

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: <u>0042796</u></p> <p>Facility Name: <u>ASTA CARE CENTER OF TOLUCA, LLC</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>07/01/97</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>01/01/2007</u> to <u>12/31/2007</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="3" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MICHAEL GILLMAN</u></td> </tr> <tr> <td>(Title) <u>MEMBER</u></td> </tr> </table> <table border="1"> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(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> </table> <p>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></p> <p>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>	(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>
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Facility Name & ID Number ASTA CARE CENTER OF TOLUCA, LLC

0042796 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,045	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	1,074	147	2,875	4,096	8
9	SNF/PED					9
10	ICF	25,780	1,330	156	27,266	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,854	1,477	3,031	31,362	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.62%

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 07/01/97

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 _____ and days of care provided 2,875

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA, LLC # 0042796 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	253,726	30,278	7,679	291,683		291,683		291,683		1
2	Food Purchase		183,773		183,773	(23,944)	159,829	(5,347)	154,482		2
3	Housekeeping	178,551	38,027		216,578		216,578		216,578		3
4	Laundry	96,712	22,625	2,193	121,530		121,530		121,530		4
5	Heat and Other Utilities			87,661	87,661		87,661	121	87,782		5
6	Maintenance	112,511	50,919	51,528	214,958		214,958	1,171	216,129		6
7	Other (specify):*			8,468	8,468		8,468		8,468		7
8	TOTAL General Services	641,500	325,622	157,529	1,124,651	(23,944)	1,100,707	(4,055)	1,096,652		8
	B. Health Care and Programs										
9	Medical Director			10,500	10,500		10,500		10,500		9
10	Nursing and Medical Records	1,157,389	64,759	15,345	1,237,493		1,237,493	524	1,238,017		10
10a	Therapy	937	729		1,666		1,666		1,666		10a
11	Activities	68,334	3,505	1,848	73,687		73,687		73,687		11
12	Social Services	60,731		1,500	62,231		62,231		62,231		12
13	CNA Training										13
14	Program Transportation			90	90		90		90		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,287,391	68,993	29,283	1,385,667		1,385,667	524	1,386,191		16
	C. General Administration										
17	Administrative	82,384		250,172	332,556		332,556	(106,363)	226,193		17
18	Directors Fees										18
19	Professional Services			53,958	53,958		53,958	1,509	55,467		19
20	Dues, Fees, Subscriptions & Promotions			38,580	38,580		38,580	(14,080)	24,500		20
21	Clerical & General Office Expenses	90,350	20,364	29,726	140,440		140,440	9,135	149,575		21
22	Employee Benefits & Payroll Taxes			301,486	301,486	23,944	325,430		325,430		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,446	4,446		4,446	517	4,963		24
25	Other Admin. Staff Transportation			12,480	12,480		12,480	(1,274)	11,206		25
26	Insurance-Prop.Liab.Malpractice			65,234	65,234		65,234	1,812	67,046		26
27	Other (specify):*			5,792	5,792		5,792	3,460	9,252		27
28	TOTAL General Administration	172,734	20,364	761,874	954,972	23,944	978,916	(105,284)	873,632		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,101,625	414,979	948,686	3,465,290		3,465,290	(108,815)	3,356,475		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,679
	REPAIRS & MAINTENANCE	
		0
		7,679
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,193
		0
		2,193
5	HEAT & OTHER UTILITIES	
	GAS HEAT	23,987
	ELECTRICITY	27,734
	WATER	32,574
	CABLE TV - LOBBY	3,366
		0
		87,661
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,129
	PAINTING & DECORATING	0
	BUILDING REPAIRS	6,978
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	25,972
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	425
	FIRE SERVICE	6,054
	PAINTING & DECORATING	7,970
		0
		0
		0
		51,528
7	OTHER	
	SCAVENGER	8,468
	SECURITY SERVICE	0
		0
		0
		8,468
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	10,500
		10,500

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	3,476
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	360
	PHARMACY CONSULTANT XVIII B 39-2	783
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	9,000
	RN CONSULTANT XVIII B 38-2	1,726
		0
		0
		15,345
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY 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	1,848
		0
		1,848
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,500
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,500
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	90
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	250,172
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,760
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	41,198
		0
		53,958
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	13,473
	EMPLOYEE WANT ADS XIX F	11,473
	CONTRIBUTIONS VI 20 XIX F	1,000
	DUES & SUBSCRIPTIONS XIX F	7,189
	LICENSES & PERMITS XIX F	2,971
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	470
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	800
	PATIENT BACKGROUND CHECKS XIX F	1,204
		38,580
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,474
	EQUIPMENT REPAIR & MAINTENANCE	929
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,474
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	19,495
	MESSENGER SERVICE	4,354
		0
		29,726

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	158,835
	UNEMPLOYMENT COMPENSATION XIX D	28,934
	WORKERS COMPENSATION INSURANC XIX D	65,518
	HOSPITALIZATION INSURANCE XIX D	44,874
	EMPLOYEE BENEFITS - OTHER XIX D	536
	EMPLOYEE PHYSICAL EXAMS XIX D	2,789
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		301,486
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	4,446
	TRAVEL XIX G	0
		4,446
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	12,480
		12,480
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	65,234
		65,234
27	OTHER	
	BAD DEBTS VI 24	5,792
		5,792

GRAND TOTAL COLUMN 3 OTHER

948,686

ASTA CARE CENTER OF TOLUCA, LLC
SCHEDULES
12/31/2007

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

TOTAL FOOD PURCHASE	183,773
LESS SALES TAX	<u>(5,347)</u>
NET FOOD	178,426

TOTAL PATIENT CENSUS	31,362
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	94,086

ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	14,600

PATIENT MEALS	94,086
ADD EMPLOYEE MEALS	<u>14,600</u>
TOTAL MEALS/YEAR	108,686

NET FOOD	178,426
DIVIDE TOTAL MEALS/YEAR	<u>108,686</u>

COST PER MEAL	1.64
TIME EMPLOYEE MEALS	<u>14,600</u>
EMPLOYEE MEAL RECLASSIFICATION	23,944

=====

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA, LLC

#0042796

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38,440	38,440		38,440	(3,234)	35,206			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,081	30,081		30,081	(5,341)	24,740			32
33	Real Estate Taxes			15,537	15,537		15,537		15,537			33
34	Rent-Facility & Grounds			432,189	432,189		432,189		432,189			34
35	Rent-Equipment & Vehicles			18,742	18,742		18,742	500	19,242			35
36	Other (specify):*											36
37	TOTAL Ownership			534,989	534,989		534,989	(8,075)	526,914			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,726	251,028	358,754		358,754		358,754			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,940	56,940		56,940		56,940			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		107,726	307,968	415,694		415,694		415,694			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,101,625	522,705	1,791,643	4,415,973		4,415,973	(116,890)	4,299,083			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,234)	30		9
10	Interest and Other Investment Income	(82)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,347)	2		13
14	Non-Care Related Interest	(5,259)	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	(2,474)	21		18
19	Entertainment		20		19
20	Contributions	(1,000)	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	(5,792)	27		24
25	Fund Raising, Advertising and Promotional	(13,473)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(470)	20		28
29	Other-Attach Schedule	(5,847)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,978)		\$	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)	(73,912)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (73,912)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (116,890)		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, LLC

ID# 0042796

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	DEFERRED MAINTENANCE	\$ 824	6	1
2				2
3	STAFF TRANSPORTATION - MARKETING	(6,671)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,847)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,347)	0	0	0	0	0	0	0	0	0	0	(5,347)	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	121	0	0	0	0	0	0	0	0	0	121	5
6	Maintenance	824	347	0	0	0	0	0	0	0	0	0	1,171	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,523)	468	0	(4,055)	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	524	0	0	0	0	0	0	0	0	0	524	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	524	0	524	16								
	C. General Administration													
17	Administrative	0	(106,363)	0	0	0	0	0	0	0	0	0	(106,363)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,509	0	0	0	0	0	0	0	0	0	1,509	19
20	Fees, Subscriptions & Promotions	(14,943)	863	0	0	0	0	0	0	0	0	0	(14,080)	20
21	Clerical & General Office Expenses	(2,474)	11,609	0	0	0	0	0	0	0	0	0	9,135	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	517	0	0	0	0	0	0	0	0	0	517	24
25	Other Admin. Staff Transportation	(6,671)	5,397	0	0	0	0	0	0	0	0	0	(1,274)	25
26	Insurance-Prop.Liab.Malpractice	0	1,812	0	0	0	0	0	0	0	0	0	1,812	26
27	Other (specify):*	(5,792)	9,252	0	0	0	0	0	0	0	0	0	3,460	27
28	TOTAL General Administration	(29,880)	(75,404)	0	(105,284)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,403)	(74,412)	0	(108,815)	29								

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

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

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

	Capital Expense	PAGES 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	(3,234)	0	0	0	0	0	0	0	0	0	0	(3,234)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,341)	0	0	0	0	0	0	0	0	0	0	(5,341)	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	500	0	0	0	0	0	0	0	0	0	500	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,575)	500	0	(8,075)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(42,978)	(73,912)	0	0	0	0	0	0	0	0	0	(116,890)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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	\$ 250,172	ASTA HEALTHCARE MANAGEMENT		\$	(250,172)	1	
2	V	5 UTILITIES				121	121	2	
3	V	6 MAINTENANCE				347	347	3	
4	V	10 NURSING				524	524	4	
5	V	17 ADMINISTRATIVE				143,809	143,809	5	
6	V	19 PROFESSIONAL FEES				1,509	1,509	6	
7	V	20 LICENSES & PERMITS				863	863	7	
8	V	21 OFFICE EXPENSE				11,609	11,609	8	
9	V	24 SEMINARS				517	517	9	
10	V	25 STAFF TRANS/ TRAVEL				5,397	5,397	10	
11	V	26 INSURANCE GEN / WC				1,812	1,812	11	
12	V	27 PAYR. TAXES & GRP INS				9,252	9,252	12	
13	V	35 EQUIPMENT RENTAL				500	500	13	
14	Total		\$ 250,172			\$ 176,260	\$ *	(73,912)	14

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA, LLC # 0042796 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN			50.00		LIST	ATTACHED	SALARY	\$ 25,725	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										2
3	SETH GILLMAN					LIST	ATTACHED	SALARY	25,725	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										4
5	SALARY FROM ASTA CARE OF TOLUCA \$30,097							SALARY	30,097	17-1	5
6	CRAIG FRANK					LIST	ATTACHED	SALARY	25,725	17-7	6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$38,397										8
9	DAVID MEISELMAN-TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$153,958					LIST	ATTACHED	SALARY	24,004	17-7	9
10	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,159										10
11	ALIZA FRANK - TOTAL SALARY RECEIVED FROM					LIST	ATTACHED	SALARY	5,366	21-7	11
12	ASTA HEALTHCARE \$34,417										12
13								TOTAL	\$ 136,642		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, LLC

0042796

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	186,106	6	\$ 773	29,016	\$ 121	1
2	6	MAINTENANCE	PATIENT DAYS	186,106	6	2,228	29,016	347	2
3	10	NURSING	PATIENT DAYS	186,106	6	3,360	29,016	524	3
4	17	OFFICER'S SALARY -MG	PATIENT DAYS	186,106	6	165,000	29,016	25,725	4
5	17	OFFICER'S SALARY - SETH	PATIENT DAYS	186,106	6	165,000	29,016	25,725	5
6	17	ADMIN. SALARY -CF	PATIENT DAYS	186,106	6	165,000	29,016	25,725	6
7	17	ADMIN. SALARY - DM	PATIENT DAYS	186,106	6	153,958	29,016	24,004	7
8	17	ADMIN. SALARY	PATIENT DAYS	186,106	6	273,426	29,016	42,630	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	186,106	6	9,677	29,016	1,509	9
10	20	LICENSES & PERMITS	PATIENT DAYS	186,106	6	5,535	29,016	863	10
11	21	OFFICE EXPENSE	PATIENT DAYS	186,106	6	74,457	29,016	11,609	11
12	24	SEMINARS	PATIENT DAYS	186,106	6	3,319	29,016	517	12
13	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	186,106	6	34,613	29,016	5,397	13
14	26	INSURANCE GEN / WC	PATIENT DAYS	186,106	6	11,622	29,016	1,812	14
15	27	PAYR. TAXES & GRP INS	PATIENT DAYS	186,106	6	59,344	29,016	9,252	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	186,106	6	3,205	29,016	500	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,130,517	\$ 960,161	\$ 176,260	25

Facility Name & ID Number

ASTA CARE CENTER OF TOLUCA, LLC

0042796

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	MORGAN CHASE	X	LINE OF CREDIT	INTEREST	REVOLV	100,000				16,381	6								
7	BED TAX	X	BED TAX							7,132	7								
8	A.I. CREDIT CORP	X	INSURANCE POLICIES							1,309	8								
9	TOTAL Facility Related					\$ 100,000	\$			\$ 24,822	9								
B. Non-Facility Related*																			
10	IRS, IDR, ETC	X	LATE FEES								10								
11	MICHAEL GILLMAN	X	WORKING CAPITAL			110,856				5,259	11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$ 110,856	\$			\$ 5,259	14								
15	TOTALS (line 9+line14)					\$ 210,856	\$			\$ 30,081	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 17,972	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.)		\$ 16,754	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (1,218)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 16,755	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.		\$ 15,537	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	14,586	8
	2003	15,433	9
	2004	16,330	10
	2005	15,758	11
	2006	16,754	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 2006 TAX BILL.			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

Report Period Beginning:

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

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SIGN		1997	950	24	39	24		245	9
10		WATER HEATER		1997	2,824	73	39	73		745	10
11		NURSES STATION		1998	6,622	170	39	170		1,551	11
12		ELECTRICAL WATER HEATER		1998	3,400	87	39	87		794	12
13		HANDRAILS		1998	4,445	114	39	114		1,040	13
14		LAUNDRY BUILDING		1999	69,014	2,510	27.5	2,510		20,812	14
15		DOORS		2000	3,400	124	27.5	124		935	15
16		REKEY LOCKS		2000	1,672	61	27.5	61		460	16
17		DOORS		2000	10,080	366	27.5	366		2,761	17
18		BUSHES		2000	2,493	166	15	166		1,252	18
19		ROOF		2000	16,511	600	27.5	600		4,525	19
20		FENCE		2000	2,981	199	15	199		1,501	20
21		FURNISHING		2000	2,271	100	7	100		2,271	21
22		ROOF		2001	6,500	236	27.5	236		1,544	22
23		DOOR ACCESS SYSTEM		2001	2,825	103	27.5	103		674	23
24		FLASHING		2001	1,250	46	27.5	46		301	24
25		DOOR SYSTEM		2002	2,461	89	27.5	89		493	25
26		GAS/ELECTRIC ROOFTOP UNIT		2002	10,997	400	27.5	400		2,217	26
27		AIR HANDLER		2002	2,237	81	27.5	81		449	27
28		CODE ALERT RESIDENT SECURITY SYSTEM		2002	2,561	93	27.5	93		515	28
29		WATER HEATER		2002	5,490	200	27.5	200		1,108	29
30		FURNISHING - CARPETING		2003	907	52	5	181	129	803	30
31		AWNING		2003	2,010	73	27.5	73		331	31
32		SINKS		2003	619	22	27.5	22		100	32
33		5 TON AIR CONDITIONER FOR KITCHEN		2003	1,700	62	27.5	62		282	33
34		FIRE DAMPERS		2004	5,542	202	27.5	202		648	34
35		ASPHALTING DRIVEWAY		2005	5,700	380	15	380		839	35
36		WATER HEATER		2005	4,509	164	27.5	164		417	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		\$ 167	37
38	ROOF TOP UNIT	2005	3,745	136	27.5	136		346	38
39	GENERATOR	2006	19,135	696	27.5	696		725	39
40	SIDEWALKS	2006	6,000	400	15	400		450	40
41	SIDEWALKS	2007	7,020	215	15	215		215	41
42	PHOTOELECTRIC SMOKE DETECTORS WITH PANEL	2007	2,510	34	27.5	34		34	42
43	ACCESS DOORS IN DUCTS ABOVE DOORS	2007	2,766	38	27.5	38		38	43
44	FIRE ALARM ANNUNCIATOR	2007	3,689	50	27.5	50		50	44
45	CHECK VALVE & MIXING VALVE	2007	6,254	86	27.5	86		86	45
46	COIL & LOW AMBIENT CONTROLS	2007	3,228	44	27.5	44		44	46
47	WATER HEATER	2007	4,100	56	27.5	56		56	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
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68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 242,229	\$ 8,618		\$ 8,747	\$ 129	\$ 51,824	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	\$ 243,495	\$ 19,661	\$ 23,919	\$ 4,258	10 YRS	\$ 151,448	71
72	Current Year Purchases	50,803	10,161	2,540	(7,621)	10 YRS	2,540	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 294,298	\$ 29,822	\$ 26,459	\$ (3,363)		\$ 153,988	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 536,527	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,440	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,206	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,234)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 205,812	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>432,189</u>	<u>30</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		104		\$ 432,189			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 18,742 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. /2008 \$ 432,189

13. /2009 \$ 432,189

14. /2010 \$ 432,189

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 35,226	\$		\$ 35,226	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,194			3,194	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			208,739			208,739	4
5	Physician Care		visits							5
6	Dental Care		visits				86,539		86,539	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	rentals, other services Other (specify): <u>supplies,lab,radiology</u>	39-8 39-8				3,869	21,187		<u>3,869</u> 21,187	13
14	TOTAL			\$		\$ 251,028	\$ 107,726		\$ 358,754	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2007**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,815	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	666,182		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,507		6
7	Other Prepaid Expenses	740		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 752,244	\$	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	239,051		15
16	Equipment, at Historical Cost	297,476		16
17	Accumulated Depreciation (book methods)	(278,590)		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)	\$ 257,937	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,010,181	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 994,321	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	920,338		29
30	Accrued Salaries Payable	95,753		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,440		31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,755		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,044,607	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	110,856		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 110,856	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,155,463	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,145,282)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,010,181	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (952,971)	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)	\$ (952,970)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(192,312)	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)	\$ (192,312)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,145,282)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA, LLC# 0042796Report Period Beginning: 01/01/2007Ending: 12/31/2007

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,101,402	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,101,402	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,177	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 122,177	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***	82	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 82	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,223,661	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,124,651	31
32	Health Care	1,385,667	32
33	General Administration	954,972	33
B. Capital Expense			
34	Ownership	534,989	34
C. Ancillary Expense			
35	Special Cost Centers	358,754	35
36	Provider Participation Fee	56,940	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,415,973	40
41	Income before Income Taxes (line 30 minus line 40)**	(192,312)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (192,312)	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, LLC**

0042796

Report Period Beginning: **01/01/2007**

Ending:

12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,060	2,291	\$ 81,366	\$ 35.52	1
2	Assistant Director of Nursing	2,138	2,434	58,618	24.08	2
3	Registered Nurses	13,909	15,455	324,081	20.97	3
4	Licensed Practical Nurses	3,631	4,022	78,396	19.49	4
5	CNAs & Orderlies	45,275	50,356	582,238	11.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	75	84	937	11.15	8
9	Activity Director	2,038	2,198	26,386	12.00	9
10	Activity Assistants	5,273	5,698	41,948	7.36	10
11	Social Service Workers	3,657	4,047	60,731	15.01	11
12	Dietician					12
13	Food Service Supervisor	2,175	2,378	45,858	19.28	13
14	Head Cook	7,013	8,290	91,107	10.99	14
15	Cook Helpers/Assistants	11,402	12,454	116,761	9.38	15
16	Dishwashers					16
17	Maintenance Workers	9,242	9,841	112,511	11.43	17
18	Housekeepers	16,651	18,996	178,551	9.40	18
19	Laundry	10,845	11,886	96,712	8.14	19
20	Administrator	2,029	2,086	82,384	39.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,525	3,788	77,855	20.55	23
24	Clerical	3,601	3,913	12,495	3.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,998	2,226	32,690	14.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,537	162,443	\$ 2,101,625 *	\$ 12.94	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 7,679	1-3	35
36	Medical Director	O	10,500	9-3	36
37	Medical Records Consultant	N	360	10-3	37
38	Nurse Consultant	T	1,726	10-3	38
39	Pharmacist Consultant	H	783	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,848	11-3	44
45	Social Service Consultant	E	1,500	12-3	45
46	Other(specify) <u>psycho-social</u>	S	3,476	10-3	46
47	<u>Psychiatric Consultant</u>		9,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,872		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
JENNIFER SWINGLE	ADMINISTRATOR	0	\$ 52,287	Workers' Compensation Insurance	\$ 65,518	IDPH License Fee	\$ 995		
	ASST ADMIN		0	Unemployment Compensation Insurance	28,934	Advertising: Employee Recruitment	11,473		
SETH GILLMAN	OTHER ADMIN	0	30,097	FICA Taxes	158,835	Health Care Worker Background Check	800		
				Employee Health Insurance	44,874	(Indicate # of checks performed <u>80</u>)			
				Employee Meals	23,944	Patient Background Checks <u>120</u>	1,204		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,000		
				EMPLOYEE BENEFITS - OTHER	536	MARKETING/ADV/PROMO	13,943		
				EMPLOYEE PHYSICAL EXAMS	2,789	LICENSES/DUES/SUBSCRIPTIONS	9,165		
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	863		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,000)		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(13,473)		
						Yellow page advertising	(470)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 82,384				\$ 325,430			\$ 24,500		
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			\$ 250,172				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)				TOTAL			Seminar Expense		4,446
\$ 250,172				\$			MANGEMENT COMP ALLOCATION		517
C. Professional Services							Entertainment Expense		
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
ENLOE DRUGS	DATA PROCESSING		\$ 1,800				TOTAL		\$ 4,963
E-HEALTH DATA SOLUTIONS	DATA PROCESSING		2,760						
HEALTH DATA SYSTEMS	DATA PROCESSING		8,200						
KBKB	ACCOUNTING		20,650						
OSTROW REISIN BERK	ACCOUNTING		1,250						
STONE,MCGUIREM,BENJAMIN	LEGAL		7,688						
GEORGE ROUMELL	MEDIATOR		1,292						
PERSONNEL PLANNERS	UC CONSULTANT		1,020						
RICHARD PEELO	MEDICARE COST REPORT		2,750						
PROGRESS BILLING	MED B BILLING		6,548						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
\$ 53,958									

* 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/04	\$ 1,081	3 YRS	\$ 180	\$ 360	\$ 360	\$ 181												
2	PAINT/DECORATING	06/04	1,930	3 YRS		322	643	643	322											
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 3,011		\$ 180	\$ 682	\$ 1,003	\$ 824	\$ 322											

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. \$6,760
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,327 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. \$ 23,944 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.