

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	117	Skilled (SNF)	117	42,705	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	117	TOTALS	117	42,705	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	904	7	2,694	3,605	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	20,530	2,634	621	23,785	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,434	2,641	3,315	27,390	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.14%

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 09/01/96

J. Was the facility purchased or leased after January 1, 1978?

YES Date 09/01/96 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 79 and days of care provided 2,126

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number **ASTA CARE CENTER OF BLOOMINGTO** # **0042283** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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	277,450	23,803	9,945	311,198		311,198		311,198		
2	Food Purchase		200,351		200,351		200,351	(1,390)	198,961		
3	Housekeeping	201,059	35,432		236,491		236,491		236,491		
4	Laundry	67,527	18,063	1,009	86,599		86,599		86,599		
5	Heat and Other Utilities			152,890	152,890		152,890		152,890		
6	Maintenance	72,582	24,597	46,864	144,043		144,043	784	144,827		
7	Other (specify):*			24,413	24,413		24,413		24,413		
8	TOTAL General Services	618,618	302,246	235,121	1,155,985		1,155,985	(606)	1,155,379		
	B. Health Care and Programs										
9	Medical Director			11,187	11,187		11,187		11,187		
10	Nursing and Medical Records	1,317,148	129,076	26,082	1,472,306		1,472,306	1,996	1,474,302		
10a	Therapy	83,161			83,161		83,161		83,161		
11	Activities	268,087	8,979		277,066		277,066		277,066		
12	Social Services	44,853			44,853		44,853		44,853		
13	CNA Training										
14	Program Transportation			672	672		672		672		
15	Other (specify):*										
16	TOTAL Health Care and Programs	1,713,249	138,055	37,941	1,889,245		1,889,245	1,996	1,891,241		
	C. General Administration										
17	Administrative	70,264			70,264		70,264	78,920	149,184		
18	Directors Fees										
19	Professional Services			72,946	72,946		72,946	(753)	72,193		
20	Dues, Fees, Subscriptions & Promotions			28,631	28,631		28,631	(7,426)	21,205		
21	Clerical & General Office Expenses	159,729	32,818	85,533	278,080		278,080	(32,018)	246,062		
22	Employee Benefits & Payroll Taxes			310,894	310,894		310,894		310,894		
23	Inservice Training & Education										
24	Travel and Seminar			2,508	2,508		2,508	42	2,550		
25	Other Admin. Staff Transportation			5,549	5,549		5,549	5,820	11,369		
26	Insurance-Prop.Liab.Malpractice			48,984	48,984		48,984	1,416	50,400		
27	Other (specify):*			51,662	51,662		51,662	(44,730)	6,932		
28	TOTAL General Administration	229,993	32,818	606,707	869,518		869,518	1,271	870,789		
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,561,860	473,119	879,769	3,914,748		3,914,748	2,661	3,917,409		

*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	9,576
	REPAIRS & MAINTENANCE	369
		0
		9,945
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,009
		0
		1,009
5	HEAT & OTHER UTILITIES	
	GAS HEAT	17,801
	ELECTRICITY	85,697
	WATER	40,263
	CABLE TV - LOBBY	9,129
		0
		152,890
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,272
	PAINTING & DECORATING	284
	BUILDING REPAIRS	1,968
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	33,773
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,898
	FIRE SERVICE	2,669
		0
		0
		0
		0
		46,864
7	OTHER	
	SCAVENGER	24,413
	SECURITY SERVICE	0
		0
		0
		24,413
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,187
		11,187

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	8,753
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	3,872
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	2,857
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	10,000
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		26,082
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 CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
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	672
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,352
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	56,594
		0
		72,946
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,563
	EMPLOYEE WANT ADS XIX F	7,404
	CONTRIBUTIONS VI 20 XIX F	100
	DUES & SUBSCRIPTIONS XIX F	4,975
	LICENSES & PERMITS XIX F	4,770
	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	1,776
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,043
	PATIENT BACKGROUND CHECKS XIX F	2,000
		28,631
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,295
	EQUIPMENT REPAIR & MAINTENANCE	6,367
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	46,456
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	24,415
	MESSENGER SERVICE	0
		0
		85,533

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	193,487
	UNEMPLOYMENT COMPENSATION XIX D	29,816
	WORKERS COMPENSATION INSURANC XIX D	46,887
	HOSPITALIZATION INSURANCE XIX D	39,363
	EMPLOYEE BENEFITS - OTHER XIX D	752
	EMPLOYEE PHYSICAL EXAMS XIX D	589
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		310,894
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,508
	TRAVEL XIX G	0
		2,508
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	5,549
		5,549
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	48,984
		48,984
27	OTHER	
	BAD DEBTS VI 24	51,662
		51,662

GRAND TOTAL COLUMN 3 OTHER

879,769

ASTA CARE CENTER OF BLOOMINGTON
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	200,351
LESS SALES TAX	<u>(1,390)</u>
NET FOOD	198,961

TOTAL PATIENT CENSUS	27,390
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	82,170

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	82,170
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	82,170

NET FOOD	198,961
DIVIDE TOTAL MEALS/YEAR	<u>82,170</u>

COST PER MEAL	2.42
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 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	
	D. Ownership											
30	Depreciation			21,715	21,715		21,715	9,015	30,730			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,933	54,933		54,933	(15,492)	39,441			32
33	Real Estate Taxes			50,053	50,053		50,053		50,053			33
34	Rent-Facility & Grounds			538,740	538,740		538,740		538,740			34
35	Rent-Equipment & Vehicles			47,624	47,624		47,624		47,624			35
36	Other (specify):*											36
37	TOTAL Ownership			713,065	713,065		713,065	(6,477)	706,588			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,353	481,822	600,175		600,175		600,175			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,058	64,058		64,058		64,058			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		118,353	545,880	664,233		664,233		664,233			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,561,860	591,472	2,138,714	5,292,046		5,292,046	(3,816)	5,288,230			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	9,015	30		9
10	Interest and Other Investment Income	(7,470)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,390)	2		13
14	Non-Care Related Interest	(8,022)	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	(46,456)	21		18
19	Entertainment		20		19
20	Contributions	(1,876)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(383)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,662)	27		24
25	Fund Raising, Advertising and Promotional	(6,563)	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	(20,533)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (135,340)		\$	30

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)	131,524		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 131,524		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,816)		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

BHF USE ONLY					
48		49		50	51
					52

STATE OF ILLINOIS
 ASTA CARE CENTER OF BLOOMINGTON

ID# 0042283
 Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3	MARKETING SALARY	(19,117)	21	3
4	MARKETING TRAVEL	(813)	25	4
5	PROFESSIONAL FEES	(603)	19	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		(20,533)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON# 0042283

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(1,390)	0	0	0	0	0	0	0	0	0	0	(1,390)	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	784	0	0	0	0	0	0	0	0	0	784	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,390)	784	0	(606)	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	1,996	0	0	0	0	0	0	0	0	0	1,996	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	1,996	0	1,996	16								
	C. General Administration													
17	Administrative	0	78,920	0	0	0	0	0	0	0	0	0	78,920	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(986)	233	0	0	0	0	0	0	0	0	0	(753)	19
20	Fees, Subscriptions & Promotions	(8,439)	1,013	0	0	0	0	0	0	0	0	0	(7,426)	20
21	Clerical & General Office Expenses	(65,573)	33,555	0	0	0	0	0	0	0	0	0	(32,018)	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	42	0	0	0	0	0	0	0	0	0	42	24
25	Other Admin. Staff Transportation	(813)	6,633	0	0	0	0	0	0	0	0	0	5,820	25
26	Insurance-Prop.Liab.Malpractice	0	1,416	0	0	0	0	0	0	0	0	0	1,416	26
27	Other (specify):*	(51,662)	6,932	0	0	0	0	0	0	0	0	0	(44,730)	27
28	TOTAL General Administration	(127,473)	128,744	0	1,271	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(128,863)	131,524	0	2,661	29								

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON# 0042283

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	9,015	0	0	0	0	0	0	0	0	0	0	9,015	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,492)	0	0	0	0	0	0	0	0	0	0	(15,492)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,477)	0	0	0	0	0	0	0	0	0	0	(6,477)	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)	(135,340)	131,524	0	(3,816)	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		
				COMPANY, INC.	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				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, INC.				1
2	V	6				784	784	2
3	V	10				1,996	1,996	3
4	V	17				78,920	78,920	4
5	V	19				233	233	5
6	V	20				1,013	1,013	6
7	V	21				33,555	33,555	7
8	V	24				42	42	8
9	V	25				6,633	6,633	9
10	V	26				1,416	1,416	10
11	V	27				6,932	6,932	11
12	V							12
13	V							13
14	Total		\$			\$ 131,524	\$ * 131,524	14

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGT # 0042283 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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							SALARY	\$ 29,933	17-7	1
2											2
3	SETH GILLMAN							SALARY	1,037	17-7	3
4								PROF FEES			4
5					SEE		SEE				5
6					ATTACHED		ATTACHED				6
7	CRAIG FRANK				SCHEDULE		SCHEDULE	SALARY	25,232	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,333										8
9											9
10											10
11											11
12	ALIZA FRANK							SALARY	5,219	17-7	12
13								TOTAL	\$ 61,421		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 OF BLOOMINGTON

0042283

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	178,434	6	\$ 5,107	27,390	\$ 784	1	
2	10	NURSING	PATIENT DAYS	178,434	6	13,000	13,000	27,390	1,996	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	178,434	6	195,000	195,000	27,390	29,933	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	178,434	6	6,755	6,755	27,390	1,037	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	178,434	6	164,375	164,375	27,390	25,232	5
6	17	ADMIN. SALARY -AF	PATIENT DAYS	178,434	6	34,000	34,000	27,390	5,219	6
7	17	ADMIN. SALARY- JS	PATIENT DAYS	178,434	6	114,000	114,000	27,390	17,499	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,434	6	1,518		27,390	233	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,434	6	6,596		27,390	1,013	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,434	6	218,597	139,019	27,390	33,555	10
11	24	SEMINARS	PATIENT DAYS	178,434	6	275		27,390	42	11
12	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	178,434	6	43,211		27,390	6,633	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,434	6	9,222		27,390	1,416	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,434	6	45,157		27,390	6,932	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 856,813	\$ 666,149	\$	131,524	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6			X	BLOOMINGTON PROP							40,520	6					
7			X	INSURANCE POLICIES							4,177	7					
8											2,214	8					
9	TOTAL Facility Related						\$	\$			\$	46,911	9				
	B. Non-Facility Related*																
10												10					
11				BED TAX INTEREST							8,022	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	8,022	14				
15	TOTALS (line 9+line14)						\$	\$			\$	54,933	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

1. Real Estate Tax accrual used on 2008 report.		\$	47,308	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.)		\$	48,680	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,373	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	48,680	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.		\$	50,053	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	42,477	8	
	2005	43,745	9	
	2006	44,982	10	
	2007	47,308	11	
	2008	48,680	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. 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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>48,680.30</u>	\$ <u>48,680.30</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: _____ B. General Construction Type: Exterior _____ 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **ASTA CARE CENTER OF BLOOMINGTON**# **0042283**

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ROOF & DOORS	1997		8,588	220	39	220		2,686	9
10		FIRE ALARM CONTROL PANEL	1998		2,880	74	39	74		854	10
11		CHECK VALVES INSTALLATION	1998		3,192	82	39	82		946	11
12		WATER HEATER	1998		5,965	153	39	153		1,766	12
13		ROOF & DOORS	1999		14,774	537	27.5	537		5,661	13
14		GARAGE	1999		9,320	339	27.5	339		3,574	14
15		FENCE	1999		3,510	234	15	234		2,467	15
16		A/C ROOF UNIT COMPRESSOR	1999		2,314	84	27.5	84		886	16
17		VALVES	2000		1,232	44	27.5	44		420	17
18		BUILD IN CHART RACKS	2000		1,980	72	27.5	72		687	18
19		ROOF & DOORS	2000		13,310	484	27.5	484		4,622	19
20		ELECTRICAL WORK	2000		1,600	58	27.5	58		554	20
21		DISPOSAL	2000		1,820	66	27.5	66		630	21
22		ELECTRICAL	2000		1,774	64	27.5	64		611	22
23		WATER LINE	2000		3,100	114	27.5	114		1,087	23
24		CURTAINS	2000		1,679		10	168	168	1,602	24
25		CARPETING	2000		4,599		10	460	460	4,370	25
26		ELECTRICAL	2001		11,927	434	27.5	434		3,707	26
27		ROOF TOP UNIT	2001		6,886	250	27.5	250		2,136	27
28		FLASHING ON ROOF	2001		5,930	215	27.5	215		1,837	28
29		FENCE	2001		1,722	63	27.5	63		538	29
30		BATHROOM	2001		3,370	123	27.5	123		1,050	30
31		CARPETING	2001		6,671		10	667	667	5,670	31
32		TILING	2001		8,363		10	836	836	7,106	32
33		PLUMBING	2002		10,533	383	27.5	383		2,889	33
34		TILING	2002		6,761	246	27.5	246		1,855	34
35		ROOF TOP UNIT	2002		6,775	246	27.5	246		1,855	35
36		ROOF TOP HEAT/COOL UNIT	2003		6,950	253	27.5	253		1,655	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	2	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	DOOR ALARM SYSTEM	2004	\$ 7,077	\$ 258	27.5	\$ 258		\$ 1,301	37
38	PTAC HEAT PUMP/COOL	2004	1,440	52	27.5	52		262	38
39	SIDEWALK	2005	6,119	408	15	221	(187)	1,105	39
40	DOOR ALARM	2005	4,523	164	27.5	164		718	40
41	NEW VALVE	2005	4,719	171	27.5	171		748	41
42	ELECTRICAL WORK	2005	1,661	61	27.5	61		267	42
43	CARPETING	2006	9,844	1,134	10	984	(150)	3,444	43
44	WATER HEATER	2006	9,407	342	27.5	342		1,182	44
45	ROOFTOP HEAT/COOL UNIT	2006	9,114	331	27.5	331		1,145	45
46	SIDEWALK & CONCRETE PAVING	2006	7,695	513	15	513		1,817	46
47	NEW WATER SYSTEM	2007	22,144	805	27.5	805		1,912	47
48	PLUMBING REMODELING FOR DIALYSIS AREA	2007	12,483	454	27.5	454		1,079	48
49	WIRING FOR DIALYSIS ROOM	2007	2,656	97	27.5	97		230	49
50	SIDEWALKS	2007	5,603	374	15	374		919	50
51	SIDEWALK	2009	5,675	189	15	189		189	51
52	ROOFTOP HEAT/COOL UNIT	2009	12,671	96	27.5	96		96	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)		\$ 280,356	\$ 10,287		\$ 12,081	\$ 1,794	\$ 80,135	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	\$ 195,383	\$ 7,396	\$ 18,313	\$ 10,917		\$ 130,725	71
72	Current Year Purchases	6,720	4,032	336	(3,696)		336	72
73	Fully Depreciated Assets	53,317					53,317	73
74								74
75	TOTALS	\$ 255,420	\$ 11,428	\$ 18,649	\$ 7,221		\$ 184,378	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	ADMIN, ACTIVITY	1995 FORD	1997	\$ 3,384	\$	\$	\$		\$ 33,841	76
77										77
78										78
79										79
80	TOTALS			\$ 3,384	\$	\$	\$		\$ 33,841	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)	\$ 539,160	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,715	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,730	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,015	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 298,354	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: BLOOMINGTON PROPERTY LLC

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:		<u>117</u>		\$ <u>538,740</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		117		\$ 538,740			7

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. 2010 \$ 538,740

13. 2011 \$ 538,740

14. 2012 \$ 538,740

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: _____ *

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: \$ 47,624 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

* 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.

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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 106,532	\$		\$ 106,532	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			61,909			61,909	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			264,283			264,283	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				114,290		114,290	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Med. Supplies,I.V. Therapy</u>					49,098	4,063		<u>49,098</u> 4,063	13
14	TOTAL			\$		\$ 481,822	\$ 118,353		\$ 600,175	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 OF BLOOMINGTON# 0042283Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009 (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	\$ 2,380	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	631,400		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,418		6
7	Other Prepaid Expenses	17,187		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>employee loans,adv wage assgn</u>	18,685		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 704,070	\$	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	249,200		15
16	Equipment, at Historical Cost	320,417		16
17	Accumulated Depreciation (book methods)	(367,005)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 202,612	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 906,682	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 860,084	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,334,631		29
30	Accrued Salaries Payable	110,029		30
31	Accrued Taxes Payable (excluding real estate taxes)	119,336		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,680		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)	\$ 3,472,760	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	320,856		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)	\$ 320,856	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,793,616	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,886,934)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 906,682	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,070,590)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,070,590)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(816,344)	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)	\$ (816,344)	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)	\$ (2,886,934)	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	\$ 4,198,642	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,198,642	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	269,590	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 269,590	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***	7,470	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,470	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,475,702	30	

		2		
Expenses		Amount		
A. Operating Expenses				
31	General Services	1,155,985	31	
32	Health Care	1,889,245	32	
33	General Administration	869,518	33	
B. Capital Expense				
34	Ownership	713,065	34	
C. Ancillary Expense				
35	Special Cost Centers	600,175	35	
36	Provider Participation Fee	64,058	36	
D. Other Expenses (specify):				
37	OUT-OF-PERIOD EXPENSES		37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,292,046	40	
41	Income before Income Taxes (line 30 minus line 40)**	(816,344)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (816,344)	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 OF BLOOMINGTON

0042283

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	1,974	2,272	\$ 68,410	\$ 30.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,058	6,629	158,182	23.86	3
4	Licensed Practical Nurses	19,546	21,231	467,857	22.04	4
5	CNAs & Orderlies	52,971	55,912	588,572	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,314	4,644	83,161	17.91	8
9	Activity Director	1,239	1,287	13,536	10.52	9
10	Activity Assistants	21,649	23,506	254,551	10.83	10
11	Social Service Workers	3,579	3,879	44,853	11.56	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,164	23,907	11.05	13
14	Head Cook	9,357	10,502	116,016	11.05	14
15	Cook Helpers/Assistants	13,358	14,284	137,527	9.63	15
16	Dishwashers					16
17	Maintenance Workers	4,463	4,914	72,582	14.77	17
18	Housekeepers	17,768	19,617	201,059	10.25	18
19	Laundry	5,968	6,589	67,527	10.25	19
20	Administrator	1,990	2,103	70,264	33.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,410	9,148	159,729	17.46	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	1,796	1,949	34,127	17.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,368	190,630	\$ 2,561,860 *	\$ 13.44	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	\$ 9,576	1-3	35
36	Medical Director	O	11,187	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	2,857	10-3	38
39	Pharmacist Consultant	H	600	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		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,220		49

C. CONTRACT NURSES

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

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 HEALTH CARE ASSOC. \$5920
- (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. \$ 18,772 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. \$ 64,058
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: _____
- (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.