

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	1,634		2,275	3,909	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	21,712	5,541	1,017	28,270	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,346	5,541	3,292	32,179	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.35%

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 2,208

Medicare Intermediary ADMINASTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	257,680	19,253	8,171	285,104		285,104		285,104		1
2	Food Purchase		176,455		176,455		176,455	(2,218)	174,237		2
3	Housekeeping	152,102	28,821		180,923		180,923		180,923		3
4	Laundry	53,212	13,624	823	67,659		67,659		67,659		4
5	Heat and Other Utilities			156,355	156,355		156,355	134	156,489		5
6	Maintenance	51,243	23,899	37,850	112,992		112,992	385	113,377		6
7	Other (specify):*			24,414	24,414		24,414		24,414		7
8	TOTAL General Services	514,237	262,052	227,613	1,003,902		1,003,902	(1,699)	1,002,203		8
	B. Health Care and Programs										
9	Medical Director			12,204	12,204		12,204		12,204		9
10	Nursing and Medical Records	997,173	98,422	18,588	1,114,183		1,114,183	581	1,114,764		10
10a	Therapy	44,558	365		44,923		44,923		44,923		10a
11	Activities	313,978	9,559	600	324,137		324,137		324,137		11
12	Social Services	50,530		1,488	52,018		52,018		52,018		12
13	CNA Training										13
14	Program Transportation			965	965		965		965		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,406,239	108,346	33,845	1,548,430		1,548,430	581	1,549,011		16
	C. General Administration										
17	Administrative	73,604		13,993	87,597		87,597	145,494	233,091		17
18	Directors Fees										18
19	Professional Services			67,912	67,912		67,912	1,183	69,095		19
20	Dues, Fees, Subscriptions & Promotions			42,438	42,438		42,438	(10,639)	31,799		20
21	Clerical & General Office Expenses	161,871	29,166	49,984	241,021		241,021	(28,983)	212,038		21
22	Employee Benefits & Payroll Taxes			294,259	294,259		294,259		294,259		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,457	3,457		3,457	574	4,031		24
25	Other Admin. Staff Transportation			3,554	3,554		3,554	4,184	7,738		25
26	Insurance-Prop.Liab.Malpractice			118,770	118,770		118,770	2,010	120,780		26
27	Other (specify):*			71,869	71,869		71,869	(61,608)	10,261		27
28	TOTAL General Administration	235,475	29,166	666,236	930,877		930,877	52,215	983,092		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,155,951	399,564	927,694	3,483,209		3,483,209	51,097	3,534,306		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	7,276
	REPAIRS & MAINTENANCE	895
		0
		8,171
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	823
		0
		823
5	HEAT & OTHER UTILITIES	
	GAS HEAT	25,141
	ELECTRICITY	87,549
	WATER	34,536
	CABLE TV - LOBBY	9,129
		0
		156,355
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,409
	PAINTING & DECORATING	0
	BUILDING REPAIRS	4,562
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	24,199
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,036
	FIRE SERVICE	4,644
		0
		0
		0
		0
		37,850
7	OTHER	
	SCAVENGER	24,414
	SECURITY SERVICE	0
		0
		0
		24,414
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,204
		12,204

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	14,738
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	3,300
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	550
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		18,588
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY 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	600
		0
		600
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,488
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,488
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	965
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	13,993
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,955
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	54,957
		0
		67,912
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	9,196
	EMPLOYEE WANT ADS XIX F	18,520
	CONTRIBUTIONS VI 20 XIX F	2,400
	DUES & SUBSCRIPTIONS XIX F	8,095
	LICENSES & PERMITS XIX F	2,327
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	900
	PATIENT BACKGROUND CHECKS XIX F	1,000
		42,438
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,925
	EQUIPMENT REPAIR & MAINTENANCE	1,452
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	24,597
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	22,010
	MESSENGER SERVICE	0
		0
		49,984

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	162,432
	UNEMPLOYMENT COMPENSATION XIX D	25,944
	WORKERS COMPENSATION INSURANC XIX D	70,072
	HOSPITALIZATION INSURANCE XIX D	31,858
	EMPLOYEE BENEFITS - OTHER XIX D	1,352
	EMPLOYEE PHYSICAL EXAMS XIX D	2,601
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		294,259
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,457
	TRAVEL XIX G	0
		3,457
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,554
		3,554
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	118,770
		118,770
27	OTHER	
	BAD DEBTS VI 24	71,869
		71,869

GRAND TOTAL COLUMN 3 OTHER

927,694

**ASTA CARE CENTER OF BLOOMINGTON
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	176,455
LESS SALES TAX	<u>(2,218)</u>
NET FOOD	174,237

TOTAL PATIENT CENSUS	32,179
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	96,537

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

PATIENT MEALS	96,537
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	96,537

NET FOOD	174,237
DIVIDE TOTAL MEALS/YEAR	<u>96,537</u>

COST PER MEAL	1.80
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

ASTA CARE CENTER OF BLOOMINGTON

#0042283

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			27,852	27,852		27,852	4,732	32,584			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,290	55,290		55,290	(9,546)	45,744			32
33	Real Estate Taxes			46,219	46,219		46,219		46,219			33
34	Rent-Facility & Grounds			538,741	538,741		538,741		538,741			34
35	Rent-Equipment & Vehicles			9,094	9,094		9,094	554	9,648			35
36	Other (specify):*											36
37	TOTAL Ownership			677,196	677,196		677,196	(4,260)	672,936			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,036	328,624	333,660		333,660		333,660			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,058	64,058		64,058		64,058			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5,036	392,682	397,718		397,718		397,718			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,155,951	404,600	1,997,572	4,558,123		4,558,123	46,837	4,604,960			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,732	30		9
10	Interest and Other Investment Income	(1,526)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,218)	2		13
14	Non-Care Related Interest	(8,020)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(24,597)	21		18
19	Entertainment		20		19
20	Contributions	(2,400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(490)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(71,869)	27		24
25	Fund Raising, Advertising and Promotional	(9,196)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(19,061)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (134,645)		\$	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)	181,482		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 181,482		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 46,837		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3	STAFF TRANSPORTATION - MARKETING	(1,801)	25	3
4	MARKETING SALARY	(17,260)	21	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	(19,061)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(2,218)	0	0	0	0	0	0	0	0	0	0	(2,218)	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	134	0	0	0	0	0	0	0	0	0	134	5
6	Maintenance	0	385	0	0	0	0	0	0	0	0	0	385	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,218)	519	0	(1,699)	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	581	0	0	0	0	0	0	0	0	0	581	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	581	0	581	16								
	C. General Administration													
17	Administrative	0	145,494	0	0	0	0	0	0	0	0	0	145,494	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(490)	1,673	0	0	0	0	0	0	0	0	0	1,183	19
20	Fees, Subscriptions & Promotions	(11,596)	957	0	0	0	0	0	0	0	0	0	(10,639)	20
21	Clerical & General Office Expenses	(41,857)	12,874	0	0	0	0	0	0	0	0	0	(28,983)	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	574	0	0	0	0	0	0	0	0	0	574	24
25	Other Admin. Staff Transportation	(1,801)	5,985	0	0	0	0	0	0	0	0	0	4,184	25
26	Insurance-Prop.Liab.Malpractice	0	2,010	0	0	0	0	0	0	0	0	0	2,010	26
27	Other (specify):*	(71,869)	10,261	0	0	0	0	0	0	0	0	0	(61,608)	27
28	TOTAL General Administration	(127,613)	179,828	0	52,215	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(129,831)	180,928	0	51,097	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	4,732	0	0	0	0	0	0	0	0	0	0	4,732	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,546)	0	0	0	0	0	0	0	0	0	0	(9,546)	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	554	0	0	0	0	0	0	0	0	0	554	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,814)	554	0	(4,260)	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)	(134,645)	181,482	0	46,837	45								

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17 MANAGEMENT FEES	\$ 13,993	ASTA HEALTHCARE COMPANY, INC.		\$	(13,993)	1	
2	V	5 UTILITIES				134	134	2	
3	V	6 MAINTENANCE				385	385	3	
4	V	10 NURSING				581	581	4	
5	V	17 ADMINISTRATIVE				159,487	159,487	5	
6	V	19 PROFESSIONAL FEES				1,673	1,673	6	
7	V	20 LICENSES & PERMITS				957	957	7	
8	V	21 OFFICE EXPENSE				12,874	12,874	8	
9	V	24 SEMINARS				574	574	9	
10	V	25 STAFF TRANS/ TRAVEL				5,985	5,985	10	
11	V	26 INSURANCE GEN / WC				2,010	2,010	11	
12	V	27 PAYR. TAXES & GRP INS				10,261	10,261	12	
13	V	35 EQUIPMENT RENTAL				554	554	13	
14	Total		\$ 13,993			\$ 195,475	\$ *	181,482	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: 01/01/2007 Ending: 12/31/2007

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		LIST	ATTACHED	SALARY	\$ 28,530	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										2
3	SETH GILLMAN			7.50		LIST	ATTACHED	SALARY	28,530	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										4
5	SALARY FROM ASTA CARE OF TOLUCA \$30,097										5
6	CRAIG FRANK					LIST	ATTACHED	SALARY	28,530	17-7	6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$38,397										8
9	DAVID MEISELMAN-TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$153,958					LIST	ATTACHED	SALARY	26,620	17-7	9
10	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,159										10
11	ALIZA FRANK - TOTAL SALARY RECEIVED FROM				7.50	LIST	ATTACHED	SALARY	5,951	21-7	11
12	ASTA HEALTHCARE \$34,417										12
13								TOTAL	\$ 118,161		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:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization ASTA HEALTHCARE
 Street Address 134 N. MCLEAN
 City / State / Zip Code ELGIN, IL 60123
 Phone Number (847)742-8822
 Fax Number (847) 742-9013

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	186,106	6	\$ 773	\$ 32,179	\$ 134	1
2	6	MAINTENANCE	PATIENT DAYS	186,106	6	2,228	32,179	385	2
3	10	NURSING	PATIENT DAYS	186,106	6	3,360	32,179	581	3
4	17	OFFICER'S SALARY -MG	PATIENT DAYS	186,106	6	165,000	32,179	28,530	4
5	17	OFFICER'S SALARY - SETH	PATIENT DAYS	186,106	6	165,000	32,179	28,530	5
6	17	ADMIN. SALARY -CF	PATIENT DAYS	186,106	6	165,000	32,179	28,530	6
7	17	ADMIN. SALARY - DM	PATIENT DAYS	186,106	6	153,958	32,179	26,620	7
8	17	ADMIN. SALARY	PATIENT DAYS	186,106	6	273,426	32,179	47,277	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	186,106	6	9,677	32,179	1,673	9
10	20	LICENSES & PERMITS	PATIENT DAYS	186,106	6	5,535	32,179	957	10
11	21	OFFICE EXPENSE	PATIENT DAYS	186,106	6	74,457	32,179	12,874	11
12	24	SEMINARS	PATIENT DAYS	186,106	6	3,319	32,179	574	12
13	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	186,106	6	34,613	32,179	5,985	13
14	26	INSURANCE GEN / WC	PATIENT DAYS	186,106	6	11,622	32,179	2,010	14
15	27	PAYR. TAXES & GRP INS	PATIENT DAYS	186,106	6	59,344	32,179	10,261	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	186,106	6	3,205	32,179	554	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,130,517	\$ 960,161	\$ 195,475	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										
										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		X	BLOOMINGTON PROPERTIES						22,568	4									
5																			
Working Capital																			
6			L.O.C. CHASE	INTEREST			REVOLV	PRIME +	16,381	6									
7		X	INSURANCE POLICIES						3,062	7									
8			HARRIS	INTEREST					5,259	8									
9	TOTAL Facility Related								47,270	9									
B. Non-Facility Related*																			
10										10									
11		x	BED TAX INTEREST						8,020	11									
12										12									
13										13									
14	TOTAL Non-Facility Related								8,020	14									
15	TOTALS (line 9+line14)								55,290	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 2006 report.	\$	43,745	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.)	\$	44,982	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,237	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	44,982	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.	\$	46,219	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	39,873	8
	2003	40,362	9
	2004	42,477	10
	2005	43,745	11
	2006	44,982	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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 ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		2,246	9
10		FIRE ALARM CONTROL PANEL		1998	2,880	74	39	74		706	10
11		CHECK VALVES INSTALLATION		1998	3,192	82	39	82		782	11
12		WATER HEATER		1998	5,965	153	39	153		1,460	12
13		ROOF & DOORS		1999	14,774	537	27.5	537		4,587	13
14		GARAGE		1999	9,320	339	27.5	339		2,896	14
15		FENCE		1999	3,510	234	15	234		1,999	15
16		A/C ROOF UNIT COMPRESSOR		1999	2,314	84	27.5	84		718	16
17		VALVES		2000	1,232	44	27.5	44		332	17
18		BUILD IN CHART RACKS		2000	1,980	72	27.5	72		543	18
19		ROOF & DOORS		2000	13,310	484	27.5	484		3,654	19
20		ELECTRICAL WORK		2000	1,600	58	27.5	58		438	20
21		DISPOSAL		2000	1,820	66	27.5	66		498	21
22		ELECTRICAL		2000	1,774	64	27.5	64		483	22
23		WATER LINE		2000	3,100	114	27.5	114		859	23
24		CURTAINS		2000	1,679	75	10	168	93	1,266	24
25		CARPETING		2000	4,599	205	10	460	255	3,450	25
26		ELECTRICAL		2001	11,927	434	27.5	434		2,839	26
27		ROOF TOP UNIT		2001	6,886	250	27.5	250		1,636	27
28		FLASHING ON ROOF		2001	5,930	215	27.5	215		1,407	28
29		FENCE		2001	1,722	63	27.5	63		412	29
30		BATHROOM		2001	3,370	123	27.5	123		804	30
31		CARPETING		2001	6,671		10	667	667	4,336	31
32		TILING		2001	8,363		10	836	836	5,434	32
33		PLUMBING		2002	10,533	383	27.5	383		2,123	33
34		TILING		2002	6,761	246	27.5	246		1,363	34
35		ROOF TOP UNIT		2002	6,775	246	27.5	246		1,363	35
36		ROOF TOP HEAT/COOL UNIT		2003	6,950	253	27.5	253		1,149	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		\$ 785	37
38	PTAC HEAT PUMP/COOL	2004	1,440	52	27.5	52		158	38
39	SIDEWALK	2005	6,119	408	15	221	(187)	663	39
40	DOOR ALARM	2005	4,523	164	27.5	164		390	40
41	NEW VALVE	2005	4,719	171	27.5	171		406	41
42	ELECTRICAL WORK	2005	1,661	61	27.5	61		145	42
43	CARPETING	2006	9,844	3,150	10	984	(2,166)	1,476	43
44	WATER HEATER	2006	9,407	342	27.5	342		498	44
45	ROOFTOP HEAT/COOL UNIT	2006	9,114	331	27.5	331		483	45
46	SIDEWALK & CONCRETE PAVING	2006	7,695	513	15	513		791	46
47	NEW WATER SYSTEM	2007	22,144	302	27.5	302		302	47
48	PLUMBING REMODELING FOR DIALYSIS AREA	2007	12,483	171	27.5	171		171	48
49	WIRING FOR DIALYSIS ROOM	2007	2,656	36	27.5	36		36	49
50	SIDEWALKS	2007	5,603	171	15	171		171	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)		\$ 262,010	\$ 11,248		\$ 10,746	\$ (502)	\$ 56,258	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	\$ 228,629	\$ 14,134	\$ 21,221	\$ 7,087	10 YRS	\$ 137,209	71
72	Current Year Purchases	12,342	2,468	617	(1,851)	10YRS	617	72
73	Fully Depreciated Assets	7,729					7,729	73
74								74
75	TOTALS	\$ 248,700	\$ 16,602	\$ 21,838	\$ 5,236		\$ 145,555	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	\$ 2	\$	\$ (2)		\$ 33,841	76
77										77
78										78
79										79
80	TOTALS			\$ 33,841	\$ 2	\$	\$ (2)		\$ 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)	\$ 544,551	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 27,852	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,584	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,732	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 235,654	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>538,741</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>117</u>		\$ <u>538,741</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: \$ 9,094 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			\$ _____	\$ _____	18
19			\$ _____	\$ _____	19
20			\$ _____	\$ _____	20
21	TOTAL		\$ _____	\$ _____	21

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. /2008 \$ 538,740

13. /2009 \$ 538,740

14. /2010 \$ 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	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 76,215	\$		\$ 76,215	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			29,833			29,833	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			123,702			123,702	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts			95,761			95,761	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					3,113	5,036		8,149	13
14	TOTAL			\$		\$ 328,624	\$ 5,036		\$ 333,660	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	911,404		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,243		6
7	Other Prepaid Expenses	5,913		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee loans,adv wage assgn</u>	17,641		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 993,201	\$	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	230,854		15
16	Equipment, at Historical Cost	313,697		16
17	Accumulated Depreciation (book methods)	(322,251)		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)	\$ 222,300	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,215,501	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 822,473	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,739,954		29
30	Accrued Salaries Payable	73,562		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,277		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,982		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)	\$ 2,694,248	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	320,856		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 320,856	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,015,104	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,799,603)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,215,501	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,690,795)	1
2	Restatements (describe):		2
3	POST CLOSING ENTRY-BAD DEBT	18,783	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,672,012)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(127,591)	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)	\$ (127,591)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,799,603)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,016,132	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,016,132	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	312,449	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 312,449	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,526	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,526	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Adjustment of prior years exp.</u>	100,425	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 100,425	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,430,532	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,003,902	31
32	Health Care	1,548,430	32
33	General Administration	930,877	33
	B. Capital Expense		
34	Ownership	677,196	34
	C. Ancillary Expense		
35	Special Cost Centers	333,660	35
36	Provider Participation Fee	64,058	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,558,123	40
41	Income before Income Taxes (line 30 minus line 40)**	(127,591)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (127,591)	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: 01/01/2007

Ending: 12/31/2007

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	1,609	1,729	\$ 45,227	\$ 26.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,820	5,093	110,513	21.70	3
4	Licensed Practical Nurses	18,295	20,145	428,013	21.25	4
5	CNAs & Orderlies	34,250	36,028	384,546	10.67	5
6	CNA Trainees					6
7	Licensed Therapist	1,943	2,054	44,558	21.69	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,672	4,029	73,522	18.25	9
10	Activity Assistants	21,521	23,156	240,456	10.38	10
11	Social Service Workers	3,631	3,883	50,530	13.01	11
12	Dietician					12
13	Food Service Supervisor	2,115	2,363	26,541	11.23	13
14	Head Cook	10,161	11,353	127,499	11.23	14
15	Cook Helpers/Assistants	10,580	11,513	103,640	9.00	15
16	Dishwashers					16
17	Maintenance Workers	2,557	2,941	51,243	17.42	17
18	Housekeepers	14,539	16,069	152,102	9.47	18
19	Laundry	5,087	5,622	53,212	9.46	19
20	Administrator	2,037	2,238	73,604	32.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,049	9,684	161,871	16.72	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	1,707	1,819	28,874	15.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,573	159,719	\$ 2,155,951 *	\$ 13.50	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	\$ 7,276	1-3	35
36	Medical Director	O	12,204	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	550	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	600	11-3	44
45	Social Service Consultant	E	1,488	12-3	45
46	Other(specify)	S			46
47	Psycho - Social		3,300	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,418		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	
LAURA ARBUCKLE	ADMINISTRATOR	0	\$ 73,604	Workers' Compensation Insurance	\$ 70,072	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	25,944	Advertising: Employee Recruitment	18,520	
	OTHER ADMIN		0	FICA Taxes	162,432	Health Care Worker Background Check	900	
				Employee Health Insurance	31,858	(Indicate # of checks performed 90)		
				Employee Meals	0	Patient Background Checks	100	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,400	
				EMPLOYEE BENEFITS - OTHER	1,352	MARKETING/ADV/PROMO	9,196	
				EMPLOYEE PHYSICAL EXAMS	2,601	LICENSES/DUES/SUBSCRIPTIONS	10,422	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	957	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(2,400)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(9,196)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 73,604	TOTAL (agree to Schedule V, line 22, col.8)	\$ 294,259	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 31,799	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
ASTA HEALTHCARE			\$ 13,993				Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 13,993				Seminar Expense	3,457
(Attach a copy of any management service agreement)							MANGEMENT COMP ALLOCATION	574
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
SEE SCHEDULE ATTACHED			67,912					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 67,912					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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.\$6,997
- (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? _____
- (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. \$ 20,000 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 _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 64,058
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees