

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	69	Skilled (SNF)	69	25,185	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	69	TOTALS	69	25,185	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	6,475	1,787	1,355	9,617	8
9	SNF/PED					9
10	ICF	7,914	1,191		9,105	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,389	2,978	1,355	18,722	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.34%

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 07/01/02

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/02/02 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 17 and days of care provided 1,294

Medicare Intermediary ADMINISTAR OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	157,847	2,456	5,941	166,244		166,244		166,244		1
2	Food Purchase		106,795		106,795		106,795	(1,092)	105,703		2
3	Housekeeping	135,308	12,983		148,291		148,291		148,291		3
4	Laundry		3,002		3,002		3,002		3,002		4
5	Heat and Other Utilities			82,856	82,856		82,856		82,856		5
6	Maintenance	29,659	7,523	19,573	56,755		56,755		56,755		6
7	Other (specify):*			4,177	4,177		4,177		4,177		7
8	TOTAL General Services	322,814	132,759	112,547	568,120		568,120	(1,092)	567,028		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	710,344	74,037	70,660	855,041		855,041		855,041		10
10a	Therapy		572		572		572		572		10a
11	Activities	44,078	6,473	1,284	51,835		51,835		51,835		11
12	Social Services	19,522		1,588	21,110		21,110		21,110		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	773,944	81,082	79,532	934,558		934,558		934,558		16
	C. General Administration										
17	Administrative	27,788		71,068	98,856		98,856	17,123	115,979		17
18	Directors Fees										18
19	Professional Services			37,409	37,409		37,409	680	38,089		19
20	Dues, Fees, Subscriptions & Promotions			16,883	16,883		16,883	(2,720)	14,163		20
21	Clerical & General Office Expenses	66,941	12,956	24,702	104,599		104,599	(10,539)	94,060		21
22	Employee Benefits & Payroll Taxes			209,446	209,446		209,446		209,446		22
23	Inservice Training & Education										23
24	Travel and Seminar			188	188		188		188		24
25	Other Admin. Staff Transportation			4,926	4,926		4,926	2,629	7,555		25
26	Insurance-Prop.Liab.Malpractice			66,965	66,965		66,965	420	67,385		26
27	Other (specify):*			498	498		498	5,224	5,722		27
28	TOTAL General Administration	94,729	12,956	432,085	539,770		539,770	12,817	552,587		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,191,487	226,797	624,164	2,042,448		2,042,448	11,725	2,054,173		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	4,565
	REPAIRS & MAINTENANCE		1,376
			0
			5,941
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		23,463
	ELECTRICITY		28,502
	WATER		30,389
	CABLE TV - LOBBY		502
			0
			82,856
6	MAINTENANCE		
	GROUNDS MAINTENANCE		7,304
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		6,086
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		1,400
	FIRE SERVICE		4,783
			0
			0
			0
			19,573
7	OTHER		
	SCAVENGER		4,177
	SECURITY SERVICE		0
			4,177
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000
			6,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	48,691
	LABORATORY & XRAY EXPENSE		30
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	1,224
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	1,387
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	3,100
	PSYCHIATRIC	XVIII B __-2	11,465
	RN CONSULTANT	XVIII B 38-2	0
	PROGRAM CONSULTANT		3,150
	DENTAL SERVICES		1,613
			70,660
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,284
			0
			1,284
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,588
	SOCIAL WORKER	XVIII B 45-2	0
			0
			1,588
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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	71,068
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	9,590
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	27,819
		0
		37,409
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,425
	EMPLOYEE WANT ADS XIX F	6,532
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	3,666
	LICENSES & PERMITS XIX F	1,945
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	62
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,253
		16,883
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,315
	EQUIPMENT REPAIR & MAINTENANCE	2,590
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	5,330
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	37
	TELEPHONE	14,430
	MESSENGER SERVICE	0
		0
		24,702

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	89,256
	UNEMPLOYMENT COMPENSATION XIX D	40,934
	WORKERS COMPENSATION INSURANCE XIX D	27,801
	HOSPITALIZATION INSURANCE XIX D	50,618
	EMPLOYEE BENEFITS - OTHER XIX D	837
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		209,446
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	188
	TRAVEL XIX G	0
		0
		0
		188
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,926
		4,926
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	66,965
		66,965
27	OTHER	
	BAD DEBTS VI 24	498
		498

GRAND TOTAL COLUMN 3 OTHER

624,164

ASTA CARE CENTER - FORD COUNTY
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	106,795	PATIENT MEALS	56166
LESS SALES TAX	(1,092)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	105,703	TOTAL MEALS/YEAR	56166
TOTAL PATIENT CENSUS	18,722	NET FOOD	105703
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	56166

TOTAL PATIENT MEALS	56166	COST PER MEAL	1.88
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

#0045823

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,290	7,290		7,290	(293)	6,997			30
31	Amortization of Pre-Op. & Org.			8,625	8,625		8,625		8,625			31
32	Interest			30,747	30,747		30,747		30,747			32
33	Real Estate Taxes			69,362	69,362		69,362		69,362			33
34	Rent-Facility & Grounds			88,616	88,616		88,616		88,616			34
35	Rent-Equipment & Vehicles			9,055	9,055		9,055	812	9,867			35
36	Other (specify):* amort comp software			2,086	2,086		2,086		2,086			36
37	TOTAL Ownership			215,781	215,781		215,781	519	216,300			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		34,529	83,994	118,523		118,523		118,523			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,777	37,777		37,777		37,777			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		34,529	121,771	156,300		156,300		156,300			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,191,487	261,326	961,716	2,414,529		2,414,529	12,244	2,426,773			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(293)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,092)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(5,330)	21		18
19	Entertainment		20		19
20	Contributions		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	(498)	27		24
25	Fund Raising, Advertising and Promotional	(3,425)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(62)	20		28
29	Other-Attach Schedule	(12,823)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,523)		\$	30

OHF 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)	35,767		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 35,767		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 12,244		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 - FORD COUNTY

ID# 0045823

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0		1
2	BANK CHARGES	(2,315)	21	2
3	PROFESSIONAL FEES SPECIAL DELIVERIES	(430)	19	3
4	MARKETING SALARY	(10,078)	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	(12,823)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY# 0045823

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,092)	0	0	0	0	0	0	0	0	0	0	(1,092)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,092)	0	0	0	0	0	0	0	0	0	0	(1,092)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	17,123	0	0	0	0	0	0	0	0	0	17,123	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(430)	1,110	0	0	0	0	0	0	0	0	0	680	19
20	Fees, Subscriptions & Promotions	(3,487)	767	0	0	0	0	0	0	0	0	0	(2,720)	20
21	Clerical & General Office Expenses	(17,723)	7,184	0	0	0	0	0	0	0	0	0	(10,539)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	2,629	0	0	0	0	0	0	0	0	0	2,629	25
26	Insurance-Prop.Liab.Malpractice	0	420	0	0	0	0	0	0	0	0	0	420	26
27	Other (specify):*	(498)	5,722	0	0	0	0	0	0	0	0	0	5,224	27
28	TOTAL General Administration	(22,138)	34,955	0	12,817	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,230)	34,955	0	11,725	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(293)	0	0	0	0	0	0	0	0	0	0	(293)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	812	0	0	0	0	0	0	0	0	0	812	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(293)	812	0	519	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)	(23,523)	35,767	0	12,244	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	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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	\$ 71,068	ASTA HEALTHCARE COMPANY			(71,068)	1
2	V	17	OFFICERS SALARY-MG			22,714		22,714	2
3	V	17	OFFICERS SALARY-SETH			18,278		18,278	3
4	V	17	ADMIN. SALARY-CF			15,635		15,635	4
5	V	17	ADMIN. SALARY-DM			15,954		15,954	5
6	V	17	ADMIN. SALARY			15,610		15,610	6
7	V	19	PROFESSIONAL FEES			1,110		1,110	7
8	V	20	DUES & SUBSCRIPTIONS			767		767	8
9	V	21	OFFICE EXPENSE			7,184		7,184	9
10	V	25	AUTO & TRAVEL			2,629		2,629	10
11	V	26	INSURANCE GEN & W/C			420		420	11
12	V	27	PAYROLL TAX & EMPL BEN			5,722		5,722	12
13	V	35	EQUIPMENT RENTAL			812		812	13
14	Total		\$ 71,068			\$ 106,835	\$ *	35,767	14

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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			60.00					\$		1
2	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$210,000							SALARY	22,714	17-7	2
3											3
4	SETH GILLMAN			10.00							4
5	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$168,982							SALARY	18,278	17-7	5
6											6
7	CRAIG FRANK			10.00				SALARY	27,788	17-1	7
8	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$144,547							SALARY	15,635	17-7	8
9											9
10	DAVID MEISELMAN			10.00							10
11	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$147,499							SALARY	15,954	17-7	11
12	ALIZA FRANK-TOTAL SAL. RECEIVED FR ASTA HEALTH \$27,096							SALARY	2,931	21-7	12
13								TOTAL	\$ 103,300		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 - FORD COUNTY

0045823

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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)742-8822

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	OFFICERS SALARY-MG	PATIENT DAYS	173,090	6	\$ 210,000	\$ 210,000	18,722	\$ 22,714	1
2	17	OFFICERS SALARY-SETH	PATIENT DAYS	173,090	6	168,982	168,982	18,722	18,278	2
3	17	ADMIN. SALARY-CF	PATIENT DAYS	173,090	6	144,547	144,547	18,722	15,635	3
4	17	ADMIN. SALARY-DM	PATIENT DAYS	173,090	6	147,499	147,499	18,722	15,954	4
5	17	ADMIN. SALARY	PATIENT DAYS	173,090	6	144,315	144,315	18,722	15,610	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	173,090	6	10,265		18,722	1,110	6
7	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	173,090	6	7,090		18,722	767	7
8	21	OFFICE EXPENSE	PATIENT DAYS	173,090	6	66,421	27,096	18,722	7,184	8
9	25	AUTO & TRAVEL	PATIENT DAYS	173,090	6	24,306		18,722	2,629	9
10	26	INSURANCE GEN & W/C	PATIENT DAYS	173,090	6	3,885		18,722	420	10
11	27	PAYROLL TAX & EMPL BEN	PATIENT DAYS	173,090	6	52,906		18,722	5,722	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	173,090	6	7,509		18,722	812	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 987,725	\$ 842,439		\$ 106,835	25

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$	1					
2													2					
3													3					
4													4					
5	BARRY KIRSCHENBAUM	X		WORKING CAPITAL								2,000	5					
	Working Capital																	
6	ALBANY BANK		X	WORKING CAPITAL	INTEREST	REVOLV		278,080	REVOLV	PRIME +		24,736	6					
7			X	INSURANCE POLICIES								1,665	7					
8			X	BED TAX INTEREST								2,346	8					
9	TOTAL Facility Related						\$	\$ 278,080				\$ 30,747	9					
	B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES									10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$	14					
15	TOTALS (line 9+line14)						\$	\$ 278,080				\$ 30,747	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 2004 report.		\$		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.)		\$	37,569	2
3. Under or (over) accrual (line 2 minus line 1).		\$	37,569	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	31,793	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.		\$	69,362	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	8
	2001	9
	2002	10
	2003	11
	2004	31,348

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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 2004 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: 33,800 B. General Construction Type: Exterior BRICK/WOOD 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).

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:

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

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	69			\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	NURSE STATION		2002	10,000	364	27.5	364		1,228	9
10	ROOF		2002	28,434	1,034	27.5	1,034		3,490	10
11	NURSE STATION		2002	10,000	363	27.5	363		1,225	11
12	ROOF		2004	31,800	1,156	27.5	1,156		2,264	12
13	ELECTRICAL WORK		2005	3,959	78	27.5	78		78	13
14	SECURITY SYSTEM		2005	52,942	722	27.5	722		722	14
15	ASPHALT SIDEWALK		2005	2,200	55	15	55		55	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 139,335	\$ 3,772		\$ 3,772	\$	\$ 9,062	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	\$ 13,893	\$ 1,669	\$ 1,389	\$ (280)	10 YR	\$ 3,480	71
72	Current Year Purchases	4,140	1,035	207	(828)	10 YR	207	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 18,033	\$ 2,704	\$ 1,596	\$ (1,108)		\$ 3,687	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	FACILITY	2001 FORD VAN	2005	\$ 16,288	\$ 814	\$ 1,629	\$ 815	5 YR	\$ 1,629	76
77										77
78										78
79										79
80	TOTALS			\$ 16,288	\$ 814	\$ 1,629	\$ 815		\$ 1,629	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)	\$ 173,656	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,290	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 6,997	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (293)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,378	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: THE COUNTY OF FORD

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>69</u>		\$ <u>88,616</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>69</u>		\$ <u>88,616</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: PURCHASE PRICE \$2,415,000 *

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: \$ 9,055 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. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

* 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	39-8	hrs	\$		\$ 10,704	\$		\$ 10,704	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			5,444			5,444	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			55,812			55,812	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				26,928		26,928	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY, INHALATION, Other (specify): <u>supplies, lab</u>	39-8				12,034	7,601		19,635	13
14	TOTAL			\$		\$ 83,994	\$ 34,529		\$ 118,523	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 - FORD COUNTY

0045823

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 11,075	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	539,152		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	20,956		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 571,183	\$	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	139,335		15
16	Equipment, at Historical Cost	49,344		16
17	Accumulated Depreciation (book methods)	(37,324)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	69,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(30,188)		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)	\$ 190,167	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 761,350	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 903,579	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	278,080		29
30	Accrued Salaries Payable	51,531		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,253		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,793		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)	\$ 1,277,236	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	140,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 140,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,417,236	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (655,886)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 761,350	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (392,486)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (392,486)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(263,400)	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)	\$ (263,400)	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)	\$ (655,886)	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	\$ 2,033,277	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,033,277	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	112,003	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 112,003	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSE	5,849	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,849	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,151,129	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	568,120	31
32	Health Care	934,558	32
33	General Administration	539,770	33
	B. Capital Expense		
34	Ownership	215,781	34
	C. Ancillary Expense		
35	Special Cost Centers	118,523	35
36	Provider Participation Fee	37,777	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,414,529	40
41	Income before Income Taxes (line 30 minus line 40)**	(263,400)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (263,400)	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 - FORD COUNTY

0045823

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	1,612	1,778	\$ 39,839	\$ 22.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,268	9,998	197,948	19.80	3
4	Licensed Practical Nurses	9,823	10,160	180,038	17.72	4
5	CNAs & Orderlies	31,924	33,296	292,519	8.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,062	1,178	11,989	10.18	9
10	Activity Assistants	3,872	4,074	32,089	7.88	10
11	Social Service Workers	1,952	2,104	19,522	9.28	11
12	Dietician					12
13	Food Service Supervisor	1,950	2,122	30,121	14.19	13
14	Head Cook	5,137	5,427	44,700	8.24	14
15	Cook Helpers/Assistants	11,688	12,109	83,026	6.86	15
16	Dishwashers					16
17	Maintenance Workers	1,942	2,143	29,659	13.84	17
18	Housekeepers	17,066	17,906	135,308	7.56	18
19	Laundry					19
20	Administrator	1,902	1,926	27,788	14.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,056	2,207	30,387	13.77	23
24	Clerical	3,331	3,595	36,554	10.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,585	110,023	\$ 1,191,487 *	\$ 10.83	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	\$ 4,565	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,387	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		0	10a-3	43
44	Activity Consultant	F	1,284	11-3	44
45	Social Service Consultant	E	1,588	12-3	45
46	Other(specify)	E			46
47	psychiatric consultant	S	11,465	10-3	47
48	program consultant		3,150	10-3	48
49	TOTAL (lines 35 - 48)		\$ 29,439		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	29	\$ 1,157	10-3	50
51	Licensed Practical Nurses	573	20,065	10-3	51
52	Certified Nurse Assistants/Aides	1,181	27,469	10-3	52
53	TOTAL (lines 50 - 52)	1,783	\$ 48,691		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	
CRAIG FRANK	ADMIN	10	\$ 27,788	Workers' Compensation Insurance	\$ 27,801	IDPH License Fee	\$ 995	
	ASST ADMIN		0	Unemployment Compensation Insurance	40,934	Advertising: Employee Recruitment	6,532	
				FICA Taxes	89,256	Health Care Worker Background Check	1,253	
				Employee Health Insurance	50,618	(Indicate # of checks performed)		
				Employee Meals	0	MARKETING/ADV/PROMO	3,487	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	837	LICENSES & PERMITS	950	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	3,666	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	767	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense (0	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(3,425)	
						Yellow page advertising	(62)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 27,788	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
ASTA HEALTH CARE - MANAGEMENT FEE			\$ 71,068					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 71,068					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ACCU-MED SERVICES	DATA PROCESSING		\$ 3,060				Out-of-State Travel	\$
HEALTH DATA SYSTEMS	DATA PROCESSING		6,530					
KRUPNICK BOKOR	ACCOUNTING		17,325				In-State Travel	0
MCGUIRE & SIEGEL	LEGAL FEES		1,977					
MCGUIRE & BENJAMIN	LEGAL FEES		3,537				Seminar Expense	188
PERSONNEL PLANNERS	UC CONSULTANT		1,800					
RICHARD PEELO	MEDICARE CONSULTANT		2,750				Entertainment Expense (
SPECIAL DELIVERIES			430				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 188
SEE SCHEDULE ATTACHED				TOTAL		\$		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 37,409					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY

0045823

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTHCARE ASSOC, \$3,491
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,852 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. \$ 37,777
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? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 5%
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees