

		FOR BHF USE					

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**2008**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2008)**

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.

**I. IDPH License ID Number:** 0042796

**Facility Name:** ASTA CARE CENTER OF TOLUCA

**Address:** 101 EAST VIA GHIGLIERI TOLUCA 61369  
 Number City Zip Code

**County:** MARSHALL

**Telephone Number:** ( 847 ) 742-8822 **Fax #** ( 847 ) 742-9013

**HFS ID Number:** 36-4163264

**Date of Initial License for Current Owners:** 07/01/1997

**Type of Ownership:**

<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
<b>IRS Exemption Code</b> _____	<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 _____	

**In the event there are further questions about this report, please contact:**  
**Name:** BOB KAGDA **Telephone Number:** ( 847 ) 675-3585  
**Email Address:** \_\_\_\_\_

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2008 to 12/31/2008 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>MICHAEL GILLMAN</u>	
	(Title) <u>MEMBER</u>	
<b>Paid Preparer</b>	(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 &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	
	(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u>	

**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**

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

# 0042796 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	25,986	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,078	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	38,064	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	124	23	1,844	1,991	8
9	SNF/PED					9
10	ICF	24,886	2,443	409	27,738	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,010	2,466	2,253	29,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.10%

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 1,844

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	257,900	17,269	7,645	282,814		282,814		282,814		1
2	Food Purchase		176,316		176,316	(24,595)	151,721	(1,966)	149,755		2
3	Housekeeping	197,520	28,524		226,044		226,044		226,044		3
4	Laundry	100,898	18,566	1,048	120,512		120,512		120,512		4
5	Heat and Other Utilities			107,480	107,480		107,480		107,480		5
6	Maintenance	126,712	45,113	35,967	207,792		207,792	1,052	208,844		6
7	Other (specify):*			8,622	8,622		8,622		8,622		7
8	<b>TOTAL General Services</b>	683,030	285,788	160,762	1,129,580	(24,595)	1,104,985	(914)	1,104,071		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,187,060	69,023	9,878	1,265,961		1,265,961	6,845	1,272,806		10
10a	Therapy	319	767		1,086		1,086		1,086		10a
11	Activities	92,219	7,792	168	100,179		100,179		100,179		11
12	Social Services	62,047		1,370	63,417		63,417		63,417		12
13	CNA Training										13
14	Program Transportation			60	60		60		60		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,341,645	77,582	20,476	1,439,703		1,439,703	6,845	1,446,548		16
	<b>C. General Administration</b>										
17	Administrative	93,286		260,905	354,191		354,191	(145,371)	208,820		17
18	Directors Fees										18
19	Professional Services			58,469	58,469		58,469	1,421	59,890		19
20	Dues, Fees, Subscriptions & Promotions			26,589	26,589		26,589	(11,494)	15,095		20
21	Clerical & General Office Expenses	103,479	21,420	55,122	180,021		180,021	(11,734)	168,287		21
22	Employee Benefits & Payroll Taxes			326,960	326,960	24,595	351,555		351,555		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,466	1,466		1,466	562	2,028		24
25	Other Admin. Staff Transportation			10,221	10,221		10,221	(203)	10,018		25
26	Insurance-Prop.Liab.Malpractice			68,243	68,243		68,243	1,759	70,002		26
27	Other (specify):*			39,941	39,941		39,941	(31,639)	8,302		27
28	<b>TOTAL General Administration</b>	196,765	21,420	847,916	1,066,101	24,595	1,090,696	(196,699)	893,997		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,221,440	384,790	1,029,154	3,635,384		3,635,384	(190,768)	3,444,616		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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	6,885
	REPAIRS & MAINTENANCE	760
		0
		7,645
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,048
		0
		1,048
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	24,457
	ELECTRICITY	51,233
	WATER	28,539
	CABLE TV - LOBBY	3,251
		0
		107,480
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	3,353
	PAINTING & DECORATING	
	BUILDING REPAIRS	3,984
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,707
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,414
	FIRE SERVICE	6,251
	PAINTING & DECORATING	5,258
		0
		0
		0
		35,967
7	<b>OTHER</b>	
	SCAVENGER	8,622
	SECURITY SERVICE	0
		0
		0
		8,622
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	708
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	720
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	7,000
	RN CONSULTANT XVIII B 38-2	850
		0
		0
		9,878
10a	<b>THERAPY</b>	
	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	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	168
		0
		168
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,370
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,370
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	60
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	260,905
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	9,391
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	49,078
		0
		58,469
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	11,985
	EMPLOYEE WANT ADS XIX F	4,795
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	6,197
	LICENSES & PERMITS XIX F	1,813
	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	499
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	700
	PATIENT BACKGROUND CHECKS XIX F	600
		26,589
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,922
	EQUIPMENT REPAIR & MAINTENANCE	1,760
	OUTSIDE CLERICAL SERVICES	1,400
	PENALTIES / OVERDRAFT CHARGES VI 18	24,837
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,048
	MESSENGER SERVICE	1,155
		0
		55,122

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	166,646
	UNEMPLOYMENT COMPENSATION XIX D	26,001
	WORKERS COMPENSATION INSURANC XIX D	98,431
	HOSPITALIZATION INSURANCE XIX D	31,762
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	4,120
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		326,960
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	1,466
	TRAVEL XIX G	0
		1,466
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	10,221
		10,221
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	68,243
		68,243
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	39,941
		39,941

GRAND TOTAL COLUMN 3 OTHER

1,029,154

**ASTA CARE CENTER OF TOLUCA  
SCHEDULES  
12/31/2008**

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

TOTAL FOOD PURCHASE	176,316
LESS SALES TAX	<u>(1,966)</u>
NET FOOD	174,350

TOTAL PATIENT CENSUS	29,729
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	89,187

ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	14,640

PATIENT MEALS	89,187
ADD EMPLOYEE MEALS	<u>14,640</u>
TOTAL MEALS/YEAR	103,827

NET FOOD	174,350
DIVIDE TOTAL MEALS/YEAR	<u>103,827</u>

COST PER MEAL	1.68
TIME EMPLOYEE MEALS	<u>14,640</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>24,595</b>

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Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

#0042796

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			52,340	52,340		52,340	(12,198)	40,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,544	29,544		29,544	(4,896)	24,648			32
33	Real Estate Taxes			21,051	21,051		21,051		21,051			33
34	Rent-Facility & Grounds			441,700	441,700		441,700		441,700			34
35	Rent-Equipment & Vehicles			21,326	21,326		21,326	487	21,813			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			565,961	565,961		565,961	(16,607)	549,354			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,888	265,330	341,218		341,218		341,218			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,096	57,096		57,096		57,096			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		75,888	322,426	398,314		398,314		398,314			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,221,440	460,678	1,917,541	4,599,659		4,599,659	(207,375)	4,392,284			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(12,198)	30		9
10	Interest and Other Investment Income	(621)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,966)	2		13
14	Non-Care Related Interest	(4,275)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(24,837)	21		18
19	Entertainment		20		19
20	Contributions	(499)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(257)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,941)	27		24
25	Fund Raising, Advertising and Promotional	(11,985)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(6,416)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (102,995)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(104,380)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (104,380)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (207,375)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ASTA CARE CENTER OF TOLUCA

ID# 0042796

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 322	6	1
2				2
3	TRAVEL	(6,738)	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	<b>Total</b>	(6,416)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	(1,966)	0	0	0	0	0	0	0	0	0	0	(1,966)	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	322	730	0	0	0	0	0	0	0	0	0	1,052	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,644)</b>	<b>730</b>	<b>0</b>	<b>(914)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,845	0	0	0	0	0	0	0	0	0	6,845	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>6,845</b>	<b>0</b>	<b>6,845</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	(145,371)	0	0	0	0	0	0	0	0	0	(145,371)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(257)	1,678	0	0	0	0	0	0	0	0	0	1,421	19
20	Fees, Subscriptions & Promotions	(12,484)	990	0	0	0	0	0	0	0	0	0	(11,494)	20
21	Clerical & General Office Expenses	(24,837)	13,103	0	0	0	0	0	0	0	0	0	(11,734)	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	562	0	0	0	0	0	0	0	0	0	562	24
25	Other Admin. Staff Transportation	(6,738)	6,535	0	0	0	0	0	0	0	0	0	(203)	25
26	Insurance-Prop.Liab.Malpractice	0	1,759	0	0	0	0	0	0	0	0	0	1,759	26
27	Other (specify):*	(39,941)	8,302	0	0	0	0	0	0	0	0	0	(31,639)	27
28	<b>TOTAL General Administration</b>	<b>(84,257)</b>	<b>(112,442)</b>	<b>0</b>	<b>(196,699)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(85,901)</b>	<b>(104,867)</b>	<b>0</b>	<b>(190,768)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

# 0042796

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,198)	0	0	0	0	0	0	0	0	0	0	(12,198)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,896)	0	0	0	0	0	0	0	0	0	0	(4,896)	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	487	0	0	0	0	0	0	0	0	0	487	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(17,094)</b>	<b>487</b>	<b>0</b>	<b>(16,607)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(102,995)</b>	<b>(104,380)</b>	<b>0</b>	<b>(207,375)</b>	<b>45</b>								

**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	\$ 260,905	ASTA HEALTHCARE MANAGEMENT		\$	(260,905)	1
2	V	6 MAINTENANCE				730	730	2
3	V	10 NURSING				6,845	6,845	3
4	V	17 ADMINISTRATIVE				115,534	115,534	4
5	V	19 PROFESSIONAL FEES				1,678	1,678	5
6	V	20 LICENSES & PERMITS				990	990	6
7	V	21 OFFICE EXPENSE				13,103	13,103	7
8	V	24 SEMINARS				562	562	8
9	V	25 STAFF TRANS/ TRAVEL				6,535	6,535	9
10	V	26 INSURANCE GEN / WC				1,759	1,759	10
11	V	27 PAYR. TAXES & GRP INS				8,302	8,302	11
12	V	35 EQUIPMENT RENTAL				487	487	12
13	V							13
14	Total		\$ 260,905			\$ 156,525	\$ * (104,380)	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: 01/01/2008 Ending: 12/31/2008

## 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	LIST	ATTACHED	SALARY	\$ 31,363	17-7	1
2											2
3	SETH GILLMAN				LIST ATTACHED	LIST	ATTACHED	SALARY	19,746	17-7	3
4	PROFESSIONAL FEE FOR WOUND BILLING (BLOOMINGTON) \$3,964										4
5	SALARY FROM ASTA CARE OF TOLUCA \$31,317								31,317	17-1	5
6											6
7	CRAIG FRANK				LIST ATTACHED	LIST	ATTACHED	SALARY	24,327	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,572										8
9											9
10	DAVID MEISELMAN				LIST ATTACHED	LIST	ATTACHED	SALARY	1,949	17-7	10
11	SALARY FROM ASTA CARE OF ELGIN \$233,408										11
12	ALIZA FRANK				LIST ATTACHED	LIST	ATTACHED	SALARY	5,421	21-7	12
13								TOTAL	\$ 114,123		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:

01/01/2008

Ending: 2/31/2008

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	184,841	6	\$ 4,539	\$ 29,729	\$ 730	1	
2	10	NURSING	PATIENT DAYS	184,841	6	42,560	42,560	29,729	6,845	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	184,841	6	195,000	195,000	29,729	31,363	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	184,841	6	122,770	122,770	29,729	19,746	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	184,841	6	151,251	151,251	29,729	24,327	5
6	17	ADMIN. SALARY - DM	PATIENT DAYS	184,841	6	12,117	12,117	29,729	1,949	6
7	17	ADMIN. SALARY	PATIENT DAYS	184,841	6	184,098	184,098	29,729	29,609	7
8	17	OUTSIDE CLERICAL	PATIENT DAYS	184,841	6	53,100		29,729	8,540	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	184,841	6	10,435		29,729	1,678	9
10	20	LICENSES & PERMITS	PATIENT DAYS	184,841	6	6,154		29,729	990	10
11	21	OFFICE EXPENSE	PATIENT DAYS	184,841	6	48,883	5,629	29,729	7,862	11
12	21	CLERICAL SALARY-AF	PATIENT DAYS	184,841	6	32,584	32,584	29,729	5,241	12
13	24	SEMINARS	PATIENT DAYS	184,841	6	3,497		29,729	562	13
14	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	184,841	6	40,634		29,729	6,535	14
15	26	INSURANCE GEN / WC	PATIENT DAYS	184,841	6	10,938		29,729	1,759	15
16	27	PAYR. TAXES & GRP INS	PATIENT DAYS	184,841	6	51,620		29,729	8,302	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	184,841	6	3,029		29,729	487	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 973,209	\$ 746,009	\$ 156,525		25

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

# 0042796

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	GLAUBACH		LOAN PAYABLE			200,000	200,000		18,000	6										
7	MEMBER LOAN	X	WORKING CAPITAL						4,523	7										
8		X	INSURANCE POLICIES						2,746	8										
9	TOTAL Facility Related					\$ 200,000	\$ 200,000		\$ 25,269	9										
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC		LATE FEES							10										
11										11										
12	BED TAX		BED TAX						4,275	12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$ 4,275	14										
15	TOTALS (line 9+line14)					\$ 200,000	\$ 200,000		\$ 29,544	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

	(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>18,902.54</u>	\$ <u>18,902.54</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>
		<b>TOTALS</b>	\$ <u>18,902.54</u>	\$ <u>18,902.54</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:**

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

Facility Name &amp; ID Number ASTA CARE CENTER OF TOLUCA

# 0042796

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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
	<b>Improvement Type**</b>										
9		<b>SIGN</b>	1997		950	24	39	24		269	9
10		<b>WATER HEATER</b>	1997		2,824	73	39	73		818	10
11		<b>NURSES STATION</b>	1998		6,622	170	39	170		1,721	11
12		<b>ELECTRICAL WATER HEATER</b>	1998		3,400	87	39	87		881	12
13		<b>HANDRAILS</b>	1998		4,445	114	39	114		1,154	13
14		<b>LAUNDRY BUILDING</b>	1999		69,014	2,510	27.5	2,510		23,322	14
15		<b>DOORS</b>	2000		3,400	124	27.5	124		1,059	15
16		<b>REKEY LOCKS</b>	2000		1,672	61	27.5	61		521	16
17		<b>DOORS</b>	2000		10,080	366	27.5	366		3,127	17
18		<b>BUSHES</b>	2000		2,493	166	15	166		1,418	18
19		<b>ROOF</b>	2000		16,511	600	27.5	600		5,125	19
20		<b>FENCE</b>	2000		2,981	199	15	199		1,700	20
21		<b>FURNISHING</b>	2000		2,271		7			2,271	21
22		<b>ROOF</b>	2001		6,500	236	27.5	236		1,780	22
23		<b>DOOR ACCESS SYSTEM</b>	2001		2,825	103	27.5	103		777	23
24		<b>FLASHING</b>	2001		1,250	46	27.5	46		347	24
25		<b>DOOR SYSTEM</b>	2002		2,461	89	27.5	89		582	25
26		<b>GAS/ELECTRIC ROOFTOP UNIT</b>	2002		10,997	400	27.5	400		2,617	26
27		<b>AIR HANDLER</b>	2002		2,237	81	27.5	81		530	27
28		<b>CODE ALERT RESIDENT SECURITY SYSTEM</b>	2002		2,561	93	27.5	93		608	28
29		<b>WATER HEATER</b>	2002		5,490	200	27.5	200		1,308	29
30		<b>FURNISHING - CARPETING</b>	2003		907	26	5	104	78	907	30
31		<b>AWNING</b>	2003		2,010	73	27.5	73		404	31
32		<b>SINKS</b>	2003		619	22	27.5	22		122	32
33		<b>5 TON AIR CONDITIONER FOR KITCHEN</b>	2003		1,700	62	27.5	62		344	33
34		<b>FIRE DAMPERS</b>	2004		5,542	202	27.5	202		850	34
35		<b>ASPHALTING DRIVEWAY</b>	2005		5,700	380	15	380		1,219	35
36		<b>WATER HEATER</b>	2005		4,509	164	27.5	164		581	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number ASTA CARE CENTER OF TOLUCA

# 0042796

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## 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		\$ 233	37
38	ROOF TOP UNIT	2005	3,745	136	27.5	136		482	38
39	GENERATOR	2006	19,135	696	27.5	696		1,421	39
40	SIDEWALKS	2006	6,000	400	15	400		850	40
41	SIDEWALKS	2007	7,020	468	15	468		683	41
42	PHOTOELECTRIC SMOKE DETECTORS WITH PANEL	2007	2,510	91	27.5	91		125	42
43	ACCESS DOORS IN DUCTS ABOVE DOORS	2007	2,766	101	27.5	101		139	43
44	FIRE ALARM ANNUNCIATOR	2007	3,689	134	27.5	134		184	44
45	CHECK VALVE & MIXING VALVE	2007	6,254	228	27.5	228		314	45
46	COIL & LOW AMBIENT CONTROLS	2007	3,228	117	27.5	117		161	46
47	WATER HEATER	2007	4,100	149	27.5	149		205	47
48	CUBICLE CURTAINS	2008	2,658	2,658	5	266	(2,392)	266	48
49	SIDEWALKS	2008	5,250	175	15	175		175	49
50	EMERGENCY LIGHTS	2008	3,641	72	27.5	72		72	50
51	SMOKE DAMPERS	2008	7,758	153	27.5	153		153	51
52	REHAB FIREDOORS	2008	3,080	61	27.5	61		61	52
53	CEILING TILE	2008	3,540	70	27.5	70		70	53
54	EMERGENCY PANEL & ANNUNCIATOR	2008	4,504	88	27.5	88		88	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)		\$ 272,660	\$ 12,534		\$ 10,220	\$ (2,314)	\$ 62,044	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	\$ 284,698	\$ 27,555	\$ 28,901	\$ 1,346	10 YRS	\$ 173,289	71
72	Current Year Purchases	20,417	12,251	1,021	(11,230)	10 YRS	1,021	72
73	Fully Depreciated Assets	9,600				10 YRS	9,600	73
74								74
75	TOTALS	\$ 314,715	\$ 39,806	\$ 29,922	\$ (9,884)		\$ 183,910	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)	\$ 587,375	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,340	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 40,142	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,198)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 245,954	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>441,700</u>	<u>30</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>104</u>		\$ <u>441,700</u>			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 21,326 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ <u>441,700</u>
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 47,041	\$		\$ 47,041	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,112			3,112	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			200,576			200,576	4
5	Physician Care		visits			1,061			1,061	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				59,811		59,811	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	rentals, other services	39-8				13,540			13,540	
	Other (specify): <u>supplies,lab,radiology</u>	39-8					16,077		16,077	13
14	TOTAL			\$		\$ 265,330	\$ 75,888		\$ 341,218	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 &amp; ID Number ASTA CARE CENTER OF TOLUCA

# 0042796

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,648	\$	1
2	Cash-Patient Deposits	582,788		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )			3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,795		6
7	Other Prepaid Expenses	1,294		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 617,525	\$	10
	<b>B. Long-Term Assets</b>			
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	274,431		15
16	Equipment, at Historical Cost	314,715		16
17	Accumulated Depreciation (book methods)	(330,930)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 258,216	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 875,741	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,224,256	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	962,696		29
30	Accrued Salaries Payable	106,081		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,385		31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,903		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,325,321	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	110,856		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 110,856	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,436,177	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,560,436)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 875,741	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,145,282)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>5</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,145,277)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(415,159)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(415,159)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,560,436)</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,090,185	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,090,185	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	83,790	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 83,790	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	621	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 621	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other Expense Adjustment</b>	9,904	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,904	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,184,500	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,129,580	31
32	Health Care	1,439,703	32
33	General Administration	1,066,101	33
	<b>B. Capital Expense</b>		
34	Ownership	565,961	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	341,218	35
36	Provider Participation Fee	57,096	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,599,659	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(415,159)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (415,159)	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: 01/01/2008

Ending: 12/31/2008

**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	2,438	2,718	\$ 106,478	\$ 39.18	1
2	Assistant Director of Nursing	2,298	2,600	66,762	25.68	2
3	Registered Nurses	12,627	14,070	319,545	22.71	3
4	Licensed Practical Nurses	2,450	2,957	61,783	20.89	4
5	CNAs & Orderlies	46,320	51,580	599,785	11.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	27	27	319	11.81	8
9	Activity Director	2,396	2,577	28,679	11.13	9
10	Activity Assistants	7,630	8,040	63,540	7.90	10
11	Social Service Workers	4,012	4,459	62,047	13.92	11
12	Dietician					12
13	Food Service Supervisor	1,822	2,157	42,205	19.57	13
14	Head Cook	4,629	5,453	63,041	11.56	14
15	Cook Helpers/Assistants	15,201	16,679	152,654	9.15	15
16	Dishwashers					16
17	Maintenance Workers	10,211	11,075	126,712	11.44	17
18	Housekeepers	19,383	21,027	197,520	9.39	18
19	Laundry	10,686	12,012	100,898	8.40	19
20	Administrator	3,983	4,438	93,286	21.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,124	6,644	103,479	15.57	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	1,939	2,141	32,707	15.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,176	170,654	\$ 2,221,440 *	\$ 13.02	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	\$ 6,885	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	720	10-3	37
38	Nurse Consultant	T	850	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	168	11-3	44
45	Social Service Consultant	E	1,370	12-3	45
46	Other(specify) <u>psycho-social</u>	S	708	10-3	46
47	<u>Psychiatric Consultant</u>		7,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,301		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	\$ 61,969	Workers' Compensation Insurance	\$ 98,431	IDPH License Fee	\$ 995	
	ASST ADMIN		0	Unemployment Compensation Insurance	26,001	Advertising: Employee Recruitment	4,795	
SETH GILMAN	OTHER ADMIN		31,317	FICA Taxes	166,646	Health Care Worker Background Check	700	
				Employee Health Insurance	31,762	(Indicate # of checks performed 70 )		
				Employee Meals	24,595	Patient Background Checks	60	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	499	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	11,985	
				EMPLOYEE PHYSICAL EXAMS	4,120	LICENSES/DUES/SUBSCRIPTIONS	7,015	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	990	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(499)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(11,985)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,286	TOTAL (agree to Schedule V, line 22, col.8)	\$ 351,555	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,095	
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			\$ 260,905			\$	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)			\$ 260,905				Seminar Expense	1,466
							MGMT CO ALLOC	562
C. Professional Services							Entertainment Expense	( )
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 2,028
SEE SCHEDULE ATTACHED			58,469					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 58,469	TOTAL		\$		

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1	<b>PAINT/DECORATING</b>	<b>06/05</b>	<b>\$ 1,930</b>	<b>3 YRS</b>	<b>\$ 322</b>	<b>\$ 643</b>	<b>\$ 643</b>	<b>\$ 322</b>	\$	\$	\$	\$	\$							
2																				
3																				
4																				
5																				
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10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		<b>\$ 1,930</b>		<b>\$ 322</b>	<b>\$ 643</b>	<b>\$ 643</b>	<b>\$ 322</b>	\$	\$	\$	\$	\$							

Facility Name &amp; ID Number ASTA CARE CENTER OF TOLUCA

# 0042796

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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 \$5,740
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,270 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. \$ 57,096  
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. \$ 24,595 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