

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608 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	<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>1,436</u>	<u>154</u>	<u>3,808</u>	<u>5,398</u>	8
9	SNF/PED					9
10	ICF	<u>24,209</u>	<u>2,923</u>	<u>680</u>	<u>27,812</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,645</u>	<u>3,077</u>	<u>4,488</u>	<u>33,210</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.20%

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)

DAYCARE

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 06/29/96 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 3,808

Medicare Intermediary ADMINISTAR 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 ELGIN # 0041608 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				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	259,048	25,422	8,774	293,244		293,244		293,244		1
2	Food Purchase		178,957		178,957		178,957	(3,054)	175,903		2
3	Housekeeping	255,304	19,257		274,561		274,561		274,561		3
4	Laundry	69,716	10,075	3,947	83,738		83,738		83,738		4
5	Heat and Other Utilities			130,803	130,803		130,803	138	130,941		5
6	Maintenance	48,415	20,163	39,713	108,291		108,291	2,311	110,602		6
7	Other (specify):*			24,902	24,902		24,902		24,902		7
8	TOTAL General Services	632,483	253,874	208,139	1,094,496		1,094,496	(605)	1,093,891		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,347,023	122,846	7,768	1,477,637		1,477,637	600	1,478,237		10
10a	Therapy	113,320	2,083	6,413	121,816		121,816		121,816		10a
11	Activities	118,303	28,721	1,668	148,692		148,692		148,692		11
12	Social Services	74,556		384	74,940		74,940		74,940		12
13	CNA Training										13
14	Program Transportation			583	583		583		583		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,653,202	153,650	37,816	1,844,668		1,844,668	600	1,845,268		16
	C. General Administration										
17	Administrative	30,159		99,000	129,159		129,159	65,597	194,756		17
18	Directors Fees										18
19	Professional Services			54,579	54,579		54,579	1,727	56,306		19
20	Dues, Fees, Subscriptions & Promotions			19,202	19,202		19,202	(5,053)	14,149		20
21	Clerical & General Office Expenses	119,094	25,267	48,377	192,738		192,738	(9,272)	183,466		21
22	Employee Benefits & Payroll Taxes			325,611	325,611		325,611		325,611		22
23	Inservice Training & Education										23
24	Travel and Seminar			837	837		837	592	1,429		24
25	Other Admin. Staff Transportation			2,410	2,410		2,410	4,359	6,769		25
26	Insurance-Prop.Liab.Malpractice			111,582	111,582		111,582	2,074	113,656		26
27	Other (specify):*			12,107	12,107		12,107	(1,517)	10,590		27
28	TOTAL General Administration	149,253	25,267	673,705	848,225		848,225	58,507	906,732		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,434,938	432,791	919,660	3,787,389		3,787,389	58,502	3,845,891		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	8,286
	REPAIRS & MAINTENANCE	488
		0
		8,774
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,947
		0
		3,947
5	HEAT & OTHER UTILITIES	
	GAS HEAT	41,384
	ELECTRICITY	48,920
	WATER	38,329
	CABLE TV - LOBBY	2,170
		0
		130,803
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,518
	PAINTING & DECORATING	0
	BUILDING REPAIRS	5,133
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,383
	ELEVATOR MAINTENANCE & REPAIR	3,403
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,375
	FIRE SERVICE	6,901
		0
		0
		0
		0
		39,713
7	OTHER	
	SCAVENGER	24,458
	SECURITY SERVICE	444
		0
		0
		24,902
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	21,000
		21,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	963
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	4,776
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,579
	PHARMACY CONSULTANT XVIII B 39-2	450
	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
		7,768
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	413
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	6,000
	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
		6,413
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,668
		0
		1,668
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	192
	SOCIAL WORKER XVIII B 45-2	192
		0
		384
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	583
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	99,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	15,435
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	39,144
		0
		54,579
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,311
	EMPLOYEE WANT ADS XIX F	1,459
	CONTRIBUTIONS VI 20 XIX F	2,730
	DUES & SUBSCRIPTIONS XIX F	7,109
	LICENSES & PERMITS XIX F	2,693
	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	800
	PATIENT BACKGROUND CHECKS XIX F	1,100
		19,202
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,000
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	1,850
	PENALTIES / OVERDRAFT CHARGES VI 18	3,310
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	37,537
	MESSENGER SERVICE	2,680
		0
		48,377

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	185,069
	UNEMPLOYMENT COMPENSATION XIX D	27,463
	WORKERS COMPENSATION INSURANC XIX D	71,589
	HOSPITALIZATION INSURANCE XIX D	39,976
	EMPLOYEE BENEFITS - OTHER XIX D	564
	EMPLOYEE PHYSICAL EXAMS XIX D	950
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		325,611
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	837
	TRAVEL XIX G	0
		837
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,410
		2,410
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	111,582
		111,582
27	OTHER	
	BAD DEBTS VI 24	12,107
		12,107

GRAND TOTAL COLUMN 3 OTHER

919,660

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

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

TOTAL FOOD PURCHASE	178,957
LESS SALES TAX	<u>(3,054)</u>
NET FOOD	175,903

TOTAL PATIENT CENSUS	33,210
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	99,630

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

PATIENT MEALS	99,630
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	99,630

NET FOOD	175,903
DIVIDE TOTAL MEALS/YEAR	<u>99,630</u>

COST PER MEAL	1.77
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number

ASTA CARE CENTER OF ELGIN

#0041608

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			29,065	29,065		29,065	6,193	35,258			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			94,333	94,333		94,333	(9,607)	84,726			32
33	Real Estate Taxes			88,610	88,610		88,610		88,610			33
34	Rent-Facility & Grounds			464,280	464,280		464,280		464,280			34
35	Rent-Equipment & Vehicles			17,808	17,808		17,808	572	18,380			35
36	Other (specify):*											36
37	TOTAL Ownership			694,096	694,096		694,096	(2,842)	691,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		187,437	177,968	365,405		365,405		365,405			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		187,437	233,813	421,250		421,250		421,250			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,434,938	620,228	1,847,569	4,902,735		4,902,735	55,660	4,958,395			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	6,193	30		9
10	Interest and Other Investment Income	(3,980)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,054)	2		13
14	Non-Care Related Interest	(5,627)	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	(3,310)	21		18
19	Entertainment		20		19
20	Contributions	(2,730)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,107)	27		24
25	Fund Raising, Advertising and Promotional	(3,311)	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	(19,154)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,080)		\$	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)	102,740		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 102,740		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 55,660		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,913	6	1
2	STAFF TRANSPORTATION - MARKETING	(1,818)	25	2
3	MARKETING SALARIES	(19,249)	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	(19,154)		49

STATE OF ILLINOIS

Summary A

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

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	(3,054)	0	0	0	0	0	0	0	0	0	0	(3,054)	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	138	0	0	0	0	0	0	0	0	0	138	5
6	Maintenance	1,913	398	0	0	0	0	0	0	0	0	0	2,311	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,141)	536	0	(605)	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	600	0	0	0	0	0	0	0	0	0	600	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	600	0	600	16								
	C. General Administration													
17	Administrative	0	65,597	0	0	0	0	0	0	0	0	0	65,597	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,727	0	0	0	0	0	0	0	0	0	1,727	19
20	Fees, Subscriptions & Promotions	(6,041)	988	0	0	0	0	0	0	0	0	0	(5,053)	20
21	Clerical & General Office Expenses	(22,559)	13,287	0	0	0	0	0	0	0	0	0	(9,272)	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	592	0	0	0	0	0	0	0	0	0	592	24
25	Other Admin. Staff Transportation	(1,818)	6,177	0	0	0	0	0	0	0	0	0	4,359	25
26	Insurance-Prop.Liab.Malpractice	0	2,074	0	0	0	0	0	0	0	0	0	2,074	26
27	Other (specify):*	(12,107)	10,590	0	0	0	0	0	0	0	0	0	(1,517)	27
28	TOTAL General Administration	(42,525)	101,032	0	58,507	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,666)	102,168	0	58,502	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	6,193	0	0	0	0	0	0	0	0	0	0	6,193	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,607)	0	0	0	0	0	0	0	0	0	0	(9,607)	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	572	0	0	0	0	0	0	0	0	0	572	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,414)	572	0	(2,842)	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)	(47,080)	102,740	0	55,660	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 CO.	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEE	\$ 99,000	ASTA HEALTHCARE COMPANY, INC.		\$	(99,000)	1
2	V	5 UTILITIES				138	138	2
3	V	6 MAINTENANCE				398	398	3
4	V	10 NURSING				600	600	4
5	V	17 ADMINISTRATIVE				164,597	164,597	5
6	V	19 PROFESSIONAL FEES				1,727	1,727	6
7	V	20 LICENSES & PERMITS				988	988	7
8	V	21 OFFICE EXPENSE				13,287	13,287	8
9	V	24 SEMINARS				592	592	9
10	V	25 STAFF TRANS/ TRAVEL				6,177	6,177	10
11	V	26 INSURANCE GEN / WC				2,074	2,074	11
12	V	27 PAYR. TAXES & GRP INS				10,590	10,590	12
13	V	35 EQUIPMENT RENTAL				572	572	13
14	Total		\$ 99,000			\$ 201,740	\$ * 102,740	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: 01/01/2007 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	\$ 29,444	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										2
3	SETH GILLMAN			7.50		LIST	ATTACHED	SALARY	29,444	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	29,444	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	27,473	17-7	9
10	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,159							SALARY	30,159	17-1	10
11	ALIZA FRANK - TOTAL SALARY RECEIVED FROM			7.50		LIST	ATTACHED	SALARY	6,142	21-7	11
12	ASTA HEALTHCARE \$34,417										12
13								TOTAL	\$ 152,106		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:

01/01/2007

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 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	5	UTILITIES	PATIENT DAYS	186,106	6	\$ 773	\$ 33,210	\$ 138	1
2	6	MAINTENANCE	PATIENT DAYS	186,106	6	2,228	33,210	398	2
3	10	NURSING	PATIENT DAYS	186,106	6	3,360	33,210	600	3
4	17	OFFICER'S SALARY -MG	PATIENT DAYS	186,106	6	165,000	33,210	29,444	4
5	17	OFFICER'S SALARY - SETH	PATIENT DAYS	186,106	6	165,000	33,210	29,444	5
6	17	ADMIN. SALARY -CF	PATIENT DAYS	186,106	6	165,000	33,210	29,444	6
7	17	ADMIN. SALARY - DM	PATIENT DAYS	186,106	6	153,958	33,210	27,473	7
8	17	ADMIN. SALARY	PATIENT DAYS	186,106	6	273,426	33,210	48,792	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	186,106	6	9,677	33,210	1,727	9
10	20	LICENSES & PERMITS	PATIENT DAYS	186,106	6	5,535	33,210	988	10
11	21	OFFICE EXPENSE	PATIENT DAYS	186,106	6	74,457	33,210	13,287	11
12	24	SEMINARS	PATIENT DAYS	186,106	6	3,319	33,210	592	12
13	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	186,106	6	34,613	33,210	6,177	13
14	26	INSURANCE GEN / WC	PATIENT DAYS	186,106	6	11,622	33,210	2,074	14
15	27	PAYR. TAXES & GRP INS	PATIENT DAYS	186,106	6	59,344	33,210	10,590	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	186,106	6	3,205	33,210	572	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,130,517	\$ 960,161	\$ 201,740	25

Facility Name & ID Number

ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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							\$	\$				\$						
2																		
3	ELGIN NURSING HOME PROP.		X									24,660						
4																		
5																		
	Working Capital																	
6	FIRST CHICAGO BANK		X	WORKING CAPITAL	INTEREST	REVOLV		594,933	REVOLV	PRIME+		55,943						
7	HARRIS BANK		X	WORKING CAPITAL								5,259						
8	INSURANCE		X	INT ON INS POLICIES								2,844						
9	TOTAL Facility Related						\$	594,933			\$	88,706						
	B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES														
11	BED TAX		X	INT ON BED TAX								5,586						
12	ILL DEPT OF EMPL SECUR		X									41						
13	MISC																	
14	TOTAL Non-Facility Related						\$				\$	5,627						
15	TOTALS (line 9+line14)						\$	594,933			\$	94,333						

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.	\$	80,254	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.)	\$	84,432	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,178	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	84,432	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.	\$	88,610	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	68,219	8
	2003	71,235	9
	2004	75,184	10
	2005	80,254	11
	2006	84,432	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>77,130.42</u>	\$ <u>77,130.42</u>
2. <u>06-15-176-043</u>	<u>NURSING HOME</u>	\$ <u>980.02</u>	\$ <u>980.02</u>
3. <u>06-15-176-044</u>	<u>NURSING HOME</u>	\$ <u>6,322.00</u>	\$ <u>6,322.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>84,432.44</u>	\$ <u>84,432.44</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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 ELGIN# 0041608

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		FLOOR DRAIN		1997	1,297	33	39	33		348	9
10		INSTALL SHOWER VALVE AND DRAIN		1997	4,142	105	39	105		1,108	10
11		RE KEY DOOR LOCKS		1997	4,085	104	39	104		1,097	11
12		NEW AIR VENTS		1997	616	18	39	18		189	12
13		FIRE ALARM SYSTEM		1997	2,192	56	39	56		590	13
14		AWNINGS		1997	1,020	26	39	26		274	14
15		SEWAGE EJECTOR PUMP		1998	3,961	102	39	102		981	15
16		HOT WATER PUMP		1998	5,439	139	39	139		1,280	16
17		AWNINGS		1999	685	25	27.5	25		214	17
18		FLOORING		1999	2,474	90	27.5	90		769	18
19		ELECTRICAL WORK		1999	9,378	341	27.5	341		2,913	19
20		MAGNETIC DOOR LOCKS		1999	2,054	74	27.5	74		632	20
21		FIRE SPRINKLER SYSTEM		1999	3,868	141	27.5	141		1,204	21
22		BOILER		1999	4,890	178	27.5	178		1,520	22
23		NURSE STATION		2000	16,280	592	27.5	592		4,465	23
24		CONDENSING UNIT		2000	4,683	170	27.5	170		1,282	24
25		WATER HEATER		2000	8,731	317	27.5	317		2,391	25
26		POWER VENT FOR WATER HEATER		2000	2,682	98	27.5	98		739	26
27		NEW WALLS		2000	2,000	73	27.5	73		550	27
28		HOT WATER PIPING		2000	4,708	171	27.5	171		1,290	28
29		DRAPERIES		2000	2,303	53	7		(53)	2,303	29
30		EJECTOR PUMP		2001	14,041	511	27.5	511		3,343	30
31		ROOF		2001	6,218	226	27.5	226		1,478	31
32		COMPRESSOR		2001	3,501	127	27.5	127		831	32
33		PRESSURE BACK FLOW PREVENTER		2002	3,870	141	27.5	141		781	33
34		FIRE ALARM SYSTEM		2002	37,625	1,368	27.5	1,368		7,581	34
35		RE KEY LOCKS		2002	1,346	49	27.5	49		272	35
36		PATIENT SECURITY SYSTEM		2002	2,719	99	27.5	99		548	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.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

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	
	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		\$ 981	37
38	NEW PIPE	2002	1,575	57	27.5	57		316	38
39	VINYL FLOORING	2002	17,779	717	5		(717)	17,779	39
40	HANDRAILS,BUMPERS,CORNER	2003	17,903	651	27.5	651		2,957	40
41	SMOKE DAMPERS	2003	1,904	69	27.5	69		313	41
42	DOOR ALARM SYSTEM	2003	3,097	113	27.5	113		513	42
43	SMOKING PORCH	2003	764	28	27.5	28		127	43
44	WALLCOVERINGS & PAINTING	2003	26,197	2,113	5	5,241	3,128	26,197	44
45	DIALYSIS ROOM	2004	23,267	846	27.5	846		2,996	45
46	VALVE ACTUATOR	2004	3,240	118	27.5	118		359	46
47	HOT WATER HEATER	2004	6,837	248	27.5	248		754	47
48	CURTAINS	2005	1,513	290	5	323	33	949	48
49	FIRE ALARM SYSTEM	2005	4,026	146	27.5	146		371	49
50	SPRINKLER HEADS	2005	2,530	92	27.5	92		234	50
51	FIRE DOOR	2005	547	20	27.5	20		51	51
52	ASPHALT	2005	6,000	400	15	400		1,017	52
53	ELEVATOR EMERGENCY STOP SWITCH	2006	1,849	67	27.5	67		103	53
54	PARKING LOT	2007	26,200	801	15	801		801	54
55	BOILER	2007	4,245	71	27.5	71		71	55
56	WATER HEATER	2007	6,453	107	27.5	107		107	56
57	NURSE CALL SYSTEM	2007	2,536	42	27.5	42		42	57
58	A/C CONDENSER	2007	5,928	99	27.5	99		99	58
59	5 TON A/C	2007	3,000	50	27.5	50		50	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)		\$ 329,062	\$ 12,749		\$ 15,140	\$ 2,391	\$ 98,160	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	\$ 220,084	\$ 14,662	\$ 19,704	\$ 5,042		\$ 177,260	71
72	Current Year Purchases	8,272	1,654	414	(1,240)		414	72
73	Fully Depreciated Assets	40,828						73
74								74
75	TOTALS	\$ 269,184	\$ 16,316	\$ 20,118	\$ 3,802		\$ 177,674	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 598,246	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,065	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,258	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,193	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 275,834	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: \$ 17,808 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 \$ 464,280

13. /2009 \$ 464,280

14. /2010 \$ _____

* 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	\$		\$ 37,897	\$		\$ 37,897	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,591			6,591	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			129,340			129,340	4
5	Physician Care	39-3	visits			1,052			1,052	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				169,055		169,055	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	supplies, radiology, laboratory, Other (specify): <u>inhalation therapy</u>	39-2				3,088	18,382		21,470	13
14	TOTAL			\$		\$ 177,968	\$ 187,437		\$ 365,405	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: 01/01/2007

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	\$ 5,748	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	789,330		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,502		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	405,267		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,295,847	\$	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	281,270		15
16	Equipment, at Historical Cost	316,976		16
17	Accumulated Depreciation (book methods)	(341,779)		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): SECURITY DEPOSIT	13,773		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 270,240	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,566,087	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,028,089	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	773,780		29
30	Accrued Salaries Payable	83,601		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,102		31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,432		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)	\$ 1,983,004	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	MEMBERS LOANS	532,264		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 532,264	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,515,268	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (949,181)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,566,087	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,022,834)	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,022,833)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	73,652	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)	\$ 73,652	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)	\$ (949,181)	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	\$ 4,665,661	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,665,661	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	213,833	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 213,833	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***	3,980	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,980	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR INC ADJUSTMENT	92,913	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 92,913	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,976,387	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,094,496	31
32	Health Care	1,844,668	32
33	General Administration	848,225	33
	B. Capital Expense		
34	Ownership	694,096	34
	C. Ancillary Expense		
35	Special Cost Centers	365,405	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,902,735	40
41	Income before Income Taxes (line 30 minus line 40)**	73,652	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 73,652	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: 01/01/2007

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	1,793	1,954	\$ 98,581	\$ 50.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,848	3,103	156,574	50.46	3
4	Licensed Practical Nurses	15,869	17,259	469,387	27.20	4
5	CNAs & Orderlies	42,627	46,476	580,944	12.50	5
6	CNA Trainees					6
7	Licensed Therapist	7,019	4,031	95,374	23.66	7
8	Rehab/Therapy Aides	1,208	1,436	17,946	12.50	8
9	Activity Director	2,013	2,281	38,818	17.02	9
10	Activity Assistants	7,971	8,652	79,485	9.19	10
11	Social Service Workers	3,357	3,607	74,556	20.67	11
12	Dietician					12
13	Food Service Supervisor	2,010	2,211	50,478	22.83	13
14	Head Cook	13,216	14,743	175,603	11.91	14
15	Cook Helpers/Assistants	3,787	4,109	32,967	8.02	15
16	Dishwashers					16
17	Maintenance Workers	2,045	2,319	48,415	20.88	17
18	Housekeepers	22,258	24,969	255,304	10.22	18
19	Laundry	6,407	7,145	69,716	9.76	19
20	Administrator	2,085	2,081	30,159	14.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,640	1,757	45,475	25.88	23
24	Clerical	3,658	4,097	73,619	17.97	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	1,938	2,139	41,537	19.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,749	154,369	\$ 2,434,938 *	\$ 15.77	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	\$ 8,286	1-3	35
36	Medical Director	O	21,000	9-3	36
37	Medical Records Consultant	N	1,579	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	450	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,668	11-3	44
45	Social Service Consultant	E	384	12-3	45
46	Other(specify) <u>Rehab Consultant</u>	S	6,000	10a-3	46
47	<u>Psycho-social consultant</u>		4,776	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,143		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		\$ 30,159	Workers' Compensation Insurance	\$ 71,589	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	27,463	Advertising: Employee Recruitment	1,459	
			0	FICA Taxes	185,069	Health Care Worker Background Check	800	
				Employee Health Insurance	39,976	(Indicate # of checks performed <u>80</u>)		
				Employee Meals	0	Patient Background Checks	110	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,730	
				EMPLOYEE BENEFITS - OTHER	564	MARKETING/ADV/PROMO	3,311	
				EMPLOYEE PHYSICAL EXAMS	950	LICENSES/DUES/SUBSCRIPTIONS	9,802	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	988	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(2,730)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(3,311)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 30,159	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 325,611		\$ 14,149		
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.			\$ 99,000			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 99,000				Seminar Expense	837
							MANGEMENT COMP ALLOCATION	592
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 1,429
SEE SCHEDULE ATTACHED			54,579					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 54,579	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								
																	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
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																									
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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: 01/01/2007

Ending: 12/31/2007

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. ILLINOIS HEALTHCARE ASSOC. \$6,630
- (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. \$ 9,722 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 \$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