

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

<p>I. IDPH License ID Number: <u>0051227</u></p> <p>Facility Name: <u>ASTA CARE CENTER OF COLFAX</u></p> <p>Address: <u>402 SOUTH HARRISON COLFAX 61728</u> <small>Number City Zip Code</small></p> <p>County: <u>MCLEAN</u></p> <p>Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/10/10</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>SANFORD BOKOR</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2013</u> to <u>12/31/2013</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Date) _____ (Type or Print Name) <u>MICHAEL GILLMAN</u> (Title) <u>MEMBER</u> </td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u> </td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>MICHAEL GILLMAN</u> (Title) <u>MEMBER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>MICHAEL GILLMAN</u> (Title) <u>MEMBER</u>							
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>							

Facility Name & ID Number ASTA CARE CENTER OF COLFAX

0051227 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF			895	895	8
9	SNF/PED					9
10	ICF	9,301	3,073	29	12,403	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,301	3,073	924	13,298	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.72%

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 12/01/2010

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

YES Date 12/1/2010 NO

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

YES NO If YES, enter number of beds certified 60 and days of care provided 895

Medicare Intermediary WISCONSIN PHYSICIANS SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

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	184,147	7,551	5,575	197,273		197,273	197,273			1
2	Food Purchase		78,067		78,067		78,067	78,067			2
3	Housekeeping	45,034	7,975		53,009		53,009	53,009			3
4	Laundry	34,888	5,486	891	41,265		41,265	41,265			4
5	Heat and Other Utilities			67,691	67,691		67,691	67,691			5
6	Maintenance	38,260	4,748	18,027	61,035		61,035	61,035			6
7	Other (specify):*			8,809	8,809		8,809	8,809			7
8	TOTAL General Services	302,329	103,827	100,993	507,149		507,149	507,149			8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600	9,600			9
10	Nursing and Medical Records	686,682	56,471	5,290	748,443		748,443	1,974	750,417		10
10a	Therapy	60,895			60,895		60,895		60,895		10a
11	Activities	46,858	1,748		48,606		48,606		48,606		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation			6,529	6,529		6,529		6,529		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	794,435	58,219	21,419	874,073		874,073	1,974	876,047		16
	C. General Administration										
17	Administrative	75,334		30,000	105,334		105,334	27,906	133,240		17
18	Directors Fees										18
19	Professional Services			66,772	66,772		66,772	2,919	69,691		19
20	Dues, Fees, Subscriptions & Promotions			10,832	10,832		10,832	(2,379)	8,453		20
21	Clerical & General Office Expenses	64,714	12,519	38,448	115,681		115,681	(3,186)	112,495		21
22	Employee Benefits & Payroll Taxes			141,587	141,587		141,587		141,587		22
23	Inservice Training & Education			825	825		825		825		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			9,509	9,509		9,509	2,771	12,280		25
26	Insurance-Prop.Liab.Malpractice			23,806	23,806		23,806		23,806		26
27	Other (specify):*			6,653	6,653		6,653	(4,036)	2,617		27
28	TOTAL General Administration	140,048	12,519	328,432	480,999		480,999	23,995	504,994		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,236,812	174,565	450,844	1,862,221		1,862,221	25,969	1,888,190		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,096
	REPAIRS & MAINTENANCE	479
		0
		5,575
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	891
		0
		891
5	HEAT & OTHER UTILITIES	
	GAS HEAT	8,804
	ELECTRICITY	39,291
	WATER	13,307
	CABLE TV - LOBBY	6,289
		0
		67,691
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,820
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,826
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	576
	FIRE SERVICE	3,805
		0
		0
		0
		0
		18,027
7	OTHER	
	SCAVENGER	8,809
	SECURITY SERVICE	0
		0
		0
		8,809
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,600
		9,600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	2,005
	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	0
	PHARMACY CONSULTANT XVIII B 39-2	3,285
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		5,290
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	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		6,529
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	30,000
	DIRECTORS FEES		
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	32,644
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	34,128
			0
			66,772
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,056
	EMPLOYEE WANT ADS	XIX F	2,755
	CONTRIBUTIONS	VI 20 XIX F	35
	DUES & SUBSCRIPTIONS	XIX F	1,328
	LICENSES & PERMITS	XIX F	3,471
	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	500
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	387
	PATIENT BACKGROUND CHECKS	XIX F	300
			10,832
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		12,833
	EQUIPMENT REPAIR & MAINTENANCE		4,227
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	5,849
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		15,539
	MESSENGER SERVICE		0
			0
			38,448

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	92,984
	UNEMPLOYMENT COMPENSATION	XIX D	10,362
	WORKERS COMPENSATION INSURANC	XIX D	37,210
	HOSPITALIZATION INSURANCE	XIX D	0
	EMPLOYEE BENEFITS - OTHER	XIX D	960
	EMPLOYEE PHYSICAL EXAMS	XIX D	71
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
	CHICAGO HEAD TAX	XIX D	0
			0
			141,587
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		825
			825
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		9,509
			9,509
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		23,806
			23,806
27	OTHER		
	BAD DEBTS	VI 24	6,653
			6,653

GRAND TOTAL COLUMN 3 OTHER

450,844

ASTA CARE CENTER OF COLFAX
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	78,067	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	78,067	
TOTAL PATIENT CENSUS	13,298	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	39,894	
ADD # EMPLOYEE MEALS/DAY	0	
TIMES # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	39,894	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	39,894	
NET FOOD	78,067	
DIVIDE TOTAL MEALS/YEAR	<u>39,894</u>	
COST PER MEAL	1.96	
TIMES EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>	

Facility Name & ID Number ASTA CARE CENTER OF COLFAX

#0051227

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			724	724	724		724			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			49,133	49,133	49,133	(13,797)	35,336			32
33	Real Estate Taxes			16,399	16,399	16,399		16,399			33
34	Rent-Facility & Grounds			127,500	127,500	127,500		127,500			34
35	Rent-Equipment & Vehicles			11,909	11,909	11,909		11,909			35
36	Other (specify):* Amortization			10,929	10,929	10,929		10,929			36
37	TOTAL Ownership			216,594	216,594	216,594	(13,797)	202,797			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		31,069	197,828	228,897	228,897	8,007	236,904			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			107,018	107,018	107,018		107,018			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		31,069	304,846	335,915	335,915	8,007	343,922			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,236,812	205,634	972,284	2,414,730	2,414,730	20,179	2,434,909			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 CENTER OF COLFAX

0051227

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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		30		9
10	Interest and Other Investment Income	(8,443)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(5,354)	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	(5,849)	21		18
19	Entertainment		20		19
20	Contributions	(535)	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	(6,653)	27		24
25	Fund Raising, Advertising and Promotional	(2,056)	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	(4,602)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,492)		\$	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)	53,671		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 53,671		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 20,179		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

ASTA CARE CENTER OF COLFAX

ID# 0051227

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	STAFF TRANSPORTATION - MARKETING	\$		1
2	MARKETING SALARY	(12,609)	21	2
3	RELATED PARTY THERAPY ADJUSTMENT	8,007	39	3
4	DISALLOWED PROFESSIONAL FEES			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
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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		(4,602)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF COLFAX# 0051227

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	1,974	0	0	0	0	0	0	0	0	0	1,974	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	1,974	0	0	0	0	0	0	0	0	0	1,974	16
	C. General Administration													
17	Administrative	0	27,906	0	0	0	0	0	0	0	0	0	27,906	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,919	0	0	0	0	0	0	0	0	0	2,919	19
20	Fees, Subscriptions & Promotions	(2,591)	212	0	0	0	0	0	0	0	0	0	(2,379)	20
21	Clerical & General Office Expenses	(18,458)	15,272	0	0	0	0	0	0	0	0	0	(3,186)	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	2,771	0	0	0	0	0	0	0	0	0	2,771	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(6,653)	2,617	0	0	0	0	0	0	0	0	0	(4,036)	27
28	TOTAL General Administration	(27,702)	51,697	0	0	0	0	0	0	0	0	0	23,995	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,702)	53,671	0	0	0	0	0	0	0	0	0	25,969	29

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF COLFAX# 0051227

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,797)	0	0	0	0	0	0	0	0	0	0	(13,797)	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	(13,797)	0	0	0	0	0	0	0	0	0	0	(13,797)	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	8,007	0	0	0	0	0	0	0	0	0	0	8,007	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	8,007	0	0	0	0	0	0	0	0	0	0	8,007	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(33,492)	53,671	0	0	0	0	0	0	0	0	0	20,179	45

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	50	ASTA CARE CENTER OF BLOOMINGTON	BLOOMINGTON	ASTA		
DARYLE GILLMAN	50	ASTA CARE CENTER OF ELGIN	ELGIN	HEALTHCARE CO.	ELGIN	MANAGEMENT
		ASTA CARE CENTER OF FORD COUNTY	PAXTON			
		ASTA CARE CENTER OF PONTIAC	PONTIAC			
		ASTA CARE CENTER OF ROCKFORD	ROCKFORD	ASTA THERAPY		THERAPY
		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. 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	10 NURSING	\$	ASTA HEALTHCARE COMPANY, INC.		\$ 1,974	\$ 1,974	1	
2	V	17 OFFICER'S SALARY -MG		ASTA HEALTHCARE COMPANY, INC.		13,901	13,901	2	
3	V	17 ADMIN. SALARY -CF		ASTA HEALTHCARE COMPANY, INC.		11,642	11,642	3	
4	V	17 ADMIN. SALARY -AF		ASTA HEALTHCARE COMPANY, INC.		2,363	2,363	4	
5	V	19 PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY, INC.		2,919	2,919	5	
6	V	20 LICENSES & PERMITS		ASTA HEALTHCARE COMPANY, INC.		212	212	6	
7	V	21 OFFICE EXPENSE		ASTA HEALTHCARE COMPANY, INC.		15,272	15,272	7	
8	V	25 STAFF TRANS/ TRAVEL		ASTA HEALTHCARE COMPANY, INC.		2,771	2,771	8	
9	V	27 PAYR. TAXES & W/C		ASTA HEALTHCARE COMPANY, INC.		2,617	2,617	9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 53,671	\$ *	53,671	14

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

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 CENTER OF COLFAX # 0051227 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	PRESIDENT	ADMINISTRATIVE					SALARY	\$ 13,901	17-7	1
2			MANAGEMENT	50.00							2
3											3
4	CRAIG FRANK	CFO	FINANCE/MGMT		SEE	SEE		SALARY	11,642	17-7	4
5					ATTACHED	ATTACHED		MGT FEE	30,000	17-3	5
6	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY \$97,500				SCHEDULE	SCHEDULE					6
7											7
8											8
9	DAVID MEISELMAN	THERAPY MGMNT	MANAGEMENT					SALARY	23,036	39-3	9
10											10
11	ALIZA FRANK	PAYROLL CLERK	PAYROLL					SALARY	2,363	17-7	11
12											12
13								TOTAL	\$ 80,942		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 COLFAX

0051227

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

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	
10	NURSING	PATIENT DAYS	191,321	7	\$ 28,405	\$ 28,303	13,298	\$ 1,974	1
17	OFFICER'S SALARY -MG	PATIENT DAYS	191,321	7	200,000	200,000	13,298	13,901	2
17	ADMIN. SALARY -CF	PATIENT DAYS	191,321	7	167,500	167,500	13,298	11,642	3
17	ADMIN. SALARY -AF	PATIENT DAYS	191,321	7	34,000	34,000	13,298	2,363	4
19	PROFESSIONAL FEES	PATIENT DAYS	191,321	7	42,001		13,298	2,919	5
20	LICENSES & PERMITS	PATIENT DAYS	191,321	7	3,043		13,298	212	6
21	OFFICE EXPENSE	PATIENT DAYS	191,321	7	219,718	184,734	13,298	15,272	7
25	STAFF TRANS/ TRAVEL	PATIENT DAYS	191,321	7	39,861		13,298	2,771	8
27	PAYR. TAXES & W/C	PATIENT DAYS	191,321	7	37,656		13,298	2,617	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 772,184	\$ 614,537		\$ 53,671	25

Facility Name & ID Number

ASTA CARE CENTER OF COLFAX

0051227

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6	MIDCAP FINANCIAL		X	LINE OF CREDIT		REVOLV		815,381	REVOLV		41,867	6				
7				INSURANCE POLICIES							1,912	7				
8												8				
9	TOTAL Facility Related						\$	\$ 815,381			\$ 43,779	9				
	B. Non-Facility Related*															
10	IDPA			BED TAX							5,354	10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ 5,354	14				
15	TOTALS (line 9+line14)						\$	\$ 815,381			\$ 49,133	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$	<u>18,463</u>		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.)		\$	<u>17,431</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,032)</u>		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>17,431</u>		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.		\$	<u>16,399</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY	
	2009	_____	9		
	2010	_____	10	13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____ 13
	2011	<u>18,463</u>	11	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14
	2012	<u>17,431</u>	12	15	LESS REFUND FROM LINE 6 \$ _____ 15
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL				16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.					

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.

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 COLFAX

0051227

Report Period Beginning:

01/01/2013 Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	CARPENTRY		2011		3,750	250	15	250		750	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

*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 CENTER OF COLFAX**

0051227

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,750	\$ 250		\$ 250	\$	\$ 750	70

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

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	\$ 4,739	\$ 474	\$ 474	\$	10 yrs	\$ 1,659	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 4,739	\$ 474	\$ 474	\$		\$ 1,659	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 8,489	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 724	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 724	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,409	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: COLFAX HEALTHCARE PROPERTIES

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:		60	12/12/2010	\$ 127,500			3
4	Additions							4
5								5
6								6
7	TOTAL		60		\$ 127,500			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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 11,909 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 CENTER OF COLFAX # 0051227 Report Period Beginning: 01/01/2013 Ending: 12/31/2013
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 60,576	\$		\$ 60,576	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,267			9,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			127,805			127,805	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				31,034		31,034	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology, Lab Other (specify): <u>Medical Supplies</u>					180	35		180 35	13
14	TOTAL			\$		\$ 197,828	\$ 31,069		\$ 228,897	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 COLFAX# 0051227Report Period Beginning: 01/01/2013Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	\$ 18,815	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (11,000))	766,199		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,264		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	952,727		8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	21,354		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,782,359	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,750		14
15	Leasehold Improvements, at Historical Cost	8,739		15
16	Equipment, at Historical Cost	(6,211)		16
17	Accumulated Depreciation (book methods)			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): <u>Option Deposit, Loan Cost</u>	78,603		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 84,881	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,867,240	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 481,123	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	815,381		29
30	Accrued Salaries Payable	51,558		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,665		31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,431		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO RELATED PARTY</u>	647,166		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,017,324	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,929		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)	\$ 6,929	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,024,253	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (157,013)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,867,240	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 88,904	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 88,902	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(245,915)	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)	\$ (245,915)	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)	\$ (157,013)	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,066,747	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,066,747	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	90,907	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 90,907	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***	8,443	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,443	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)	\$ 2,166,097	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	507,149	31
32	Health Care	874,073	32
33	General Administration	480,999	33
B. Capital Expense			
34	Ownership	216,594	34
C. Ancillary Expense			
35	Special Cost Centers	228,897	35
36	Provider Participation Fee	107,018	36
D. Other Expenses (specify):			
37	OUT OF PERIOD EXPENSE ADJUSTMENT	(2,857)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,411,873	40
41	Income before Income Taxes (line 30 minus line 40)**	(245,776)	41
42	Income Taxes	(139)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (245,915)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,086,534	44
45	Private Pay - Net Inpatient Revenue	579,425	45
46	Medicare - Net Inpatient Revenue	372,198	46
47	Other-(specify)		47
48	Other-(specify) INSURANCE	28,590	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,066,747	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 CENTER OF COLFAX

0051227

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,600	2,760	\$ 72,783	\$ 26.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,399	1,639	64,362	39.27	3
4	Licensed Practical Nurses	6,835	7,275	211,292	29.04	4
5	CNAs & Orderlies	27,833	30,873	338,245	10.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,641	3,400	60,895	17.91	8
9	Activity Director	2,630	3,200	33,850	10.58	9
10	Activity Assistants	1,011	1,171	13,008	11.11	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,376	3,651	37,348	10.23	13
14	Head Cook	4,183	4,840	67,888	14.03	14
15	Cook Helpers/Assistants	6,697	7,592	78,911	10.39	15
16	Dishwashers					16
17	Maintenance Workers	1,792	2,152	38,260	17.78	17
18	Housekeepers	3,483	4,178	45,034	10.78	18
19	Laundry	3,144	3,464	34,888	10.07	19
20	Administrator	1,990	2,150	75,334	35.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,051	3,350	64,714	19.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	72,665	81,695	\$ 1,236,812 *	\$ 15.14	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,096	1-3	35
36	Medical Director	O	9,600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,285	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)		\$ 17,981		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>KIM COLBROOK</u>	<u>ADMINISTRATOR</u>		\$ <u>75,334</u>	<u>Workers' Compensation Insurance</u>	\$ <u>37,210</u>	<u>IDPH License Fee</u>	\$ _____	
			<u>0</u>	<u>Unemployment Compensation Insurance</u>	<u>10,362</u>	<u>Advertising: Employee Recruitment</u>	<u>2,755</u>	
			<u>0</u>	<u>FICA Taxes</u>	<u>92,984</u>	<u>Health Care Worker Background Check</u>	<u>387</u>	
				<u>Employee Health Insurance</u>	<u>0</u>	<u>(Indicate # of checks performed <u>38</u>)</u>		
				<u>Employee Meals</u>	<u>0</u>	<u>Patient Background Checks</u>	<u>30</u> <u>300</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	<u>535</u>	
				<u>EMPLOYEE BENEFITS - OTHER</u>	<u>960</u>	<u>MARKETING/ADV/PROMO</u>	<u>2,056</u>	
				<u>EMPLOYEE PHYSICAL EXAMS</u>	<u>71</u>	<u>LICENSES/DUES/SUBSCRIPTIONS</u>	<u>4,799</u>	
				<u>PENSION/PROFIT SHARING PLANS</u>	<u>0</u>	<u>MGMT CO ALLOC</u>	<u>212</u>	
				<u>CHICAGO HEAD TAX</u>	<u>0</u>	<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	<u>(535)</u>	
				<u>INSURANCE - EXECUTIVE LIFE</u>	<u>0</u>	<u>Less: Public Relations Expense</u>	<u>(0)</u>	
				<u>INSURANCE - EXECUTIVE LIFE VI 21</u>	<u>0</u>	<u>Non-allowable advertising</u>	<u>(2,056)</u>	
						<u>Yellow page advertising</u>	<u>(0)</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>75,334</u>	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>141,587</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>8,453</u>	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>CRAIG FRANK</u>			\$ <u>30,000</u>			\$ _____	<u>Out-of-State Travel</u>	\$ _____
							<u>In-State Travel</u>	<u>0</u>
							<u>Seminar Expense</u>	<u>0</u>
							<u>Entertainment Expense</u>	<u>(_____)</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>30,000</u>	TOTAL		\$ _____	TOTAL (agree to Sch. V, line 24, col. 8)	\$ _____
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$ _____					
<u>SEE SCHEDULE ATTACHED</u>			<u>66,772</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>66,772</u>					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTHCARE ASSOC. \$1,180
- (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. \$ 16,127 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. \$ 107,018
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.