

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	117	Skilled (SNF)	117	42,705	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	117	42,705	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,481		2,725	4,206	8
9	SNF/PED					9
10	ICF	19,676	5,299	1,046	26,021	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,157	5,299	3,771	30,227	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.78%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/96 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 24 and days of care provided 2,645

Medicare Intermediary ADMINASTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	252,331	15,996	7,235	275,562		275,562	0	275,562		1
2	Food Purchase		149,789		149,789	0	149,789	(1,561)	148,228		2
3	Housekeeping	130,682	26,835	0	157,517		157,517	0	157,517		3
4	Laundry	52,382	11,890	582	64,854	0	64,854	0	64,854		4
5	Heat and Other Utilities			129,235	129,235		129,235	0	129,235		5
6	Maintenance	62,985	19,645	26,310	108,940		108,940	1,118	110,058		6
7	Other (specify):*			19,922	19,922		19,922	0	19,922		7
8	TOTAL General Services	498,380	224,155	183,284	905,819	0	905,819	(443)	905,376		8
	B. Health Care and Programs										
9	Medical Director	0		10,676	10,676		10,676	0	10,676		9
10	Nursing and Medical Records	994,512	58,888	17,790	1,071,190		1,071,190	435	1,071,625		10
10a	Therapy	43,573		0	43,573		43,573	0	43,573		10a
11	Activities	284,478	8,398	1,152	294,028		294,028	0	294,028		11
12	Social Services	48,924		1,680	50,604		50,604	0	50,604		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			100	100		100	0	100		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,371,487	67,286	31,398	1,470,171	0	1,470,171	435	1,470,606		16
	C. General Administration										
17	Administrative	57,754		0	57,754		57,754	142,037	199,791		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			44,228	44,228		44,228	799	45,027		19
20	Dues, Fees, Subscriptions & Promotions			25,559	25,559		25,559	(8,013)	17,546		20
21	Clerical & General Office Expenses	132,126	25,974	31,984	190,084		190,084	(17,836)	172,248		21
22	Employee Benefits & Payroll Taxes			301,375	301,375	0	301,375	0	301,375		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			1,456	1,456		1,456	221	1,677		24
25	Other Admin. Staff Transportation			3,422	3,422		3,422	2,646	6,068		25
26	Insurance-Prop.Liab.Malpractice			148,881	148,881		148,881	2,186	151,067		26
27	Other (specify):*			30,989	30,989		30,989	(21,634)	9,355		27
28	TOTAL General Administration	189,880	25,974	587,894	803,748	0	803,748	100,406	904,154		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,059,747	317,415	802,576	3,179,738	0	3,179,738	100,398	3,280,136		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	6,513
	REPAIRS & MAINTENANCE	722
		0
		7,235
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	582
		0
		582
5	HEAT & OTHER UTILITIES	
	GAS HEAT	21,717
	ELECTRICITY	62,679
	WATER	35,811
	CABLE TV - LOBBY	9,028
		0
		129,235
6	MAINTENANCE	
	GROUNDS MAINTENANCE	495
	PAINTING & DECORATING	680
	BUILDING REPAIRS	1,059
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	19,980
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,946
	FIRE SERVICE	2,150
		0
		0
		0
		0
		26,310
7	OTHER	
	SCAVENGER	19,309
	SECURITY SERVICE	613
		0
		0
		19,922
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	10,676
		10,676

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	9,238
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	3,216
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	500
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	1,000
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICE	2,808
	RESPIRATORY	1,028
		17,790
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,152
		0
		1,152
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,104
	SOCIAL WORKER XVIII B 45-2	576
		0
		1,680
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	100
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,151
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	28,077
		0
		44,228
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,089
	EMPLOYEE WANT ADS XIX F	7,427
	CONTRIBUTIONS VI 20 XIX F	990
	DUES & SUBSCRIPTIONS XIX F	7,193
	LICENSES & PERMITS XIX F	1,360
	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	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,500
	PATIENT BACKGROUND CHECKS XIX F	0
		25,559
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,468
	EQUIPMENT REPAIR & MAINTENANCE	667
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,725
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	113
	TELEPHONE	21,730
	MESSENGER SERVICE	281
		0
		31,984

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	154,611
	UNEMPLOYMENT COMPENSATION XIX D	42,032
	WORKERS COMPENSATION INSURANC XIX D	53,204
	HOSPITALIZATION INSURANCE XIX D	47,848
	EMPLOYEE BENEFITS - OTHER XIX D	437
	EMPLOYEE PHYSICAL EXAMS XIX D	3,243
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		301,375
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,456
	TRAVEL XIX G	0
		1,456
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,422
		3,422
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	148,881
		148,881
27	OTHER	
	BAD DEBTS VI 24	30,989
		30,989

GRAND TOTAL COLUMN 3 OTHER

802,576

ASTA CARE CENTER OF BLOOMINGTON
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	149,789	PATIENT MEALS	90681
LESS SALES TAX	(1,561)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	148,228	TOTAL MEALS/YEAR	90681
TOTAL PATIENT CENSUS	30,227	NET FOOD	148228
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	90681

TOTAL PATIENT MEALS	90681	COST PER MEAL	1.63
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

ASTA CARE CENTER OF BLOOMINGTON

#0042283

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			29,186	29,186		29,186	2,313	31,499			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			45,242	45,242		45,242	(9,933)	35,309			32
33	Real Estate Taxes			45,017	45,017		45,017	0	45,017			33
34	Rent-Facility & Grounds			538,740	538,740		538,740	0	538,740			34
35	Rent-Equipment & Vehicles			9,464	9,464		9,464	0	9,464			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			667,649	667,649	0	667,649	(7,620)	660,029			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		78,103	137,975	216,078		216,078	0	216,078			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			63,881	63,881		63,881	0	63,881			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	78,103	201,856	279,959	0	279,959	0	279,959			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,059,747	395,518	1,672,081	4,127,346	0	4,127,346	92,778	4,220,124			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	2,313	30		9
10	Interest and Other Investment Income	(123)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,561)	2		13
14	Non-Care Related Interest	(9,810)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(3,725)	21		18
19	Entertainment	0	20		19
20	Contributions	(990)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(229)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,989)	27		24
25	Fund Raising, Advertising and Promotional	(7,089)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(24,704)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,907)		\$ 0	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	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)	169,685		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 169,685		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 92,778		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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

ID# 0042283

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 381	6	1
2	BANK CHARGES	(5,468)	21	2
3	THEFT & DAMAGE	(113)	21	3
4	TRAVEL-MARKETING RELATED	(1,172)	25	4
5	MARKETING SALARY	(18,332)	21	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	(24,704)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,561)	0	0	0	0	0	0	0	0	0	0	(1,561)	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	381	737	0	0	0	0	0	0	0	0	0	1,118	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,180)	737	0	(443)	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	435	0	0	0	0	0	0	0	0	0	435	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	435	0	435	16								
	C. General Administration													
17	Administrative	0	142,037	0	0	0	0	0	0	0	0	0	142,037	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(229)	1,028	0	0	0	0	0	0	0	0	0	799	19
20	Fees, Subscriptions & Promotions	(8,079)	66	0	0	0	0	0	0	0	0	0	(8,013)	20
21	Clerical & General Office Expenses	(27,638)	9,802	0	0	0	0	0	0	0	0	0	(17,836)	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	221	0	0	0	0	0	0	0	0	0	221	24
25	Other Admin. Staff Transportation	(1,172)	3,818	0	0	0	0	0	0	0	0	0	2,646	25
26	Insurance-Prop.Liab.Malpractice	0	2,186	0	0	0	0	0	0	0	0	0	2,186	26
27	Other (specify):*	(30,989)	9,355	0	0	0	0	0	0	0	0	0	(21,634)	27
28	TOTAL General Administration	(68,107)	168,513	0	100,406	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,287)	169,685	0	100,398	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,313	0	0	0	0	0	0	0	0	0	0	2,313	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,933)	0	0	0	0	0	0	0	0	0	0	(9,933)	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	(7,620)	0	0	0	0	0	0	0	0	0	0	(7,620)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(76,907)	169,685	0	92,778	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ASTA HEALTHCARE COMPANY, INC.	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$	ASTA HEALTHCARE COMPANY, INC.		\$		1
2	V	6 MAINTENANCE				737	737	2
3	V	10 NURSING SUPPLIES				435	435	3
4	V	17 ADMINISTRATIVE				142,037	142,037	4
5	V	19 PROFESSIONAL FEES				1,028	1,028	5
6	V	20 LICENSES & PERMITS				66	66	6
7	V	21 OFFICE EXPENSE				9,802	9,802	7
8	V	24 SEMINARS				221	221	8
9	V	25 STAFF TRANS / TRAVEL				3,818	3,818	9
10	V	26 INSURANCE GEN /W/C				2,186	2,186	10
11	V	27 PAYR. TAXES & GRP INS.				9,355	9,355	11
12	V							12
13	V							13
14	Total		\$			169,685	\$ * 169,685	14

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTC # 0042283 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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			40.00				SALARY	\$ 29,574	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$175,000										2
3	SETH GILLMAN			7.50				SALARY	24,502	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986							SALARY	6,926	17-1	4
5	SALARY FROM ASTA CARE OF TOLUCA \$23,088 SALARY FROM ASTA CARE OF BLOOMINGTON \$6,926										5
6	CRAIG FRANK							SALARY	24,502	17-7	6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986										7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$30,014										8
9	DAVID MEISELMAN-TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$141,842							SALARY	23,970	17-7	9
10	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,014										10
11	ALIZA FRANK - TOTAL SALARY RECEIVED FROM				7.50			SALARY	5,506	21-7	11
12	ASTA HEALTHCARE \$32,583										12
13								TOTAL	\$ 114,980		13

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

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 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	178,865	6	\$ 4,363	\$ 30,227	\$ 737	1
2	10	NURSING SUPPLIES	PATIENT DAYS	178,865	6	2,577	30,227	435	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	178,865	6	175,000	175,000	29,574	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	178,865	6	144,986	144,986	24,502	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	178,865	6	144,986	144,986	24,502	5
6	17	ADMIN. SALARY - DM	PATIENT DAYS	178,865	6	141,842	141,842	23,970	6
7	17	ADMIN. SALARY	PATIENT DAYS	178,865	6	233,674	30,227	39,489	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,865	6	6,085	30,227	1,028	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,865	6	389	30,227	66	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,865	6	58,004	32,583	9,802	10
11	24	SEMINARS	PATIENT DAYS	178,865	6	1,310	30,227	221	11
12	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	178,865	6	22,595	30,227	3,818	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,865	6	12,935	30,227	2,186	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,865	6	55,359	30,227	9,355	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,004,105	\$ 639,397	\$ 169,685	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	JPMORGAN CHASE BANK		X	WORKING CAPITAL	INTEREST			258,267	REVOLV	PRIME +	31,800									
7			X	INSURANCE POLICIES							3,632									
8																				
9	TOTAL Facility Related					\$ 0	\$ 258,267				\$ 35,432									
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES																
11			X	BED TAX INTEREST							9,810									
12																				
13																				
14	TOTAL Non-Facility Related					\$ 0	\$ 0				\$ 9,810									
15	TOTALS (line 9+line14)					\$ 0	\$ 258,267				\$ 45,242									

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.

\$ **42,473** 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.)

\$ **43,745** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **1,272** 3

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **43,745** 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.

\$ **45,017** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	38,038	8
	2002	39,873	9
	2003	40,362	10
	2004	42,477	11
	2005	43,745	12

FOR BHF USE ONLY

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

13 FROM R. E. TAX STATEMENT FOR 2005 \$ 13

14 PLUS APPEAL COST FROM LINE 5 \$ 14

15 LESS REFUND FROM LINE 6 \$ 15

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

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.**

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			\$ 0	3

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ROOF & DOORS	1997		8,588	220	39	220		2,026	9
10		FIRE ALARM CONTROL PANEL	1998		2,880	74	39	74		632	10
11		CHECK VALVES INSTALLATION	1998		3,192	82	39	82		700	11
12		WATER HEATER	1998		5,965	153	39	153		1,307	12
13		ROOF & DOORS	1999		14,774	537	27.5	537		4,050	13
14		GARAGE	1999		9,320	339	27.5	339		2,557	14
15		FENCE	1999		3,510	234	15	234		1,765	15
16		A/C ROOF UNIT COMPRESSOR	1999		2,314	84	27.5	84		634	16
17		VALVES	2000		1,232	44	27.5	44		288	17
18		BUILD IN CHART RACKS	2000		1,980	72	27.5	72		471	18
19		ROOF & DOORS	2000		13,310	484	27.5	484		3,170	19
20		ELECTRICAL WORK	2000		1,600	58	27.5	58		380	20
21		DISPOSAL	2000		1,820	66	27.5	66		432	21
22		ELECTRICAL	2000		1,774	64	27.5	64		419	22
23		WATER LINE	2000		3,100	114	27.5	114		745	23
24		CURTAINS	2000		1,679	150	10	168	18	1,098	24
25		CARPETING	2000		4,599	411	10	460	49	2,990	25
26		ELECTRICAL	2001		11,927	434	27.5	434		2,405	26
27		ROOF TOP UNIT	2001		6,886	250	27.5	250		1,386	27
28		FLASHING ON ROOF	2001		5,930	215	27.5	215		1,192	28
29		FENCE	2001		1,722	63	27.5	63		349	29
30		BATHROOM	2001		3,370	123	27.5	123		681	30
31		CARPETING	2001		6,671	384	10	667	283	3,669	31
32		TILING	2001		8,363	481	10	836	355	4,598	32
33		PLUMBING	2002		10,533	383	27.5	383		1,740	33
34		TILING	2002		6,761	246	27.5	246		1,117	34
35		ROOF TOP UNIT	2002		6,775	246	27.5	246		1,117	35
36		ROOF TOP HEAT/COOL UNIT	2003		6,950	253	27.5	253		896	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DOOR ALARM SYSTEM	2004	\$ 7,077	\$ 258	27.5	\$ 258		\$ 527	37
38	PTAC HEAT PUMP/COOL	2004	1,440	52	27.5	52		106	38
39	SIDEWALK	2005	6,119	408	15	221	(187)	442	39
40	DOOR ALARM	2005	4,523	164	27.5	164		226	40
41	NEW VALVE	2005	4,719	171	27.5	171		235	41
42	ELECTRICAL WORK	2005	1,661	61	27.5	61		84	42
43	CARPETING	2006	9,844	1,969	10	492	(1,477)	492	43
44	WATER HEATER	2006	9,407	156	27.5	156		156	44
45	ROOFTOP HEAT/COOL UNIT	2006	9,114	152	27.5	152		152	45
46	SIDEWALK & CONCRETE PAVING	2006	7,695	278	15	278		278	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)		\$ 219,124	\$ 9,933		\$ 8,974	\$ (959)	\$ 45,512	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 217,052	\$ 15,392	\$ 21,560	\$ 6,168	10YR	\$ 122,752	71
72	Current Year Purchases	19,306	3,861	965	(2,896)	10YR	965	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 236,358	\$ 19,253	\$ 22,525	\$ 3,272		\$ 123,717	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMIN, ACTIVITY	1995 FORD	1997	\$ 33,841	\$	\$	\$ 0	5	\$ 33,841	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 33,841	\$ 0	\$ 0	\$ 0		\$ 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)	\$ 489,323	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,186	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,499	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,313	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 203,070	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BLOOMINGTON PROPERTY LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>117</u>		\$ <u>538,740</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>117</u>		\$ <u>538,740</u>			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: _____*

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: \$ 9,464 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		\$ _____	\$ <u>0</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 538,740

13. /2008 \$ 538,740

14. /2009 \$ 538,740

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 24,393	\$		\$ 24,393	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,879			2,879	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			110,670			110,670	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				76,994		76,994	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Supplies	39-3				33	1,109		1,142	13
14	TOTAL			\$		\$ 137,975	\$ 78,103		\$ 216,078	14

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 560	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	933,579		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,180		6
7	Other Prepaid Expenses	23,544		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Real Estate Escrow Dept.</u>	7,244		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,006,107	\$ 0	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	187,968		15
16	Equipment, at Historical Cost	308,591		16
17	Accumulated Depreciation (book methods)	(301,634)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 194,925	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,201,032	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,174,125	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	258,267		29
30	Accrued Salaries Payable	65,031		30
31	Accrued Taxes Payable (excluding real estate taxes)	659		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,745		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,541,827	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	350,000		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)	\$ 350,000	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,891,827	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,690,795)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,201,032	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,587,881)	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)	\$ (1,587,883)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(102,912)	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)	\$ (102,912)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,690,795)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,797,400	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,797,400	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	189,029	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 189,029	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	123	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 123	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Adjustment of prior years exp.</u>	37,882	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 37,882	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,024,434	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	905,819	31
32	Health Care	1,470,171	32
33	General Administration	803,748	33
	B. Capital Expense		
34	Ownership	667,649	34
	C. Ancillary Expense		
35	Special Cost Centers	216,078	35
36	Provider Participation Fee	63,881	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,127,346	40
41	Income before Income Taxes (line 30 minus line 40)**	(102,912)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (102,912)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	2,136	2,185	\$ 56,695	\$ 25.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,371	2,552	53,415	20.93	3
4	Licensed Practical Nurses	20,911	22,779	451,374	19.82	4
5	CNAs & Orderlies	36,624	39,283	404,031	10.29	5
6	CNA Trainees					6
7	Licensed Therapist	1,935	2,082	43,573	20.93	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,687	4,071	60,434	14.85	9
10	Activity Assistants	21,174	22,301	224,044	10.05	10
11	Social Service Workers	3,435	3,760	48,924	13.01	11
12	Dietician					12
13	Food Service Supervisor	2,883	3,281	38,886	11.85	13
14	Head Cook	6,413	7,299	86,508	11.85	14
15	Cook Helpers/Assistants	13,530	14,689	126,937	8.64	15
16	Dishwashers					16
17	Maintenance Workers	3,951	4,448	62,985	14.16	17
18	Housekeepers	13,418	14,589	130,682	8.96	18
19	Laundry	5,378	5,848	52,382	8.96	19
20	Administrator	2,002	2,128	57,754	27.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,988	7,751	132,126	17.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,644	1,842	28,997	15.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,480	160,888	\$ 2,059,747 *	\$ 12.80	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	\$ 6,513	1-3	35
36	Medical Director	O	10,676	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	500	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	1,152	11-3	44
45	Social Service Consultant	E	1,680	12-3	45
46	Other(specify) <u>Psycho - Social</u>	S	3,216	10-3	46
47	<u>Psychiatric</u>		1,000	12-3	47
48	<u>Respiratory</u>		1,028	10-3	48
49	TOTAL (lines 35 - 48)		\$ 25,765		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-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								
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAIN/DECORATING	2000	\$ 15,888	3 YRS	\$ 2,648	\$	\$	\$	\$	\$	\$	\$													
2	PAIN/DECORATING	2001	14,724	3 YRS	4,908	2,454																			
3	PAIN/DECORATING	2003	1,145	3 YRS	382	191	191	381																	
4																									
5																									
6																									
7																									
8																									
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17																									
18																									
19																									
20	TOTALS		\$ 31,757		\$ 7,938	\$ 2,645	\$ 191	\$ 381	\$	\$	\$	\$													

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. \$5920
- (3) Did the nursing home make political contributions or payments to a political action organization? NO 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. \$ _____ 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? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X 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. \$ 63,881
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, 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