

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608 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	<u>52</u>	Skilled (SNF)	<u>52</u>	<u>18,980</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,250</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>102</u>	TOTALS	<u>102</u>	<u>37,230</u>	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	<u>1,477</u>	<u>115</u>	<u>2,337</u>	<u>3,929</u>	8
9	SNF/PED					9
10	ICF	<u>24,813</u>	<u>1,925</u>	<u>910</u>	<u>27,648</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,290</u>	<u>2,040</u>	<u>3,247</u>	<u>31,577</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.82%

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 03/29/96

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

YES Date 03/29/96 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 2,337

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 ELGIN # 0041608 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	245,389	21,770	9,776	276,935		276,935	0	276,935		1
2	Food Purchase		150,831		150,831	0	150,831	(2,359)	148,472		2
3	Housekeeping	247,416	22,897	0	270,313		270,313	0	270,313		3
4	Laundry	67,599	12,338	0	79,937	0	79,937	0	79,937		4
5	Heat and Other Utilities			109,064	109,064		109,064	0	109,064		5
6	Maintenance	44,324	19,663	28,601	92,588		92,588	325	92,913		6
7	Other (specify):*			21,615	21,615		21,615	0	21,615		7
8	TOTAL General Services	604,728	227,499	169,056	1,001,283	0	1,001,283	(2,034)	999,249		8
	B. Health Care and Programs										
9	Medical Director	0		16,250	16,250		16,250	0	16,250		9
10	Nursing and Medical Records	1,235,899	101,227	7,591	1,344,717		1,344,717	455	1,345,172		10
10a	Therapy	131,446	2,413	12,000	145,859		145,859	0	145,859		10a
11	Activities	127,553	14,949	2,853	145,355		145,355	0	145,355		11
12	Social Services	78,550		1,843	80,393		80,393	0	80,393		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			1,468	1,468		1,468	0	1,468		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,573,448	118,589	42,005	1,734,042	0	1,734,042	455	1,734,497		16
	C. General Administration										
17	Administrative	30,014		33,000	63,014		63,014	115,381	178,395		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			45,634	45,634		45,634	1,074	46,708		19
20	Dues, Fees, Subscriptions & Promotions			25,886	25,886		25,886	(15,029)	10,857		20
21	Clerical & General Office Expenses	86,821	26,509	46,552	159,882		159,882	(11,046)	148,836		21
22	Employee Benefits & Payroll Taxes			312,262	312,262	0	312,262	0	312,262		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			1,042	1,042		1,042	231	1,273		24
25	Other Admin. Staff Transportation			1,594	1,594		1,594	3,989	5,583		25
26	Insurance-Prop.Liab.Malpractice			110,922	110,922		110,922	2,284	113,206		26
27	Other (specify):*			58,367	58,367		58,367	(48,594)	9,773		27
28	TOTAL General Administration	116,835	26,509	635,259	778,603	0	778,603	48,290	826,893		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,295,011	372,597	846,320	3,513,928	0	3,513,928	46,711	3,560,639		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	6,160
	REPAIRS & MAINTENANCE	640
	OUTSIDE SERVICES	2,976
		9,776
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	37,901
	ELECTRICITY	37,292
	WATER	32,558
	CABLE TV - LOBBY	1,313
		0
		109,064
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,102
	PAINTING & DECORATING	2,457
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,601
	ELEVATOR MAINTENANCE & REPAIR	3,381
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,399
	FIRE SERVICE	5,661
		0
		0
		0
		0
		28,601
7	OTHER	
	SCAVENGER	21,123
	SECURITY SERVICE	492
		0
		0
		21,615
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	16,250
		16,250

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	60
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	4,476
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,504
	PHARMACY CONSULTANT XVIII B 39-2	551
	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
		0
		7,591
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	12,000
	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
		12,000
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,853
		0
		2,853
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	115
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,152
	SOCIAL WORKER XVIII B 45-2	576
		0
		1,843
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	1,468
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	33,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,073
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	33,561
		0
		45,634
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	14,048
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	1,050
	DUES & SUBSCRIPTIONS XIX F	6,920
	LICENSES & PERMITS XIX F	2,368
	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
		25,886
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,037
	EQUIPMENT REPAIR & MAINTENANCE	622
	OUTSIDE CLERICAL SERVICES	525
	PENALTIES / OVERDRAFT CHARGES VI 18	2,243
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	37,689
	MESSENGER SERVICE	1,436
		0
		46,552

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	173,459
	UNEMPLOYMENT COMPENSATION XIX D	26,928
	WORKERS COMPENSATION INSURANC XIX D	59,104
	HOSPITALIZATION INSURANCE XIX D	46,765
	EMPLOYEE BENEFITS - OTHER XIX D	4,768
	EMPLOYEE PHYSICAL EXAMS XIX D	1,238
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		312,262
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	634
	TRAVEL XIX G	408
		1,042
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,594
		1,594
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	110,922
		110,922
27	OTHER	
	BAD DEBTS VI 24	58,367
		58,367

GRAND TOTAL COLUMN 3 OTHER

846,320

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

TOTAL FOOD PURCHASE	150,831	PATIENT MEALS	94731
LESS SALES TAX	(2,359)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	148,472	TOTAL MEALS/YEAR	94731
TOTAL PATIENT CENSUS	31,577	NET FOOD	148472
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	94731

TOTAL PATIENT MEALS	94731	COST PER MEAL	1.57
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

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			31,004	31,004		31,004	9,886	40,890			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			57,453	57,453		57,453	(5,590)	51,863			32
33	Real Estate Taxes			85,324	85,324		85,324	0	85,324			33
34	Rent-Facility & Grounds			464,280	464,280		464,280	0	464,280			34
35	Rent-Equipment & Vehicles			25,673	25,673		25,673	0	25,673			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			663,734	663,734	0	663,734	4,296	668,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		115,601	110,245	225,846		225,846	0	225,846			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			55,845	55,845		55,845	0	55,845			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	115,601	166,090	281,691	0	281,691	0	281,691			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,295,011	488,198	1,676,144	4,459,353	0	4,459,353	51,007	4,510,360			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	9,886	30		9
10	Interest and Other Investment Income	(4)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,359)	2		13
14	Non-Care Related Interest	(5,586)	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	(2,243)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,050)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,367)	27		24
25	Fund Raising, Advertising and Promotional	(14,048)	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	(19,488)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (93,259)		\$ 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)	144,266		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 144,266		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 51,007		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

ASTA CARE CENTER OF ELGIN

ID# 0041608

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (445)	6	1
2	BANK CHARGES	(4,037)	21	2
3	MARKETING SALARY	(15,006)	21	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
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	(19,488)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608

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	(2,359)	0	0	0	0	0	0	0	0	0	0	(2,359)	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	(445)	770	0	0	0	0	0	0	0	0	0	325	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,804)	770	0	(2,034)	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	455	0	0	0	0	0	0	0	0	0	455	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	455	0	455	16								
	C. General Administration													
17	Administrative	0	115,381	0	0	0	0	0	0	0	0	0	115,381	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,074	0	0	0	0	0	0	0	0	0	1,074	19
20	Fees, Subscriptions & Promotions	(15,098)	69	0	0	0	0	0	0	0	0	0	(15,029)	20
21	Clerical & General Office Expenses	(21,286)	10,240	0	0	0	0	0	0	0	0	0	(11,046)	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	231	0	0	0	0	0	0	0	0	0	231	24
25	Other Admin. Staff Transportation	0	3,989	0	0	0	0	0	0	0	0	0	3,989	25
26	Insurance-Prop.Liab.Malpractice	0	2,284	0	0	0	0	0	0	0	0	0	2,284	26
27	Other (specify):*	(58,367)	9,773	0	0	0	0	0	0	0	0	0	(48,594)	27
28	TOTAL General Administration	(94,751)	143,041	0	48,290	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(97,555)	144,266	0	46,711	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	9,886	0	0	0	0	0	0	0	0	0	0	9,886	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,590)	0	0	0	0	0	0	0	0	0	0	(5,590)	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	4,296	0	0	0	0	0	0	0	0	0	0	4,296	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)	(93,259)	144,266	0	51,007	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		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		HEALTHCARE CO	ELGIN	MANAGEMENT

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEE	\$ 33,000	ASTA HEALTHCARE COMPANY, INC.		\$	(33,000)	1
2	V	6 MAINTENANCE				770	770	2
3	V	10 NURSING SUPPLIES				455	455	3
4	V	17 ADMINISTRATIVE SALARIES				148,381	148,381	4
5	V	19 PROFESSIONAL FEES				1,074	1,074	5
6	V	20 LICENSE & PERMITS				69	69	6
7	V	21 OFFICE EXPENSE				10,240	10,240	7
8	V	24 SEMINARS				231	231	8
9	V	25 STAFF TRANS/ TRAVEL				3,989	3,989	9
10	V	26 INSURANCE GEN & W/C				2,284	2,284	10
11	V	27 PAYR. TAXES & GROUP INS				9,773	9,773	11
12	V							12
13	V							13
14	Total		\$ 33,000			\$ 177,266	\$ * 144,266	14

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	\$ 30,895	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$175,000										2
3	SETH GILLMAN							SALARY	25,596	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986										4
5	SALARY FROM ASTA CARE OF TOLUCA \$23088 SALARY FROM ASTA CARE OF BLOOMINGTON \$6926										5
6	CRAIG FRANK							SALARY	25,596	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							SALARY	25,041	17-7	9
10	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$141,842							SALARY	30,014	17-1	10
11	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,014										11
12	ALIZA FRANK - TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$32,583							SALARY	5,752	21-7	12
13								TOTAL	\$ 142,894		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 ELGIN

0041608

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 COMPANY
 Street Address 134 NORTH MCLEAN BLVD
 City / State / Zip Code ELGIN, IL 60123
 Phone Number (847) 742 - 8822
 Fax Number (847) 742 - 9013

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PATIENT DAYS	178,865	6	\$ 4,363	\$ 31,577	\$ 770	1
2	10	NURSING SUPPLIES	PATIENT DAYS	178,865	6	2,577	31,577	455	2
3	17	OFFICERS SALARY-MG	PATIENT DAYS	178,865	6	175,000	31,577	30,895	3
4	17	OFFICERS SALARY-SETH	PATIENT DAYS	178,865	6	144,986	31,577	25,596	4
5	17	ADMIN. SALARY-CF	PATIENT DAYS	178,865	6	144,986	31,577	25,596	5
6	17	ADMIN. SALARY-DM	PATIENT DAYS	178,865	6	141,842	31,577	25,041	6
7	17	ADMIN. SALARY	PATIENT DAYS	178,865	6	233,674	31,577	41,253	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,865	6	6,085	31,577	1,074	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,865	6	389	31,577	69	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,865	6	58,004	31,577	10,240	10
11	24	SEMINARS	PATIENT DAYS	178,865	6	1,310	31,577	231	11
12	25	STAFF TRANSP/ TRAVEL	PATIENT DAYS	178,865	6	22,595	31,577	3,989	12
13	26	INSURANCE GEN & W/C	PATIENT DAYS	178,865	6	12,935	31,577	2,284	13
14	27	PAYR. TAXES & GROUP INS	PATIENT DAYS	178,865	6	55,359	31,577	9,773	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	\$ 873,071	\$ 177,266	25

Facility Name & ID Number

ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	BANK ONE		X	WORKING CAPITAL	INTEREST	REVOLV	375,000	599,826	REVOLV	PRIME +	47,712	6						
7	WELLS FARGO		X	ALARM SYSTEM	\$614.00	01/20/02	36,870	152	02/20/07	0.0621	1,512	7						
8	INSURANCE		X	INT ON INS POLICIES							2,643	8						
9	TOTAL Facility Related				\$614.00		\$ 411,870	\$ 599,978			\$ 51,867	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11	BED TAX		X	INT ON BED TAX							5,586	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 5,586	14						
15	TOTALS (line 9+line14)						\$ 411,870	\$ 599,978			\$ 57,453	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	75,184	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.)		\$	80,254	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,070	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	80,254	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.		\$	85,324	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	63,122	8
	2002	68,219	9
	2003	71,235	10
	2004	75,184	11
	2005	80,254	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0041608

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-15-176-011</u>	<u>NURSING HOME</u>	\$ <u>73,313.62</u>	\$ <u>73,313.62</u>
2. <u>06-15-176-043</u>	<u>NURSING HOME</u>	\$ <u>931.52</u>	\$ <u>931.52</u>
3. <u>06-15-176-044</u>	<u>NURSING HOME</u>	\$ <u>6,009.14</u>	\$ <u>6,009.14</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>80,254.28</u>	\$ <u>80,254.28</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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 ELGIN

0041608

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		FLOOR DRAIN		1997	1,297	33	39	33		315	9
10		INSTALL SHOWER VALVE AND DRAIN		1997	4,142	105	39	105		1,003	10
11		RE KEY DOOR LOCKS		1997	4,085	104	39	104		993	11
12		NEW AIR VENTS		1997	616	18	39	18		171	12
13		FIRE ALARM SYSTEM		1997	2,192	56	39	56		534	13
14		AWNINGS		1997	1,020	26	39	26		248	14
15		SEWAGE EJECTOR PUMP		1998	3,961	102	39	102		879	15
16		HOT WATER PUMP		1998	5,439	139	39	139		1,141	16
17		AWNINGS		1999	685	25	27.5	25		189	17
18		FLOORING		1999	2,474	90	27.5	90		679	18
19		ELECTRICAL WORK		1999	9,378	341	27.5	341		2,572	19
20		MAGNETIC DOOR LOCKS		1999	2,054	74	27.5	74		558	20
21		FIRE SPRINKLER SYSTEM		1999	3,868	141	27.5	141		1,063	21
22		BOILER		1999	4,890	178	27.5	178		1,342	22
23		NURSE STATION		2000	16,280	592	27.5	592		3,873	23
24		CONDENSING UNIT		2000	4,683	170	27.5	170		1,112	24
25		WATER HEATER		2000	8,731	317	27.5	317		2,074	25
26		POWER VENT FOR WATER HEATER		2000	2,682	98	27.5	98		641	26
27		NEW WALLS		2000	2,000	73	27.5	73		477	27
28		HOT WATER PIPING		2000	4,708	171	27.5	171		1,119	28
29		DRAPERIES		2000	2,303	203	7	256	53	2,303	29
30		EJECTOR PUMP		2001	14,041	511	27.5	511		2,832	30
31		ROOF		2001	6,218	226	27.5	226		1,252	31
32		COMPRESSOR		2001	3,501	127	27.5	127		704	32
33		PRESSURE BACK FLOW PREVENTER		2002	3,870	141	27.5	141		640	33
34		FIRE ALARM SYSTEM		2002	37,625	1,368	27.5	1,368		6,213	34
35		RE KEY LOCKS		2002	1,346	49	27.5	49		223	35
36		PATIENT SECURITY SYSTEM		2002	2,719	99	27.5	99		449	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	WATER HEATER	2002	\$ 4,864	\$ 177	27.5	\$ 177		\$ 804	37
38	NEW PIPE	2002	1,575	57	27.5	57		259	38
39	VINYL FLOORING	2002	17,779	1,434	5	3,555	2,121	17,779	39
40	HANDRAILS,BUMPERS,CORNER	2003	17,903	651	27.5	651		2,306	40
41	SMOKE DAMPERS	2003	1,904	69	27.5	69		244	41
42	DOOR ALARM SYSTEM	2003	3,097	113	27.5	113		400	42
43	SMOKING PORCH	2003	764	28	27.5	28		99	43
44	WALLCOVERINGS & PAINTING	2003	26,197	2,113	5	5,239	3,126	20,956	44
45	DIALYSIS ROOM	2004	23,267	846	27.5	846		2,150	45
46	VALVE ACTUATOR	2004	3,240	118	27.5	118		241	46
47	HOT WATER HEATER	2004	6,837	248	27.5	248		506	47
48	CURTAINS	2005	1,513	484	5	323	(161)	626	48
49	FIRE ALARM SYSTEM	2005	4,026	146	27.5	146		225	49
50	SPRINKLER HEADS	2005	2,530	92	27.5	92		142	50
51	FIRE DOOR	2005	547	20	27.5	20		31	51
52	ASPHALT	2005	6,000	400	15	400		617	52
53	ELEVATOR EMERGENCY STOP SWITCH	2006	1,849	36	27.5	36		36	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 280,700	\$ 12,609		\$ 17,748	\$ 5,139	\$ 83,020	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	\$ 242,742	\$ 14,761	\$ 22,233	\$ 7,472	10 YRS	\$ 156,647	71
72	Current Year Purchases	18,170	3,634	909	(2,725)	10 YRS	909	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 260,912	\$ 18,395	\$ 23,142	\$ 4,747		\$ 157,556	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	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)	\$ 541,612	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,004	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 40,890	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,886	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 240,576	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: ELGIN NURSING HOME PROPERTY

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>102</u>		\$ <u>464,280</u>	<u>30</u>		3
4	Additions						4
5							5
6							6
7	TOTAL	102		\$ 464,280			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: \$ 19,410 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			\$ _____	\$ <u>6,263</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 6,263	21

10. Effective dates of current rental agreement:

Beginning 3/26/96

Ending 3/26/26

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 464,280

13. /2008 \$ 464,280

14. /2009 \$ 464,280

* 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		Contract	Total
		1 Drop-outs	2 Completed		
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	\$		\$ 25,089	\$		\$ 25,089	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,005			5,005	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			73,187			73,187	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs			1,738			1,738	8
9	Pharmacy	39-2	# of prescripts				111,787		111,787	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	radiology, laboratory Other (specify): <u>supplies</u>					5,226	3,814		9,040	13
14	TOTAL			\$		\$ 110,245	\$ 115,601		\$ 225,846	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 ELGIN

0041608

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,804	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	984,831		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,751		6
7	Other Prepaid Expenses	2,019		7
8	Accounts Receivable (owners or related parties)	23,324		8
9	Other(specify): <u>RE ESCROW DEPOSIT</u>	6,025		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,056,754	\$ 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	232,908		15
16	Equipment, at Historical Cost	323,442		16
17	Accumulated Depreciation (book methods)	(327,451)		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>SECURITY DEPOSIT</u>	8,030		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 236,929	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,293,683	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 985,450	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	599,978		29
30	Accrued Salaries Payable	77,273		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,154		31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,254		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)	\$ 1,755,109	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	561,408		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)	\$ 561,408	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,316,517	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,022,834)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,293,683	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (706,670)	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (706,666)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(316,168)	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)	\$ (316,168)	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)	\$ (1,022,834)	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	\$ 3,986,566	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,986,566	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	112,306	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 112,306	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	(497)	12
13	Barber and Beauty Care	537	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)	\$ 40	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>PRIOR YEAR EXPENSE/INC</u>	44,269	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 44,269	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,143,185	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,001,283	31
32	Health Care	1,734,042	32
33	General Administration	778,603	33
	B. Capital Expense		
34	Ownership	663,734	34
	C. Ancillary Expense		
35	Special Cost Centers	225,846	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,459,353	40
41	Income before Income Taxes (line 30 minus line 40)**	(316,168)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (316,168)	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 ELGIN

0041608

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	1,948	2,314	\$ 98,914	\$ 42.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,654	2,894	105,546	36.47	3
4	Licensed Practical Nurses	16,641	17,626	460,136	26.11	4
5	CNAs & Orderlies	43,239	44,011	531,857	12.08	5
6	CNA Trainees					6
7	Licensed Therapist	2,654	2,894	105,446	36.44	7
8	Rehab/Therapy Aides	1,940	2,080	26,000	12.50	8
9	Activity Director	1,947	2,183	35,405	16.22	9
10	Activity Assistants	9,291	10,002	92,148	9.21	10
11	Social Service Workers	3,688	4,028	78,550	19.50	11
12	Dietician					12
13	Food Service Supervisor	1,899	2,190	48,719	22.25	13
14	Head Cook	13,304	14,865	168,456	11.33	14
15	Cook Helpers/Assistants	3,406	3,679	28,214	7.67	15
16	Dishwashers					16
17	Maintenance Workers	2,039	2,263	44,324	19.59	17
18	Housekeepers	23,071	25,322	247,416	9.77	18
19	Laundry	6,361	7,233	67,599	9.35	19
20	Administrator	1,983	2,094	30,014	14.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,615	4,811	86,821	18.05	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	1,948	2,086	39,446	18.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,628	152,575	\$ 2,295,011 *	\$ 15.04	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	\$ 6,160	1-3	35
36	Medical Director	O	16,250	9-3	36
37	Medical Records Consultant	N	1,504	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	551	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	2,853	11-3	44
45	Social Service Consultant	E	1,728	12-3	45
46	Other(specify) <u>psycho social conslt</u>	S	4,476	10-3	46
47	<u>rehab consultant</u>		4,000	10a-3	47
48	<u>psychiatric consultant</u>		1,000	10-3	48
49	TOTAL (lines 35 - 48)		\$ 38,522		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	
DAVID MEISELMAN	ADMINISTRATOR		\$ 30,014	Workers' Compensation Insurance	\$ 59,104	IDPH License Fee	\$ 995	
			0	Unemployment Compensation Insurance	26,928	Advertising: Employee Recruitment	0	
				FICA Taxes	173,459	Health Care Worker Background Check	1,500	
				Employee Health Insurance	46,765	(Indicate # of checks performed <u>184</u>)		
				Employee Meals	0	Patient Background Checks	30	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,050	
				EMPLOYEE BENEFITS - OTHER	4,768	MARKETING/ADV/PROMO	14,048	
				EMPLOYEE PHYSICAL EXAMS	1,238	LICENSES/DUES/SUBSCRIPTIONS	8,293	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	69	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,050)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(14,048)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 30,014	TOTAL (agree to Schedule V, line 22, col.8)	\$ 312,262	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,857	
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
ASTA HEALTHCARE MANAGEMENT INC			\$ 33,000				Out-of-State Travel	\$
							In-State Travel	408
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 33,000				Seminar Expense	634
							MGMT ALLOC	231
C. Professional Services								
Vendor/Payee	Type		Amount					
HEALTH DATA SYSTEMS	DATA PROCESSING		\$ 9,058				Entertainment Expense	()
HEALTH DATA SOLUTIONS	DATA PROCESSING		1,365				(agree to Sch. V, line 24, col. 8)	
ENLOE DRUGS	DATA PROCESSING		1,650				TOTAL	\$ 1,273
KBKB	ACCOUNTING		17,900					
STONE , MCGUIRE & BEN.	LEGAL		10,206					
PERSONNEL PLANNERS	UC CONSULTANT		1,170					
RICHARD PEELO	MEDICARE CST REPORT		2,750					
MICHIGAN PEER REVIEW	EMPLOYMENT CONS.		1,365					
	COLLECTIONS		170					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 45,634	TOTAL		\$		

* 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	Amount of Expense Amortized Per Year								
						FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAIN/DECORATING	2004	\$ 3,049	3 YRS	\$	509	1,016	1,016	508					
2	PAIN/DECORATING	2005	1,757	3 YRS			293	586	586	292				
3	PAIN/DECORATING	2006	2,457	3 YRS				410	819	819	409			
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$ 7,263		\$	509	1,309	2,012	1,913	1,111	409	\$		\$

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC \$6,120
- (3) Did the nursing home make political contributions or payments to a political action organization? _____ If YES, have these costs been properly adjusted out of the cost report? _____
- (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. \$ 9,610 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. \$ 55,845
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