FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0042283

Facility Name: ASTA CARE CTR OF BLOOMINGTON

Address: 1509 N CALHOUN ST (Number) BLOOMINGTON (City) 61701 (Zip Code)

County: MCLEAN

Telephone Number: (847) 742-8822 **Fax #** (847) 742-9013

HFS ID Number:

Date of Initial License for Current Owners: 09/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MICHAEL GILLMAN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	117	Skilled (SNF)	117	42,822	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	42,822	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,437	6	2,702	4,145	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	22,678	2,986	294	25,958	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,115	2,992	2,996	30,103	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.30%

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 [X]

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

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 [X] Date 09/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 79 and days of care provided 2,501

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	288,749	21,558	15,071	325,378		325,378		325,378			1
2	Food Purchase		196,308		196,308		196,308	(798)	195,510			2
3	Housekeeping	87,458	35,249		122,707		122,707		122,707			3
4	Laundry	80,845	15,983	1,268	98,096		98,096		98,096			4
5	Heat and Other Utilities			152,507	152,507		152,507		152,507			5
6	Maintenance	69,136	32,637	30,656	132,429		132,429	56	132,485			6
7	Other (specify):*			38,329	38,329		38,329		38,329			7
8	**TOTAL General Services**	526,188	301,735	237,831	1,065,754		1,065,754	(742)	1,065,012			8
	B. Health Care and Programs											
9	Medical Director			14,238	14,238		14,238		14,238			9
10	Nursing and Medical Records	1,284,510	129,000	21,681	1,435,191		1,435,191	13,477	1,448,668			10
10a	Therapy	116,912		1,024	117,936		117,936		117,936			10a
11	Activities	84,118	2,644		86,762		86,762		86,762			11
12	Social Services	56,131			56,131		56,131		56,131			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,541,671	131,644	36,943	1,710,258		1,710,258	13,477	1,723,735			16
	C. General Administration											
17	Administrative	93,921		119,669	213,590		213,590	(55,552)	158,038			17
18	Directors Fees											18
19	Professional Services			81,069	81,069		81,069	(4,412)	76,657			19
20	Dues, Fees, Subscriptions & Promotions			22,726	22,726		22,726	(11,009)	11,717			20
21	Clerical & General Office Expenses	181,068	32,420	162,117	375,605		375,605	(103,399)	272,206			21
22	Employee Benefits & Payroll Taxes			383,628	383,628		383,628		383,628			22
23	Inservice Training & Education			610	610		610	130	740			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			12,283	12,283		12,283	7,090	19,373			25
26	Insurance-Prop.Liab.Malpractice			79,095	79,095		79,095	205	79,300			26
27	Other (specify):*			63,119	63,119		63,119	(55,387)	7,732			27
28	**TOTAL General Administration**	274,989	32,420	924,316	1,231,725		1,231,725	(222,334)	1,009,391			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,342,848	465,799	1,199,090	4,007,737		4,007,737	(209,599)	3,798,138			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.

Facility Name & ID#: ASTA CARE CTR OF BLOOMINGTON #0042283 **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,925	
	REPAIRS & MAINTENANCE		6,146	
			0	15,071
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,268	
			0	1,268
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		12,184	
	ELECTRICITY		71,233	
	WATER		57,281	
	CABLE TV - LOBBY		11,809	
			0	152,507
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		889	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		26,288	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		384	
	FIRE SERVICE		3,095	
			0	
			0	
			0	30,656
7	**OTHER**			
	SCAVENGER		38,329	
	SECURITY SERVICE		0	
			0	
			0	38,329
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	14,238	14,238

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		13,041	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	390	
	PHARMACY CONSULTANT	XVIII B 39-2	5,833	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	PSYCHO - SOCIAL		2,417	
			0	21,681
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	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	1,024	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				1,024
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON **#0042283** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	119,669	119,669
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	20,638	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	60,431	
			0	81,069
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,594	
	EMPLOYEE WANT ADS	XIX F	298	
	CONTRIBUTIONS	VI 20 XIX F	2,500	
	DUES & SUBSCRIPTIONS	XIX F	5,513	
	LICENSES & PERMITS	XIX F	3,327	
	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	1,938	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	600	
	PATIENT BACKGROUND CHECKS	XIX F	956	
				22,726
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		11,046	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		430	
	PENALTIES / OVERDRAFT CHARGES	VI 18	126,500	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		24,141	
	MESSENGER SERVICE		0	
			0	162,117

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	176,399	
	UNEMPLOYMENT COMPENSATION	XIX D	120,434	
	WORKERS COMPENSATION INSURANC	XIX D	66,416	
	HOSPITALIZATION INSURANCE	XIX D	19,274	
	EMPLOYEE BENEFITS - OTHER	XIX D	365	
	EMPLOYEE PHYSICAL EXAMS	XIX D	740	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	383,628
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		610	
				610
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,283	
				12,283
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		79,095	
				79,095
27	**OTHER**			
	BAD DEBTS	VI 24	63,119	
				63,119

GRAND TOTAL COLUMN 3 OTHER **1,199,090**

ASTA CARE CTR OF BLOOMINGTON
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	196,308
LESS SALES TAX	(798)
NET FOOD	195,510
TOTAL PATIENT CENSUS	30,103
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	90,309
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	90,309
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	90,309
NET FOOD	195,510
DIVIDE TOTAL MEALS/YEAR	90,309
COST PER MEAL	2.16
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON #0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,837	30,837		30,837	376	31,213			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			157,062	157,062		157,062	(124,307)	32,755			32
33	Real Estate Taxes			48,322	48,322		48,322		48,322			33
34	Rent-Facility & Grounds			538,740	538,740		538,740		538,740			34
35	Rent-Equipment & Vehicles			62,823	62,823		62,823		62,823			35
36	Other (specify):*			1,578	1,578		1,578		1,578			36
37	**TOTAL Ownership**			839,362	839,362		839,362	(123,931)	715,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141,908	465,739	607,647		607,647	(10,810)	596,837			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,228	229,228		229,228		229,228			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		141,908	694,967	836,875		836,875	(10,810)	826,065			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,342,848	607,707	2,733,419	5,683,974		5,683,974	(344,340)	5,339,634			45

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

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	376	30		9
10	Interest and Other Investment Income	(2,614)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(798)	2		13
14	Non-Care Related Interest	(121,693)	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	(126,500)	21		18
19	Entertainment		20		19
20	Contributions	(4,438)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,119)	27		24
25	Fund Raising, Advertising and Promotional	(7,594)	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	(42,788)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (369,168)		$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	24,828		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 24,828		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (344,340)		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 Yes	2 No	3 Amount	4 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 CTR OF BLOOMINGTON

ID# 0042283

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	STAFF TRANSPORTATION - MARKETING	(2,340)	25	2
3	MARKETING SALARY	(23,352)	21	3
4	NON ALLOWABLE PROFESSIONAL FEES	(6,286)	19	4
5	RELATED PARTY THERAPY ADJUSTMENT	(10,810)	39	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**	(42,788)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(798)	0	0	0	0	0	0	0	0	0	0	(798)	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	56	0	0	0	0	0	0	0	0	0	56	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(798)	56	0	0	0	0	0	0	0	0	0	(742)	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	13,477	0	0	0	0	0	0	0	0	0	13,477	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	13,477	0	0	0	0	0	0	0	0	0	13,477	16
	C. General Administration													
17	Administrative	0	(55,552)	0	0	0	0	0	0	0	0	0	(55,552)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,286)	1,874	0	0	0	0	0	0	0	0	0	(4,412)	19
20	Fees, Subscriptions & Promotions	(12,032)	1,023	0	0	0	0	0	0	0	0	0	(11,009)	20
21	Clerical & General Office Expenses	(149,852)	46,453	0	0	0	0	0	0	0	0	0	(103,399)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	130	0	0	0	0	0	0	0	0	0	130	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,340)	9,430	0	0	0	0	0	0	0	0	0	7,090	25
26	Insurance-Prop.Liab.Malpractice	0	205	0	0	0	0	0	0	0	0	0	205	26
27	Other (specify):*	(63,119)	7,732	0	0	0	0	0	0	0	0	0	(55,387)	27
28	**TOTAL General Administration**	(233,629)	11,295	0	0	0	0	0	0	0	0	0	(222,334)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(234,427)	24,828	0	0	0	0	0	0	0	0	0	(209,599)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	376	0	0	0	0	0	0	0	0	0	0	376	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(124,307)	0	0	0	0	0	0	0	0	0	0	(124,307)	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**	(123,931)	0	0	0	0	0	0	0	0	0	0	(123,931)	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	(10,810)	0	0	0	0	0	0	0	0	0	0	(10,810)	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**	(10,810)	0	0	0	0	0	0	0	0	0	0	(10,810)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(369,168)	24,828	0	0	0	0	0	0	0	0	0	(344,340)	45

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL GILLMAN	40	ASTA CARE CENTER OF COLFAX	COLFAX	ASTA		
DARRYLE GILLMAN	30	ASTA CARE CENTER OF ELGIN	ELGIN	HEALTHCARE CO.	ELGIN	MANAGEMENT
ARIEL GLAUBACH	7.5	ASTA CARE CENTER OF FORD COUNTY	PAXTON			
SETH GILLMAN	7.5	ASTA CARE CENTER OF PONTIAC	PONTIAC			
TAMAR MEISELMAN	7.5	ASTA CARE CENTER OF ROCKFORD	ROCKFORD	ASTA THERAPY		THERAPY
ALIZA FRANK	7.5	ASTA CARE CENTER OF TOLUCA	TOLUCA			

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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 119,669	ASTA HEALTHCARE COMPANY, INC.		$	$ (119,669)	1
2	V	6	MAINTENANCE		ASTA HEALTHCARE COMPANY, INC.		56	56	2
3	V	10	NURSING		ASTA HEALTHCARE COMPANY, INC.		13,477	13,477	3
4	V	17	ADMINISTRATIVE		ASTA HEALTHCARE COMPANY, INC.		64,117	64,117	4
5	V	19	PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY, INC.		1,874	1,874	5
6	V	20	LICENSES & PERMITS		ASTA HEALTHCARE COMPANY, INC.		1,023	1,023	6
7	V	21	OFFICE EXPENSE		ASTA HEALTHCARE COMPANY, INC.		46,453	46,453	7
8	V	23	SEMINARS		ASTA HEALTHCARE COMPANY, INC.		130	130	8
9	V	25	STAFF TRANS/TRAVEL		ASTA HEALTHCARE COMPANY, INC.		9,430	9,430	9
10	V	26	GENERAL INSURANCE		ASTA HEALTHCARE COMPANY, INC.		205	205	10
11	V	27	PAYR. TAXES & W/C		ASTA HEALTHCARE COMPANY, INC.		7,732	7,732	11
12	V								12
13	V								13
14	Total			$ 119,669			$ 144,497	$ * 24,828	14

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

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN	PRESIDENT	administrative/	40.00				SALARY	$ 31,939	17-7	1
2			management								2
3	CRAIG FRANK	CFO	finance manage.		SEE	SEE		SALARY	26,748	17-7	3
4					ATTACHED	ATTACHED					4
5	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $105,000				SCHEDULE	SCHEDULE					5
6	MANAGEMENT FEE FROM ASTA CARE OF COLFAX $30,000										6
7											7
8	ALIZA FRANK	PAYROLL CLERK	PAYROLL	7.50				SALARY	5,430	17-7	8
9	DAVID MEISELMAN	THERAPY MGMNT	management					SALARY	35,753	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 99,870		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 CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PATIENT DAYS	188,506	7	$ 353	$	30,103	$ 56	1
2	10	NURSING	PATIENT DAYS	188,506	7	84,392	84,265	30,103	13,477	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	188,506	7	200,000	200,000	30,103	31,939	3
4	17	ADMIN. SALARY -CF	PATIENT DAYS	188,506	7	167,500	167,500	30,103	26,748	4
5	17	ADMIN. SALARY -AF	PATIENT DAYS	188,506	7	34,000	34,000	30,103	5,430	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	188,506	7	11,736		30,103	1,874	6
7	20	LICENSES & PERMITS	PATIENT DAYS	188,506	7	6,406		30,103	1,023	7
8	21	OFFICE EXPENSE	PATIENT DAYS	188,506	7	290,893	229,289	30,103	46,453	8
9	23	SEMINARS	PATIENT DAYS	188,506	7	815		30,103	130	9
10	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	188,506	7	59,054		30,103	9,430	10
11	26	GENERAL INSURANCE	PATIENT DAYS	188,506	7	1,282		30,103	205	11
12	27	PAYR. TAXES & W/C	PATIENT DAYS	188,506	7	48,417		30,103	7,732	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					$ 904,848	$ 715,054		$ 144,497	25

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	ENLOE		X	TRADE PAYABLE FIN	$11,928.00	7/31/2012	627,352	597,166	6/30/2017	5.5000	5,600	6
7			X	INSURANCE POLICIES							1,073	7
8	MEMBERS LOAN	X									2,512	8
9	TOTAL Facility Related				$11,928.00		$ 627,352	$ 597,166			$ 9,185	9
	B. Non-Facility Related*											
10												10
11	Healthcare Family Services			BED TAX INTEREST							25,603	11
12	Bloomington Properties										89,750	12
13	IRS										6,340	13
14	TOTAL Non-Facility Related						$	$			$ 121,693	14
15	TOTALS (line 9+line14)						$ 627,352	$ 597,166			$ 130,878	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

*** 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.)**

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	B. KIRCHENBAUM			WORKING CAPITAL							18,250	6
7	MIDCAP FINANCIAL			L.O.C.		11/29/12		1,119,416	REVOLV	0.0700	7,934	7
8												8
9	TOTAL Facility Related						$	$ 1,119,416			$ 26,184	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,119,416			$ 26,184	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ N/A** **Line # 36**

*** 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.)**

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 39,613	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.)		$ 43,967	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,355	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 43,967	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.		$ 48,322	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	47,308	8
	2008	48,680	9
	2009	50,373	10
	2010	39,613	11
	2011	43,967	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CTR OF BLOOMINGTON COUNTY MCLEAN

FACILITY IDPH LICENSE NUMBER 0042283

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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-32-427-020	NURSING HOME	$ 43,967.48	$ 43,967.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,967.48	$ 43,967.48

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 [x] (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 [x] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF & DOORS			1997	8,588	220	39	220		3,346	9
10	FIRE ALARM CONTROL PANEL			1998	2,880	74	39	74		1,076	10
11	CHECK VALVES INSTALLATION			1998	3,192	82	39	82		1,192	11
12	WATER HEATER			1998	5,965	153	39	153		2,225	12
13	ROOF & DOORS			1999	14,774	537	27.5	537		7,272	13
14	GARAGE			1999	9,320	339	27.5	339		4,591	14
15	FENCE			1999	3,510	234	15	234		3,169	15
16	A/C ROOF UNIT COMPRESSOR			1999	2,314	84	27.5	84		1,138	16
17	VALVES			2000	1,232	44	27.5	44		552	17
18	BUILD IN CHART RACKS			2000	1,980	72	27.5	72		903	18
19	ROOF & DOORS			2000	13,310	484	27.5	484		6,074	19
20	ELECTRICAL WORK			2000	1,600	58	27.5	58		728	20
21	DISPOSAL			2000	1,820	66	27.5	66		828	21
22	ELECTRICAL			2000	1,774	64	27.5	64		803	22
23	WATER LINE			2000	3,100	114	27.5	114		1,429	23
24	CURTAINS			2000	1,679		10			1,679	24
25	CARPETING			2000	4,599		10			4,599	25
26	ELECTRICAL			2001	11,927	434	27.5	434		5,009	26
27	ROOF TOP UNIT			2001	6,886	250	27.5	250		2,886	27
28	FLASHING ON ROOF			2001	5,930	215	27.5	215		2,482	28
29	FENCE			2001	1,722	63	27.5	63		727	29
30	BATHROOM			2001	3,370	123	27.5	123		1,419	30
31	CARPETING			2001	6,671		10			6,671	31
32	TILING			2001	8,363		10			8,363	32
33	PLUMBING			2002	10,533	383	27.5	383		4,038	33
34	TILING			2002	6,761	246	27.5	246		2,593	34
35	ROOF TOP UNIT			2002	6,775	246	27.5	246		2,593	35
36	ROOF TOP HEAT/COOL UNIT			2003	6,950	253	27.5	253		2,414	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

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOOR ALARM SYSTEM	2004	$ 7,077	$ 258	27.5	$ 258	$	$ 2,075	37
38	PTAC HEAT PUMP/COOL	2004	1,440	52	27.5	52		418	38
39	SIDEWALK	2005	6,119	408	15	221	(187)	1,768	39
40	DOOR ALARM	2005	4,523	164	27.5	164		1,210	40
41	NEW VALVE	2005	4,719	171	27.5	171		1,261	41
42	ELECTRICAL WORK	2005	1,661	61	27.5	61		450	42
43	CARPETING	2006	9,844		10	984	984	6,396	43
44	WATER HEATER	2006	9,407	342	27.5	342		2,208	44
45	ROOFTOP HEAT/COOL UNIT	2006	9,114	331	27.5	331		2,138	45
46	SIDEWALK & CONCRETE PAVING	2006	7,695	513	15	513		3,356	46
47	NEW WATER SYSTEM	2007	22,144	805	27.5	805		4,327	47
48	PLUMBING REMODELING FOR DIALYSIS AREA	2007	12,483	454	27.5	454		2,441	48
49	WIRING FOR DIALYSIS ROOM	2007	2,656	97	27.5	97		521	49
50	SIDEWALKS	2007	5,603	374	15	374		2,041	50
51	SIDEWALK	2009	5,675	378	15	378		1,323	51
52	ROOFTOP HEAT/COOL UNIT	2009	12,671	461	27.5	461		1,479	52
53	GUTTERS AND DOWNSPOUTS	2010	24,611	895	27.5	895		2,200	53
54	IN SINK GARBAGE DISPOSAL	2010	2,608	95	27.5	95		233	54
55	HEAT PUMP	2010	2,916	106	27.5	106		261	55
56	A/C COMPRESSOR	2010	2,996	109	27.5	109		268	56
57	PERGO LAMINATE FLOOR	2010	6,500	236	27.5	236		580	57
58	PURIFIED WATER SYSTEM FOR DIALYSIS	2010	9,829	357	27.5	357		878	58
59	HOT WATER HEATER	2010	13,803	502	27.5	502		1,234	59
60	URSES STATIO ROOFTOP UNIT	2010	12,150	442	27.5	442		1,087	60
61	MIXING VALVES	2011	4,400	160	27.5	160		193	61
62	DOOR	2012	3,273	74	27.5	74		74	62
63	ASPHALT	2012	4,299	144	15	144		144	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 367,741	$ 12,827		$ 13,624	$ 797	$ 121,363	70

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

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 163,915	$ 3,648	$ 16,392	$ 12,744	10 YRS	$ 99,193	71
72	Current Year Purchases	23,936	14,362	1,197	(13,165)	10 YRS	1,197	72
73	Fully Depreciated Assets	140,539					140,539	73
74								74
75	TOTALS	$ 328,390	$ 18,010	$ 17,589	$ (421)		$ 240,929	75

D. Vehicle Costs. (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	$ 33,841	$	$	$		$ 33,841	76
77										77
78										78
79										79
80	TOTALS			$ 33,841	$	$	$		$ 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)	$ 729,972	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,837	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 31,213	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 376	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 396,133	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.

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] 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:		117		$ 538,740			3
4	Additions							4
5								5
6								6
7	TOTAL		117		$ 538,740 **			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: *

10. Effective dates of current rental agreement:
    Beginning 1996
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2013	$ 538,740
13.	12/31/2014	$ 538,740
14.	12/31/2015	$ 538,740

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: $ 62,823 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.

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 93,067	$		$ 93,067	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,280			15,280	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			298,895			298,895	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 prescrpts				141,908		141,908	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): I.V. THERAPY					58,497			58,497	13
14	TOTAL			$		$ 465,739	$ 141,908		$ 607,647	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 CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 39,892	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (40,000))	1,676,566		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,739		6
7	Other Prepaid Expenses	30,196		7
8	Accounts Receivable (owners or related parties)	19,855		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,809,248	$	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	336,585		15
16	Equipment, at Historical Cost	393,387		16
17	Accumulated Depreciation (book methods)	(474,368)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	56,818		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,578)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security Deposits	2,109		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 312,953	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,122,201	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 654,233	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,882,284		29
30	Accrued Salaries Payable	131,919		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,512		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,967		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)**	$ 3,735,915	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	804,902		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)**	$ 804,902	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,540,817	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,418,616)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,122,201	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,729,835)	1	
2	Restatements (describe):		2	
3		10,832	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,719,003)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	300,387	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)**	$ 300,387	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)**	$ (2,418,616)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,706,670	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,706,670	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	275,077	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 275,077	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***	2,614	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,614	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)**	$ 5,984,361	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,065,754	31
32	Health Care	1,710,258	32
33	General Administration	1,231,725	33
	B. Capital Expense		
34	Ownership	839,362	34
	C. Ancillary Expense		
35	Special Cost Centers	607,647	35
36	Provider Participation Fee	229,228	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,683,974	40
41	**Income before Income Taxes (line 30 minus line 40)****	300,387	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 300,387	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,023,373	44
45	Private Pay - Net Inpatient Revenue	517,066	45
46	Medicare - Net Inpatient Revenue	1,063,510	46
47	Other-(specify) VETERAN	20,427	47
48	Other-(specify) INSURANCE	82,294	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,706,670	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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 CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,742	1,985	$ 64,739	$ 32.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,779	7,086	149,698	21.13	3
4	Licensed Practical Nurses	18,127	19,109	376,056	19.68	4
5	CNAs & Orderlies	55,014	58,192	662,175	11.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,179	10,083	116,912	11.59	8
9	Activity Director	1,600	1,813	23,667	13.05	9
10	Activity Assistants	5,417	5,738	60,451	10.54	10
11	Social Service Workers	3,732	3,848	56,131	14.59	11
12	Dietician					12
13	Food Service Supervisor	1,918	2,059	36,181	17.57	13
14	Head Cook	8,627	9,230	97,980	10.62	14
15	Cook Helpers/Assistants	13,076	14,875	154,588	10.39	15
16	Dishwashers					16
17	Maintenance Workers	3,905	4,741	69,136	14.58	17
18	Housekeepers	8,213	9,330	87,458	9.37	18
19	Laundry	7,521	8,198	80,845	9.86	19
20	Administrator	1,838	1,998	93,921	47.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,235	9,378	181,068	19.31	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	524	698	6,482	9.29	31
32	Other Health Care(specify)	1,750	1,829	25,360	13.87	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,197	170,190	$ 2,342,848 *	$ 13.77	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,925	1-3	35
36	Medical Director	O	14,238	9-3	36
37	Medical Records Consultant	N	390	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,833	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		1,024	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) PSYCHO - SOCIAL	S	2,417	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,827		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOE AGNELLO	ADMINISTRATOR	0	$ 93,921
	ASST ADMIN		0
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,921

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE MANAGEMENT ,INC	$ 119,669
TOTAL (agree to Schedule V, line 17, col. 3)	$ 119,669
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		81,069
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 81,069

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,416
Unemployment Compensation Insurance	120,434
FICA Taxes	176,399
Employee Health Insurance	19,274
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	365
EMPLOYEE PHYSICAL EXAMS	740
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 383,628

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	298
Health Care Worker Background Check	600
(Indicate # of checks performed 60)	
Patient Background Checks 95	956
TRUST/FRANCHISE/CONTRIB/ETC	4,438
MARKETING/ADV/PROMO	7,594
LICENSES/DUES/SUBSCRIPTIONS	8,840
MGMT CO ALLOC	1,023
TRUST/FRANCHISE/CONTRIB/ETC	(4,438)
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,594)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,717

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ASTA CARE CTR OF BLOOMINGTON **#** 0042283 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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.

(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? **YEA**

(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. $ **24,859** 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. $ **229,228**
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.