

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0042796</u></p> <p>Facility Name: <u>ASTA CARE CENTER OF TOLUCA</u></p> <p>Address: <u>101 EAST VIA GHIGLIERI</u> <u>TOLUCA</u> <u>61369</u> Number City Zip Code</p> <p>County: <u>MARSHALL</u></p> <p>Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u></p> <p>HFS ID Number: <u>36-4163264</u></p> <p>Date of Initial License for Current Owners: <u>7/1/1997</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MICHAEL GILLMAN</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MICHAEL GILLMAN</u> (Date) _____		(Title) <u>MEMBER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

0042796 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>33</u>	Intermediate (ICF)	<u>33</u>	<u>12,045</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>104</u>	TOTALS	<u>104</u>	<u>37,960</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>912</u>	<u>10</u>	<u>1,880</u>	<u>2,802</u>	8
9	SNF/PED					9
10	ICF	<u>24,356</u>	<u>1,677</u>	<u>181</u>	<u>26,214</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,268</u>	<u>1,687</u>	<u>2,061</u>	<u>29,016</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.44%

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 07/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/97 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 12 and days of care provided 1,880

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	231,358	22,079	6,858	260,295		260,295	0	260,295		1
2	Food Purchase		162,925		162,925	(23,214)	139,711	(1,377)	138,334		2
3	Housekeeping	167,894	20,116	0	188,010		188,010	0	188,010		3
4	Laundry	88,146	10,671	1,278	100,095	0	100,095	0	100,095		4
5	Heat and Other Utilities			86,444	86,444		86,444	0	86,444		5
6	Maintenance	62,313	20,723	25,379	108,415		108,415	1,888	110,303		6
7	Other (specify):*			6,942	6,942		6,942	0	6,942		7
8	TOTAL General Services	549,711	236,514	126,901	913,126	(23,214)	889,912	511	890,423		8
	B. Health Care and Programs										
9	Medical Director	0		9,500	9,500		9,500	0	9,500		9
10	Nursing and Medical Records	1,109,436	62,530	8,819	1,180,785		1,180,785	418	1,181,203		10
10a	Therapy	3,278	1,822	0	5,100		5,100	0	5,100		10a
11	Activities	61,786	7,146	2,772	71,704		71,704	0	71,704		11
12	Social Services	56,677		1,912	58,589		58,589	0	58,589		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			425	425		425	0	425		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,231,177	71,498	23,428	1,326,103	0	1,326,103	418	1,326,521		16
	C. General Administration										
17	Administrative	53,027		204,000	257,027		257,027	(76,636)	180,391		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			40,191	40,191		40,191	725	40,916		19
20	Dues, Fees, Subscriptions & Promotions			33,741	33,741		33,741	(8,529)	25,212		20
21	Clerical & General Office Expenses	96,408	17,823	26,625	140,856		140,856	2,552	143,408		21
22	Employee Benefits & Payroll Taxes			305,609	305,609	23,214	328,823	0	328,823		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			1,895	1,895		1,895	213	2,108		24
25	Other Admin. Staff Transportation			11,512	11,512		11,512	(3,214)	8,298		25
26	Insurance-Prop.Liab.Malpractice			74,694	74,694		74,694	2,098	76,792		26
27	Other (specify):*			19,514	19,514		19,514	(10,534)	8,980		27
28	TOTAL General Administration	149,435	17,823	717,781	885,039	23,214	908,253	(93,325)	814,928		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,930,323	325,835	868,110	3,124,268	0	3,124,268	(92,396)	3,031,872		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,672
	REPAIRS & MAINTENANCE	186
		0
		6,858
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,278
		0
		1,278
5	HEAT & OTHER UTILITIES	
	GAS HEAT	21,661
	ELECTRICITY	39,106
	WATER	22,947
	CABLE TV - LOBBY	2,730
		0
		86,444
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,968
	PAINTING & DECORATING	698
	BUILDING REPAIRS	675
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,617
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	1,422
	EXTERMINATING SERVICE	385
	FIRE SERVICE	2,614
		0
		0
		0
		0
		25,379
7	OTHER	
	SCAVENGER	6,448
	SECURITY SERVICE	0
	REBILLED SALARIES	494
		0
		6,942
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,500
		9,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	1,752
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	710
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	500
	RN CONSULTANT XVIII B 38-2	871
	PROGRAM CONSULTANT	1,460
	DENTAL CONSULTANT	2,926
		8,819
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,772
		0
		2,772
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	142
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,194
	SOCIAL WORKER XVIII B 45-2	576
		0
		1,912
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	425
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	204,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	13,352
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	26,839
		0
		40,191
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,685
	EMPLOYEE WANT ADS XIX F	10,196
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	7,065
	LICENSES & PERMITS XIX F	6,133
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,755
	PATIENT BACKGROUND CHECKS XIX F	0
	GROUP MARKETING PROGRAM	907
		33,741
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,858
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	14,892
	MESSENGER SERVICE	4,875
		0
		26,625

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	145,860
	UNEMPLOYMENT COMPENSATION XIX D	37,866
	WORKERS COMPENSATION INSURANC XIX D	53,909
	HOSPITALIZATION INSURANCE XIX D	65,362
	EMPLOYEE BENEFITS - OTHER XIX D	934
	EMPLOYEE PHYSICAL EXAMS XIX D	1,678
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		305,609
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,895
	TRAVEL XIX G	0
		1,895
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	11,512
		11,512
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	74,694
		74,694
27	OTHER	
	BAD DEBTS VI 24	19,514
		19,514

GRAND TOTAL COLUMN 3 OTHER

868,110

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

TOTAL FOOD PURCHASE	162,925	PATIENT MEALS	87048
LESS SALES TAX	(1,377)	ADD EMPLOYEE MEALS	14600
	-----		-----
NET FOOD	161,548	TOTAL MEALS/YEAR	101648
TOTAL PATIENT CENSUS	29,016	NET FOOD	161548
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	101648

TOTAL PATIENT MEALS	87048	COST PER MEAL	1.59
		TIME EMPLOYEE MEALS	14600
ADD # EMPLOYEE MEALS/DAY	40		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	23214
	-----		=====
TOTAL EMPLOYEE MEALS	14600		

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

#0042796

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			30,621	30,621		30,621	(855)	29,766			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			39,119	39,119		39,119	(5,720)	33,399			32
33	Real Estate Taxes			17,400	17,400		17,400	0	17,400			33
34	Rent-Facility & Grounds			422,672	422,672		422,672	0	422,672			34
35	Rent-Equipment & Vehicles			21,834	21,834		21,834	0	21,834			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			531,646	531,646	0	531,646	(6,575)	525,071			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		62,963	192,409	255,372		255,372	0	255,372			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			56,940	56,940		56,940	0	56,940			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	62,963	249,349	312,312	0	312,312	0	312,312			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,930,323	388,798	1,649,105	3,968,226	0	3,968,226	(98,971)	3,869,255			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	(855)	30		9
10	Interest and Other Investment Income	(24)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,377)	2		13
14	Non-Care Related Interest	(5,696)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(262)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,514)	27		24
25	Fund Raising, Advertising and Promotional	(8,592)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(21,539)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (57,859)		\$ 0	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(41,112)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,112)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (98,971)		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 TOLUCA

ID# 0042796

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,180	6	1
2	BANK CHARGES	(6,858)	21	2
3	MARKETING TRAVEL	(6,879)	25	3
4	MARKETING SALARY	(8,982)	17	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	(21,539)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA# 0042796

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,377)	0	0	0	0	0	0	0	0	0	0	(1,377)	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	1,180	708	0	0	0	0	0	0	0	0	0	1,888	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(197)	708	0	511	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	418	0	0	0	0	0	0	0	0	0	418	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	418	0	418	16								
	C. General Administration													
17	Administrative	(8,982)	(67,654)	0	0	0	0	0	0	0	0	0	(76,636)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(262)	987	0	0	0	0	0	0	0	0	0	725	19
20	Fees, Subscriptions & Promotions	(8,592)	63	0	0	0	0	0	0	0	0	0	(8,529)	20
21	Clerical & General Office Expenses	(6,858)	9,410	0	0	0	0	0	0	0	0	0	2,552	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	213	0	0	0	0	0	0	0	0	0	213	24
25	Other Admin. Staff Transportation	(6,879)	3,665	0	0	0	0	0	0	0	0	0	(3,214)	25
26	Insurance-Prop.Liab.Malpractice	0	2,098	0	0	0	0	0	0	0	0	0	2,098	26
27	Other (specify):*	(19,514)	8,980	0	0	0	0	0	0	0	0	0	(10,534)	27
28	TOTAL General Administration	(51,087)	(42,238)	0	(93,325)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,284)	(41,112)	0	(92,396)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA# 0042796

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(855)	0	0	0	0	0	0	0	0	0	0	(855)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,720)	0	0	0	0	0	0	0	0	0	0	(5,720)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,575)	0	0	0	0	0	0	0	0	0	0	(6,575)	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)	(57,859)	(41,112)	0	(98,971)	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
MICHAEL GILLMAN	50			ASTA		
				HEALTHCARE CO.	ELGIN	MANAGEMENT
DENNIS RUBEN	50	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	\$ 204,000	ASTA HEALTHCARE MANAGEMENT		\$	(204,000)	1
2	V	6 MAINTENANCE				708	708	2
3	V	10 NURSING SUPPLIES				418	418	3
4	V	17 ADMINISTRATIVE				136,346	136,346	4
5	V	19 PROFESSIONAL FEES				987	987	5
6	V	20 LICENSE & PERMITS				63	63	6
7	V	21 OFFICE EXPENSE				9,410	9,410	7
8	V	24 SEMINARS				213	213	8
9	V	25 STAFF TRANS /TRAVEL				3,665	3,665	9
10	V	26 INSURANCE GEN / WC				2,098	2,098	10
11	V	27 PAYR. TAXES & GRP INS				8,980	8,980	11
12	V							12
13	V							13
14	Total		\$ 204,000			\$ 162,888	\$ * (41,112)	14

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN			50.00				SALARY	\$ 28,389	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$175,000										2
3	SETH GILLMAN							SALARY	23,520	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986							SALARY	23,088	17-1	4
5	SALARY FROM ASTA CARE OF TOLUCA \$23088 SALARY FROM ASTA CARE OF BLOOMINGTON \$6926										5
6	CRAIG FRANK							SALARY	23,520	17-7	6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986										7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$30,014										8
9	DAVID MEISELMAN							SALARY	23,010	17-7	9
10	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$141,842										10
11	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,014										11
12	ALIZA FRANK - TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$32,583							SALARY	5,286	21-7	12
13								TOTAL	\$ 126,813		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 TOLUCA

0042796

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PATIENT DAYS	178,865	6	\$ 4,363	\$ 29,016	\$ 708	1
2	10	NURSING SUPPLIES	PATIENT DAYS	178,865	6	2,577	29,016	418	2
3	17	OFFICER'S SALARY - MG	PATIENT DAYS	178,865	6	175,000	175,000	28,389	3
4	17	OFFICER'S SALARY -SETH	PATIENT DAYS	178,865	6	144,986	144,986	23,520	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	178,865	6	144,986	144,986	23,520	5
6	17	ADMIN. SALARY - DM	PATIENT DAYS	178,865	6	141,842	141,842	23,010	6
7	17	ADMIN. SALARY	PATIENT DAYS	178,865	6	233,674	29,016	37,907	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,865	6	6,085	29,016	987	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,865	6	389	29,016	63	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,865	6	58,004	32,583	9,410	10
11	24	SEMINARS	PATIENT DAYS	178,865	6	1,310	29,016	213	11
12	25	STAFF TRANS / TRAVEL	PATIENT DAYS	178,865	6	22,595	29,016	3,665	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,865	6	12,935	29,016	2,098	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,865	6	55,359	29,016	8,980	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,004,105	\$ 639,397	\$ 162,888	25

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

0042796

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	MORGAN CHASE		X	LINE OF CREDIT	INT ONLY	REVOLV	100,000	258,267		31,800										
7																				
8	A.I. CREDIT CORP		X	INSURANCE POLICIES						1,623										
9	TOTAL Facility Related						\$ 100,000	\$ 258,267		\$ 33,423										
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES																
11				LATE FEES BED TAX						5,696										
12																				
13																				
14	TOTAL Non-Facility Related						\$ 0	\$ 0		\$ 5,696										
15	TOTALS (line 9+line14)						\$ 100,000	\$ 258,267		\$ 39,119										

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	16,330	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.)		\$	15,758	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(572)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	17,972	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.		\$	17,400	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	14,403	8
	2002	14,586	9
	2003	15,433	10
	2004	16,330	11
	2005	15,758	12

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 2005 TAX BILL.

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

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:** 2005 REAL ESTATE TAX COST DOCUMENTATION

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

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

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

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF TOLUCA COUNTY MARSHALL

FACILITY IDPH LICENSE NUMBER 0042796

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>14-05-206-001</u>	<u>NURSING HOME</u>	\$ <u>15,758.06</u>	\$ <u>15,758.06</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>15,758.06</u>	\$ <u>15,758.06</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$ 0	3

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA# 0042796

Report Period Beginning:

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

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SIGN	1997		950	24	39	24		221	9
10		WATER HEATER	1997		2,824	73	39	73		672	10
11		NURSES STATION	1998		6,622	170	39	170		1,381	11
12		ELECTRICAL WATER HEATER	1998		3,400	87	39	87		707	12
13		HANDRAILS	1998		4,445	114	39	114		926	13
14		LAUNDRY BUILDING	1999		69,014	2,510	27.5	2,510		18,302	14
15		DOORS	2000		3,400	124	27.5	124		811	15
16		REKEY LOCKS	2000		1,672	61	27.5	61		399	16
17		DOORS	2000		10,080	366	27.5	366		2,395	17
18		BUSHES	2000		2,493	166	15	166		1,086	18
19		ROOF	2000		16,511	600	27.5	600		3,925	19
20		FENCE	2000		2,981	199	15	199		1,302	20
21		FURNISHING	2000		2,271	203	7	203		2,171	21
22		ROOF	2001		6,500	236	27.5	236		1,308	22
23		DOOR ACCESS SYSTEM	2001		2,825	103	27.5	103		571	23
24		FLASHING	2001		1,250	46	27.5	46		255	24
25		DOOR SYSTEM	2002		2,461	89	27.5	89		404	25
26		GAS/ELECTRIC ROOFTOP UNIT	2002		10,997	400	27.5	400		1,817	26
27		AIR HANDLER	2002		2,237	81	27.5	81		368	27
28		CODE ALERT RESIDENT SECURITY SYSTEM	2002		2,561	93	27.5	93		422	28
29		WATER HEATER	2002		5,490	200	27.5	200		908	29
30		FURNISHING - CARPETING	2003		907	52	5	181	129	622	30
31		AWNING	2003		2,010	73	27.5	73		258	31
32		SINKS	2003		619	22	27.5	22		78	32
33		5 TON AIR CONDITIONER FOR KITCHEN	2003		1,700	62	27.5	62		220	33
34		FIRE DAMPERS	2004		5,542	202	27.5	202		446	34
35		ASPHALTING DRIVEWAY	2005		5,700	380	15	380		459	35
36		WATER HEATER	2005		4,509	164	27.5	164		253	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	SEWER LINE	2005	\$ 1,811	\$ 66	27.5	\$ 66	\$	\$ 101	37
38	ROOF TOP UNIT	2005	3,745	136	27.5	136		210	38
39	GENERATOR	2006	19,135	29	27.5	29		29	39
40	SIDEWALKS	2006	6,000	50	15	50		50	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)		\$ 212,662	\$ 7,181		\$ 7,310	\$ 129	\$ 43,077	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	\$ 205,632	\$ 15,867	\$ 20,563	\$ 4,696	10 YR	\$ 125,636	71
72	Current Year Purchases	37,863	7,573	1,893	(5,680)	10 YR	1,893	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 243,495	\$ 23,440	\$ 22,456	\$ (984)		\$ 127,529	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 456,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,621	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,766	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (855)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 170,606	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: MONTE CASINO HEALTHCARE

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>104</u>	<u>07/97</u>	\$ <u>422,672</u>	<u>30</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>104</u>		\$ <u>422,672</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: \$3,796,000 *

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: \$ 21,834 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 07/01/97

Ending 07/01/27

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 422,672

13. /2008 \$ 422,672

14. /2009 \$ 422,672

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 58,944	\$		\$ 58,944	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,653			3,653	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			125,750			125,750	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				43,208		43,208	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): lab, supplies	39-8				4,062	19,755		23,817	13
14	TOTAL			\$		\$ 192,409	\$ 62,963		\$ 255,372	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 TOLUCA

0042796

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,994	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	781,749		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,806		6
7	Other Prepaid Expenses	123		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E. ESCROW DEPOSIT</u>	1,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 824,672	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	209,484		15
16	Equipment, at Historical Cost	267,618		16
17	Accumulated Depreciation (book methods)	(261,094)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 216,008	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,040,680	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,482,793	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	258,267		29
30	Accrued Salaries Payable	82,313		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,306		31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,972		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)	\$ 1,853,651	\$ 0	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	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,993,651	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (952,971)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,040,680	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (502,135)	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)	\$ (502,134)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(450,837)	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)	\$ (450,837)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (952,971)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,424,655	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,424,655	3
	B. Ancillary Revenue		
4	Day Care	6,550	4
5	Other Care for Outpatients		5
6	Therapy	76,842	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 83,392	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	(1,791)	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	32	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)	\$ (1,759)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	ADJ OF PRIOR YR EXPENSES	11,077	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,077	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,517,389	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	913,126	31
32	Health Care	1,326,103	32
33	General Administration	885,039	33
	B. Capital Expense		
34	Ownership	531,646	34
	C. Ancillary Expense		
35	Special Cost Centers	255,372	35
36	Provider Participation Fee	56,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,968,226	40
41	Income before Income Taxes (line 30 minus line 40)**	(450,837)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (450,837)	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 TOLUCA

0042796

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,745	2,108	\$ 68,706	\$ 32.59	1
2	Assistant Director of Nursing	2,066	2,344	54,442	23.23	2
3	Registered Nurses	14,943	16,634	336,859	20.25	3
4	Licensed Practical Nurses	3,080	3,692	68,091	18.44	4
5	CNAs & Orderlies	43,736	49,237	550,239	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	328	328	3,278	9.99	8
9	Activity Director	1,229	1,307	18,107	13.85	9
10	Activity Assistants	5,004	5,517	43,679	7.92	10
11	Social Service Workers	3,177	3,505	56,677	16.17	11
12	Dietician					12
13	Food Service Supervisor	2,045	2,254	40,466	17.95	13
14	Head Cook	7,573	8,600	93,158	10.83	14
15	Cook Helpers/Assistants	10,297	11,238	97,734	8.70	15
16	Dishwashers					16
17	Maintenance Workers	5,078	5,500	62,313	11.33	17
18	Housekeepers	15,377	17,554	167,894	9.56	18
19	Laundry	10,619	11,577	88,146	7.61	19
20	Administrator	2,378	2,604	53,027	20.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,278	2,555	56,494	22.11	23
24	Clerical	2,801	2,998	39,914	13.31	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	2,036	2,293	31,099	13.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,790	151,845	\$ 1,930,323 *	\$ 12.71	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 6,672	1-3	35
36	Medical Director	O	9,500	9-3	36
37	Medical Records Consultant	N	710	10-3	37
38	Nurse Consultant	T	871	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,772	11-3	44
45	Social Service Consultant	E	1,770	12-3	45
46	Other(specify) <u>dental consultant</u>	S	2,926	10-3	46
47	<u>Program Consultant</u>		1,460	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,281		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			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
JENNIFER SWINGLE	ADMINISTRATOR	0.00%		Workers' Compensation Insurance	\$ 53,909	IDPH License Fee	\$		
SETH GILMAN				Unemployment Compensation Insurance	37,866	Advertising: Employee Recruitment		10,196	
				FICA Taxes	145,860	Health Care Worker Background Check		1,755	
				Employee Health Insurance	65,362	(Indicate # of checks performed <u>215</u>)			
				Employee Meals	23,214	Patient Background Checks	<u>35</u>	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC		0	
				EMPLOYEE BENEFITS - OTHER	934	MARKETING/ADV/PROMO		7,685	
				EMPLOYEE PHYSICAL EXAMS	1,678	LICENSES/DUES/SUBSCRIPTIONS		13,198	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC		63	
				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		(7,685)	
						Yellow page advertising	(0	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$	53,027	TOTAL (agree to Sch. V, line 20, col. 8)		\$	25,212
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 COMPANY - MANAGEMENT FEES		\$ 204,000					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)		\$ 204,000					Seminar Expense	1,895	
C. Professional Services				TOTAL			MGMT CO ALLOC		
Vendor/Payee	Type	Amount						213	
HEALTH DATA SYSTEMS	DATA PROCESSING	\$ 10,862					Entertainment Expense	(
ENLOE DRUGS	DATA PROCESSING	1,800					(agree to Sch. V, line 24, col. 8)		
EHEALTH DATA SOLUTIONS	DATA PROCESSING	690							
KBKB	ACCOUNTING	17,900							
STONE ,MCGUIRE & SEIGEL	LEGAL	4,262							
PERSONNEL PLANNERS	U.C. CONSULTANT	637							
RICHARD PEELO & ASSOC.	MEDICARE CST RPT PREP	2,750							
C. E. BUTZOW , ARCHITECT	ARCHITECT	1,028							
	COLLECTIONS	262							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 40,191							

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	6/00	\$ 6,245	3 YRS	\$ 1,040	\$	\$	\$	\$	\$	\$	\$													
2	PAINT/DECORATING	6/01	869	3 YRS	290	144																			
3	PAINT/DECORATING	6/02	1,211	3 YRS	404	404	177																		
4	PAINT/DECORATING	6/03	1,067	3 YRS	178	356	356	177																	
5	PAINT/DECORATING	6/04	1,081	3 YRS		180	360	360	181																
6	PAINT/DECORATING	6/05	1,930	3 YRS			322	643	643	322															
7																									
8																									
9																									
10																									
11																									
12																									
13																									
14																									
15																									
16																									
17																									
18																									
19																									
20	TOTALS		\$ 12,403		\$ 1,912	\$ 1,084	\$ 1,215	\$ 1,180	\$ 824	\$ 322	\$	\$													

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA# 0042796Report Period Beginning: 01/01/2006Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC. \$6,240
- (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. \$ 19,895 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. \$ 56,940
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. \$ 23,214 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees