

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

0042796 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	333	240	1,845	2,418	8
9	SNF/PED					9
10	ICF	24,365	1,375	93	25,833	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,698	1,615	1,938	28,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.42%

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 65 and days of care provided 1,845

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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	260,223	17,106	7,119	284,448		284,448		284,448		1
2	Food Purchase		150,817		150,817		150,817	(1,820)	148,997		2
3	Housekeeping	299,027	34,350		333,377		333,377		333,377		3
4	Laundry	101,450	17,402	1,463	120,315		120,315		120,315		4
5	Heat and Other Utilities			109,065	109,065		109,065		109,065		5
6	Maintenance	125,648	30,584	35,668	191,900		191,900	809	192,709		6
7	Other (specify):*			12,114	12,114		12,114		12,114		7
8	TOTAL General Services	786,348	250,259	165,429	1,202,036		1,202,036	(1,011)	1,201,025		8
	B. Health Care and Programs										
9	Medical Director			11,246	11,246		11,246		11,246		9
10	Nursing and Medical Records	1,200,801	65,963	6,960	1,273,724		1,273,724	2,058	1,275,782		10
10a	Therapy		1,064		1,064		1,064		1,064		10a
11	Activities	94,435	8,204	2,080	104,719		104,719		104,719		11
12	Social Services	81,891		3,719	85,610		85,610		85,610		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,377,127	75,231	24,005	1,476,363		1,476,363	2,058	1,478,421		16
	C. General Administration										
17	Administrative	68,697		204,000	272,697		272,697	(122,599)	150,098		17
18	Directors Fees										18
19	Professional Services			45,914	45,914		45,914	240	46,154		19
20	Dues, Fees, Subscriptions & Promotions			21,279	21,279		21,279	(6,934)	14,345		20
21	Clerical & General Office Expenses	99,526	22,846	53,481	175,853		175,853	8,920	184,773		21
22	Employee Benefits & Payroll Taxes			282,493	282,493		282,493		282,493		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,535	3,535		3,535	44	3,579		24
25	Other Admin. Staff Transportation			15,935	15,935		15,935	(6,898)	9,037		25
26	Insurance-Prop.Liab.Malpractice			75,730	75,730		75,730	1,460	77,190		26
27	Other (specify):*			5,473	5,473		5,473	1,677	7,150		27
28	TOTAL General Administration	168,223	22,846	707,840	898,909		898,909	(124,090)	774,819		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,331,698	348,336	897,274	3,577,308		3,577,308	(123,043)	3,454,265		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,884
	REPAIRS & MAINTENANCE	235
		0
		7,119
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,463
		0
		1,463
5	HEAT & OTHER UTILITIES	
	GAS HEAT	16,352
	ELECTRICITY	61,039
	WATER	29,009
	CABLE TV - LOBBY	2,665
		0
		109,065
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,180
	PAINTING & DECORATING	2,332
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	21,691
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,954
	FIRE SERVICE	4,511
		0
		0
		0
		0
		35,668
7	OTHER	
	SCAVENGER	12,114
	SECURITY SERVICE	
		0
		0
		12,114
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,246
		11,246

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	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	360
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	6,000
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		6,960
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,080
		0
		2,080
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,331
	SOCIAL WORKER XVIII B 45-2	2,388
		0
		3,719
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		0
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	204,000
			204,000
	DIRECTORS FEES		
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	13,285
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	32,629
			0
			45,914
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,800
	EMPLOYEE WANT ADS	XIX F	2,496
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	4,493
	LICENSES & PERMITS	XIX F	2,789
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	462
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,716
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,351
	PATIENT BACKGROUND CHECKS	XIX F	2,172
			21,279
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,514
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	25,690
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		20,221
	MESSENGER SERVICE		1,056
			0
			53,481

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	175,407
	UNEMPLOYMENT COMPENSATION	XIX D	25,830
	WORKERS COMPENSATION INSURANC	XIX D	44,524
	HOSPITALIZATION INSURANCE	XIX D	34,641
	EMPLOYEE BENEFITS - OTHER	XIX D	616
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,475
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
	CHICAGO HEAD TAX	XIX D	0
			0
			282,493
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		0
			0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	3,535
	TRAVEL	XIX G	0
			3,535
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		15,935
			15,935
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		75,730
			75,730
27	OTHER		
	BAD DEBTS	VI 24	5,473
			5,473

GRAND TOTAL COLUMN 3 OTHER

897,274

ASTA CARE CENTER OF TOLUCA
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	150,817
LESS SALES TAX	<u>(1,820)</u>
NET FOOD	148,997

TOTAL PATIENT CENSUS	28,251
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	84,753

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

PATIENT MEALS	84,753
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	84,753

NET FOOD	148,997
DIVIDE TOTAL MEALS/YEAR	<u>84,753</u>

COST PER MEAL	1.76
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

#0042796

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			38,970	38,970		38,970	(6,128)	32,842			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,412	26,412		26,412	(5,717)	20,695			32
33	Real Estate Taxes			23,437	23,437		23,437		23,437			33
34	Rent-Facility & Grounds			314,885	314,885		314,885		314,885			34
35	Rent-Equipment & Vehicles			13,830	13,830		13,830		13,830			35
36	Other (specify):*											36
37	TOTAL Ownership			417,534	417,534		417,534	(11,845)	405,689			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,236	168,452	281,688		281,688		281,688			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		113,236	225,392	338,628		338,628		338,628			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,331,698	461,572	1,540,200	4,333,470		4,333,470	(134,888)	4,198,582			45

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

0042796

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,128)	30		9
10	Interest and Other Investment Income	(22)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,820)	2		13
14	Non-Care Related Interest	(5,695)	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	(25,690)	21		18
19	Entertainment		20		19
20	Contributions	(1,716)	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	(5,473)	27		24
25	Fund Raising, Advertising and Promotional	(5,800)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(462)	20		28
29	Other-Attach Schedule	(13,739)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,545)		\$	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)	(68,343)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (68,343)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (134,888)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ASTA CARE CENTER OF TOLUCA

ID# 0042796

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	NONALLOWABLE - TRAVEL	(13,739)	25	2
3				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		(13,739)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(1,820)	0	0	0	0	0	0	0	0	0	0	(1,820)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	809	0	0	0	0	0	0	0	0	0	809	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,820)	809	0	(1,011)	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	2,058	0	0	0	0	0	0	0	0	0	2,058	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	2,058	0	2,058	16								
	C. General Administration													
17	Administrative	0	(122,599)	0	0	0	0	0	0	0	0	0	(122,599)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	240	0	0	0	0	0	0	0	0	0	240	19
20	Fees, Subscriptions & Promotions	(7,978)	1,044	0	0	0	0	0	0	0	0	0	(6,934)	20
21	Clerical & General Office Expenses	(25,690)	34,610	0	0	0	0	0	0	0	0	0	8,920	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	44	0	0	0	0	0	0	0	0	0	44	24
25	Other Admin. Staff Transportation	(13,739)	6,841	0	0	0	0	0	0	0	0	0	(6,898)	25
26	Insurance-Prop.Liab.Malpractice	0	1,460	0	0	0	0	0	0	0	0	0	1,460	26
27	Other (specify):*	(5,473)	7,150	0	0	0	0	0	0	0	0	0	1,677	27
28	TOTAL General Administration	(52,880)	(71,210)	0	(124,090)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,700)	(68,343)	0	(123,043)	29								

STATE OF ILLINOIS

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

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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	(6,128)	0	0	0	0	0	0	0	0	0	0	(6,128)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,717)	0	0	0	0	0	0	0	0	0	0	(5,717)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,845)	0	0	0	0	0	0	0	0	0	0	(11,845)	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)	(66,545)	(68,343)	0	0	0	0	0	0	0	0	0	(134,888)	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	\$ 204,000	ASTA HEALTHCARE MANAGEMENT		\$	\$ (204,000)	1
2	V	6 MAINTENANCE				809	809	2
3	V	10 NURSING				2,058	2,058	3
4	V	17 ADMINISTRATIVE				81,401	81,401	4
5	V	19 PROFESSIONAL FEES				240	240	5
6	V	20 LICENSES & PERMITS				1,044	1,044	6
7	V	21 OFFICE EXPENSE				34,610	34,610	7
8	V	24 SEMINARS				44	44	8
9	V	25 STAFF TRANS/ TRAVEL				6,841	6,841	9
10	V	26 INSURANCE GEN / WC				1,460	1,460	10
11	V	27 PAYR. TAXES & GRP INS				7,150	7,150	11
12	V							12
13	V							13
14	Total		\$ 204,000			\$ 135,657	\$ * (68,343)	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: 01/01/2009 Ending: 12/31/2009

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							SALARY	\$ 30,874	17-7	1
2											2
3	SETH GILLMAN							SALARY	1,070	17-7	3
4											4
5					SEE		SEE				5
6					ATTACHED		ATTACHED				6
7	CRAIG FRANK				SCHEDULE		SCHEDULE	SALARY	26,025	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,333										8
9											9
10											10
11											11
12	ALIZA FRANK							SALARY	5,383	17-7	12
13								TOTAL	\$ 63,352		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: 01/01/2009

Ending: 2/31/2009

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	6	MAINTENANCE	PATIENT DAYS	178,434	6	\$ 5,107	28,251	\$ 809	1	
2	10	NURSING	PATIENT DAYS	178,434	6	13,000	13,000	28,251	2,058	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	178,434	6	195,000	195,000	28,251	30,874	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	178,434	6	6,755	6,755	28,251	1,070	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	178,434	6	164,375	164,375	28,251	26,025	5
6	17	ADMIN. SALARY -AF	PATIENT DAYS	178,434	6	34,000	34,000	28,251	5,383	6
7	17	ADMIN. SALARY- JS	PATIENT DAYS	178,434	6	114,000	114,000	28,251	18,049	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,434	6	1,518		28,251	240	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,434	6	6,596		28,251	1,044	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,434	6	218,597	139,019	28,251	34,610	10
11	24	SEMINARS	PATIENT DAYS	178,434	6	275		28,251	44	11
12	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	178,434	6	43,211		28,251	6,841	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,434	6	9,222		28,251	1,460	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,434	6	45,157		28,251	7,150	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 856,813	\$ 666,149		\$ 135,657	25

Facility Name & ID Number

ASTA CARE CENTER OF TOLUCA

0042796

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	GLAUBACH			LOAN PAYABLE				200,000			13,500	6				
7			X	INSURANCE POLICIES							5,003	7				
8	MEMBER LOAN	X		WORKING CAPITAL							2,214	8				
9	TOTAL Facility Related						\$	\$ 200,000			\$ 20,717	9				
	B. Non-Facility Related*															
10												10				
11												11				
12	BED TAX			BED TAX							5,695	12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ 5,695	14				
15	TOTALS (line 9+line14)						\$	\$ 200,000			\$ 26,412	15				

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2008 report.	\$	18,903	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.)	\$	21,170	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,267	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	21,170	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.	\$	23,437	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	16,330	8
	2005	15,758	9
	2006	16,754	10
	2007	18,903	11
	2008	21,170	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>21,170.18</u>	\$ <u>21,170.18</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

0042796

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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		293	9
10		WATER HEATER	1997		2,824	73	39	73		891	10
11		NURSES STATION	1998		6,622	170	39	170		1,891	11
12		ELECTRICAL WATER HEATER	1998		3,400	87	39	87		968	12
13		HANDRAILS	1998		4,445	114	39	114		1,268	13
14		LAUNDRY BUILDING	1999		69,014	2,510	27.5	2,510		25,832	14
15		DOORS	2000		3,400	124	27.5	124		1,183	15
16		REKEY LOCKS	2000		1,672	61	27.5	61		582	16
17		DOORS	2000		10,080	366	27.5	366		3,493	17
18		BUSHES	2000		2,493	166	15	166		1,584	18
19		ROOF	2000		16,511	600	27.5	600		5,725	19
20		FENCE	2000		2,981	199	15	199		1,899	20
21		FURNISHING	2000		2,271		7			2,271	21
22		ROOF	2001		6,500	236	27.5	236		2,016	22
23		DOOR ACCESS SYSTEM	2001		2,825	103	27.5	103		880	23
24		FLASHING	2001		1,250	46	27.5	46		393	24
25		DOOR SYSTEM	2002		2,461	89	27.5	89		671	25
26		GAS/ELECTRIC ROOFTOP UNIT	2002		10,997	400	27.5	400		3,017	26
27		AIR HANDLER	2002		2,237	81	27.5	81		611	27
28		CODE ALERT RESIDENT SECURITY SYSTEM	2002		2,561	93	27.5	93		701	28
29		WATER HEATER	2002		5,490	200	27.5	200		1,508	29
30		FURNISHING - CARPETING	2003		907		5			907	30
31		AWNING	2003		2,010	73	27.5	73		477	31
32		SINKS	2003		619	22	27.5	22		144	32
33		5 TON AIR CONDITIONER FOR KITCHEN	2003		1,700	62	27.5	62		406	33
34		FIRE DAMPERS	2004		5,542	202	27.5	202		1,052	34
35		ASPHALTING DRIVEWAY	2005		5,700	380	15	380		1,599	35
36		WATER HEATER	2005		4,509	164	27.5	164		745	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 299	37
38	ROOF TOP UNIT	2005	3,745	136	27.5	136		618	38
39	GENERATOR	2006	19,135	696	27.5	696		2,117	39
40	SIDEWALKS	2006	6,000	400	15	400		1,250	40
41	SIDEWALKS	2007	7,020	468	15	468		1,151	41
42	PHOTOELECTRIC SMOKE DETECTORS WITH PANEL	2007	2,510	91	27.5	91		216	42
43	ACCESS DOORS IN DUCTS ABOVE DOORS	2007	2,766	101	27.5	101		240	43
44	FIRE ALARM ANNUNCIATOR	2007	3,689	134	27.5	134		318	44
45	CHECK VALVE & MIXING VALVE	2007	6,254	228	27.5	228		542	45
46	COIL & LOW AMBIENT CONTROLS	2007	3,228	117	27.5	117		278	46
47	WATER HEATER	2007	4,100	149	27.5	149		354	47
48	CUBICLE CURTAINS	2008	4,429	708	5	266	(442)	532	48
49	SIDEWALKS	2008	5,250	350	15	350		525	49
50	EMERGENCY LIGHTS	2008	3,641	132	27.5	132		204	50
51	SMOKE DAMPERS	2008	7,758	282	27.5	282		435	51
52	REHAB FIREDOORS	2008	3,080	112	27.5	112		173	52
53	CEILING TILE	2008	3,540	129	27.5	129		199	53
54	EMERGENCY PANEL & ANNUNCIATOR	2008	4,504	164	27.5	164		252	54
55	WATER HEATER	2009	5,395	57	27.5	57		57	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)		\$ 279,826	\$ 11,165		\$ 10,723	\$ (442)	\$ 72,767	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	\$ 215,283	\$ 20,708	\$ 21,528	\$ 820		\$ 106,006	71
72	Current Year Purchases	11,827	7,097	591	(6,506)		591	72
73	Fully Depreciated Assets	99,432					99,432	73
74								74
75	TOTALS	\$ 326,542	\$ 27,805	\$ 22,119	\$ (5,686)		\$ 206,029	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)	\$ 606,368	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,970	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,842	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,128)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 278,796	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:		104	07/97	\$ 314,885	30		3
4	Additions							4
5								5
6								6
7	TOTAL		104		\$ 314,885			7

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

9. Option to Buy: YES NO Terms: PURCHASE PRICE 3796000 *

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: \$ 13,830 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

* 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.

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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist	39-3	hrs	\$			\$ 17,900	\$			\$ 17,900	1
2	Licensed Speech and Language Development Therapist	39-3	hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				136,827				136,827	4
5	Physician Care		visits				492				492	5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts						85,328		85,328	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>supplies, inhalation, lab</u>	39-8					<u>13,233</u>		27,908		<u>13,233</u> 27,908	13
14	TOTAL			\$			\$ 168,452	\$	113,236	\$	281,688	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA# 0042796Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 35,920	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	477,602		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,026		6
7	Other Prepaid Expenses	4,555		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From Rockford Properties</u>	25,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 578,103	\$	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	272,219		15
16	Equipment, at Historical Cost	334,149		16
17	Accumulated Depreciation (book methods)	(369,900)		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)	\$ 236,468	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 814,571	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,068,703	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,438,875		29
30	Accrued Salaries Payable	127,392		30
31	Accrued Taxes Payable (excluding real estate taxes)	109,359		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,170		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)	\$ 2,765,499	\$	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)	\$ 2,876,355	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,061,784)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 814,571	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,560,436)	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,560,432)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(501,352)	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)	\$ (501,352)	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)	\$ (2,061,784)	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,832,096	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,832,096	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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***	22	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22	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)	\$ 3,832,118	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,202,036	31
32	Health Care	1,476,363	32
33	General Administration	898,909	33
B. Capital Expense			
34	Ownership	417,534	34
C. Ancillary Expense			
35	Special Cost Centers	281,688	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)*	\$ 4,333,470	40
41	Income before Income Taxes (line 30 minus line 40)**	(501,352)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (501,352)	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: 01/01/2009

Ending: 12/31/2009

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	2,103	2,394	\$ 91,577	\$ 38.25	1
2	Assistant Director of Nursing	2,148	2,436	63,511	26.07	2
3	Registered Nurses	12,019	13,669	314,250	22.99	3
4	Licensed Practical Nurses	4,698	5,075	106,303	20.95	4
5	CNAs & Orderlies	44,858	50,172	588,172	11.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,035	2,158	21,577	10.00	9
10	Activity Assistants	8,400	8,841	72,858	8.24	10
11	Social Service Workers	5,342	5,942	81,891	13.78	11
12	Dietician	1,995	2,228	45,048	20.22	12
13	Food Service Supervisor					13
14	Head Cook	5,501	6,321	71,772	11.35	14
15	Cook Helpers/Assistants	14,803	15,921	143,403	9.01	15
16	Dishwashers					16
17	Maintenance Workers	9,731	10,551	125,648	11.91	17
18	Housekeepers	29,056	31,758	299,027	9.42	18
19	Laundry	9,448	10,486	101,450	9.67	19
20	Administrator	2,066	2,289	68,697	30.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,197	5,693	99,526	17.48	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	1,944	2,301	36,988	16.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,344	178,235	\$ 2,331,698 *	\$ 13.08	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	Monthly	\$ 6,884	1-3	35
36	Medical Director	Monthly	11,246	9-3	36
37	Medical Records Consultant		360	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	600	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	Monthly	2,080	11-3	44
45	Social Service Consultant		3,719	12-3	45
46	Other(specify)			10-3	46
47	Psychiatric Consultant	Monthly	6,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,889		49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

0042796

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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. \$4004
- (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. \$ 21,288 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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (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.