,570	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY# 0045823

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(8,811)	0	23,664	0	0	0	0	0	0	0	0	14,853	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,509)	0	30,221	0	0	0	0	0	0	0	0	24,712	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	56,000	0	0	0	0	0	0	0	0	56,000	34
35	Rent-Equipment & Vehicles	0	377	0	0	0	0	0	0	0	0	0	377	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,320)	377	109,885	0	95,942	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(101,558)	121,185	109,885	0	129,512	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ASTA		
				HEALTHCARE CO.	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				ASTA PAXTON	ELGIN	LANDLORD
				PROPERTIES		
				ASTA THERAPY	ELGIN	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17		ASTA HEALTHCARE COMPANY				1	
2	V	6				565	565	2	
3	V	10				5,300	5,300	3	
4	V	17				89,449	89,449	4	
5	V	19				1,299	1,299	5	
6	V	20				766	766	6	
7	V	21				10,144	10,144	7	
8	V	24				435	435	8	
9	V	25				5,060	5,060	9	
10	V	26				1,362	1,362	10	
11	V	27				6,428	6,428	11	
12	V	35				377	377	12	
13	V							13	
14	Total		\$			121,185	\$ *	121,185	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 144,000	ASTA PAXTON PROPERTIES		\$	(144,000)
16	V	34 RENT				200,000	200,000
17	V	30 DEPRECIATION-SL				23,664	23,664
18	V	32 INTEREST				30,221	30,221
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 144,000			\$ 253,885	\$ * 109,885

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN			60.00	LIST ATTACHED	LIST	ATTACHED	SALARY	\$ 24,282	17-7	1
2											2
3	SETH GILLMAN			10.00	LIST ATTACHED	LIST	ATTACHED	SALARY	15,288	17-7	3
4	PROFESSIONAL FEE FOR WOUND BILLING (BLOOMINGTON) \$3,964										4
5	SALARY FROM ASTA CARE OF TOLUCA \$31,317										5
6											6
7	CRAIG FRANK			10.00	LIST ATTACHED	LIST	ATTACHED	SALARY	18,834	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,572								43,572	17-1	8
9											9
10	DAVID MEISELMAN			10.00	LIST ATTACHED	LIST	ATTACHED	SALARY	1,509	17-7	10
11	SALARY FROM ASTA CARE OF ELGIN \$233,408										11
12	ALIZA FRANK				LIST ATTACHED	LIST	ATTACHED	SALARY	4,057	21-7	12
13								TOTAL	\$ 107,542		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization ASTA HEALTHCARE
 Street Address 134 N. MCLEAN
 City / State / Zip Code ELGIN,IL 60123
 Phone Number (847)742-8822
 Fax Number (847)742-9013

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINTENANCE	PATIENT DAYS	184,841	6	\$ 4,539	\$ 23,017	\$ 565	1	
2	10	NURSING	PATIENT DAYS	184,841	6	42,560	42,560	23,017	5,300	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	184,841	6	195,000	195,000	23,017	24,282	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	184,841	6	122,770	122,770	23,017	15,288	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	184,841	6	151,251	151,251	23,017	18,834	5
6	17	ADMIN. SALARY - DM	PATIENT DAYS	184,841	6	12,117	12,117	23,017	1,509	6
7	17	ADMIN. SALARY	PATIENT DAYS	184,841	6	184,098	184,098	23,017	22,924	7
8	17	OUTSIDE CLERICAL	PATIENT DAYS	184,841	6	53,100		23,017	6,612	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	184,841	6	10,435		23,017	1,299	9
10	20	LICENSES & PERMITS	PATIENT DAYS	184,841	6	6,154		23,017	766	10
11	21	OFFICE EXPENSE	PATIENT DAYS	184,841	6	48,883	5,629	23,017	6,087	11
12	21	CLERICAL SALARY-AF	PATIENT DAYS	184,841	6	32,584	32,584	23,017	4,057	12
13	24	SEMINARS	PATIENT DAYS	184,841	6	3,497		23,017	435	13
14	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	184,841	6	40,634		23,017	5,060	14
15	26	INSURANCE GEN / WC	PATIENT DAYS	184,841	6	10,938		23,017	1,362	15
16	27	PAYR. TAXES & GRP INS	PATIENT DAYS	184,841	6	51,620		23,017	6,428	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	184,841	6	3,029		23,017	377	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 973,209	\$ 746,009		\$ 121,185	25

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ASTA PAXTON PROPERTIES
 Street Address 134 N. MCLEAN
 City / State / Zip Code ELGIN,IL 60123
 Phone Number (847)742-8822
 Fax Number (847)742-9013

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	34	RENT	DIRECT	1	1	\$ 200,000	\$ 1	\$ 200,000	1
2	30	DEPRECIATION- SL	DIRECT	1	1	23,664	1	23,664	2
3	32	INTEREST	DIRECT	1	1	30,221	1	30,221	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 253,885	\$	\$ 253,885	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	29,792	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	30,473	2
3. Under or (over) accrual (line 2 minus line 1).		\$	681	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,473	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	31,154	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003		8
	2004	31,348	9
	2005	30,272	10
	2006	29,792	11
	2007	30,473	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER - FORD COUNTY COUNTY FORD

FACILITY IDPH LICENSE NUMBER 0045823

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-14-05-300-001</u>	<u>NURSING HOME</u>	\$ <u>30,472.92</u>	\$ <u>30,472.92</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>30,472.92</u>	\$ <u>30,472.92</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior BRICK/WOOD Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: 69,000 2. Number of Years Over Which it is Being Amortized: 8
 3. Current Period Amortization: 21,562 4. Dates Incurred: 07/01/02

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>2008</u>	<u>\$ 125,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 125,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	69	2008		\$ 992,215	\$ 16,537	27.5	\$ 16,537	\$	\$ 16,537	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	NURSE STATION		2002	10,000	364	27.5	364		2,320	9
10	ROOF		2002	28,434	1,034	27.5	1,034		6,592	10
11	NURSE STATION		2002	10,000	363	27.5	363		2,314	11
12	ROOF		2004	31,800	1,156	27.5	1,156		5,732	12
13	ELECTRICAL WORK		2005	3,959	144	27.5	144		510	13
14	SECURITY SYSTEM		2005	52,942	1,925	27.5	1,925		6,497	14
15	ASPHALT SIDEWALK		2005	2,200	147	15	147		496	15
16	10 TON PKG UNIT		2006	8,500	309	27.5	309		708	16
17	EMERGENCY SWITCH PANEL		2006	1,828	66	27.5	66		151	17
18	TILING		2006	1,091	40	27.5	40		92	18
19	WATER HEATER		2007	8,943	325	27.5	325		555	19
20	WATER MAIN WORK		2007	6,857	457	15	457		514	20
21	FLOORING		2007	11,440	3,661	5	2,288	(1,373)	3,432	21
22	DRAIN REPAIR (REL PARTY)		2008	8,612	170	27.5	170		170	22
23	FLOORING (REL PARTY)		2008	2,539	27	27.5	27		27	23
24	GENERATOR (REL PARTY)		2008	6,569	30	27.5	30		30	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,187,929	\$ 26,755		\$ 25,382	\$ (1,373)	\$ 46,677	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 35,271	\$ 4,901	\$ 3,527	\$ (1,374)	10 YRS	\$ 12,541	71
72	Current Year Purchases	9,936	5,962	497	(5,465)	10 YRS	497	72
73	Fully Depreciated Assets							73
74	REL PARTY	138,000	6,900	6,900		10 YRS	6,900	74
75	TOTALS	\$ 183,207	\$ 17,763	\$ 10,924	\$ (6,839)		\$ 19,938	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 FORD VAN	2005	\$ 6,189	\$ 2,228	\$ 1,629	\$ (599)	5 YEARS	\$ 6,516	76
77										77
78										78
79										79
80	TOTALS			\$ 6,189	\$ 2,228	\$ 1,629	\$ (599)		\$ 6,516	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,502,325	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,746	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,935	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,811)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 73,131	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		69		\$ 144,000			3
4	Additions							4
5								5
6								6
7	TOTAL		69		\$ 144,000			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: PURCHASE PRICE \$2,415,000 *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 6,505 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 86,967	\$		\$ 86,967	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			32,176			32,176	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			179,486			179,486	4
5	Physician Care	39-3	visits			77			77	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				66,357		66,357	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADIOLOGY,LAB,OUTSIDE SVCS Other (specify): <u>SUPPLIES, RENTAL</u>	39-8 39-8				3,560	5,525		3,560 5,525	13
14	TOTAL			\$		\$ 302,266	\$ 71,882		\$ 374,148	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,420	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,004,152		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,561		6
7	Other Prepaid Expenses	234,602		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,262,735	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	166,554		15
16	Equipment, at Historical Cost	72,935		16
17	Accumulated Depreciation (book methods)	(79,713)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	69,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(69,000)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	431		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 160,207	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,422,942	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 557,526	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,508,997		29
30	Accrued Salaries Payable	76,164		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,895		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,473		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,183,055	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	110,856		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 110,856	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,293,911	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (870,969)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,422,942	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,030,311)	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,030,310)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	159,341	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 159,341	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (870,969)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,112,398	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,112,398	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	279,315	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 279,315	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	292	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 292	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSE	1,624	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,624	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,393,629	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	714,777	31
32	Health Care	1,183,876	32
33	General Administration	661,229	33
	B. Capital Expense		
34	Ownership	262,377	34
	C. Ancillary Expense		
35	Special Cost Centers	374,148	35
36	Provider Participation Fee	37,881	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,234,288	40
41	Income before Income Taxes (line 30 minus line 40)**	159,341	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 159,341	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,213	2,435	\$ 67,842	\$ 27.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,847	9,535	213,589	22.40	3
4	Licensed Practical Nurses	8,903	9,431	196,309	20.82	4
5	CNAs & Orderlies	42,117	45,679	447,139	9.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,003	2,278	31,207	13.70	9
10	Activity Assistants	3,369	3,724	30,661	8.23	10
11	Social Service Workers	98	126	1,133	8.99	11
12	Dietician					12
13	Food Service Supervisor	1,879	2,163	36,227	16.75	13
14	Head Cook	5,778	6,397	62,951	9.84	14
15	Cook Helpers/Assistants	12,730	13,556	107,796	7.95	15
16	Dishwashers					16
17	Maintenance Workers	1,955	2,199	34,591	15.73	17
18	Housekeepers	14,607	16,063	139,444	8.68	18
19	Laundry	705	757	5,868	7.75	19
20	Administrator	3,997	4,511	111,047	24.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,713	6,348	96,573	15.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,914	125,202	\$ 1,582,377 *	\$ 12.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,181	1-3	35
36	Medical Director	O	2,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	840	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		848	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	576	11-3	44
45	Social Service Consultant	E	1,548	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	S	4,414	10-3	46
47	<u>PSYCHO-SOC CONSULTANT</u>		384	10-3	47
48	<u>PSYCHIATRIC</u>		7,200	10-3	48
49	TOTAL (lines 35 - 48)		\$ 23,391		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	1,185	41,480	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	1,185	\$ 41,480		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
PAUL BLANCHETTE	ADMINISTRATOR	0	\$ 33,439	Workers' Compensation Insurance	\$ 95,081	IDPH License Fee	\$ 1,990	
KIM HAAS	ADMINISTRATOR	0	34,036	Unemployment Compensation Insurance	17,414	Advertising: Employee Recruitment	4,412	
CRAIG FRANK	OTHER ADMIN	10	43,572	FICA Taxes	118,763	Health Care Worker Background Check	700	
				Employee Health Insurance	3,292	(Indicate # of checks performed <u>70</u>)		
				Employee Meals	0	Patient Background Checks	69	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,355	
				EMPLOYEE BENEFITS - OTHER	1,898	MARKETING/ADV/PROMO	8,108	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	5,467	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	766	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,355)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(8,108)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,047	TOTAL (agree to Schedule V, line 22, col.8)	\$ 236,448	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,025	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	124
							MGMT CO ALLOC	435
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 559
SEE SCHEDULE ATTACHED			31,253	TOTAL		\$		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 31,253					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING		\$		\$	\$	\$	0	\$	\$	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$		\$	\$	\$	0	\$	\$	\$	\$	\$							

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY# 0045823Report Period Beginning: 01/01/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTHCARE ASSOC \$4,089
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,789 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES _____ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 37,881
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees