FOR BHF USE

LL1

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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0042796

Facility Name: ASTA CARE CENTER OF TOLUCA

Address: 101 E VIA GHIGLIERI (Number) TOLUCA (City) 61369 (Zip Code)

County: MARSHALL

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

HFS ID Number:

Date of Initial License for Current Owners: 07/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **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 01/01/2013 to 12/31/2013 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.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) MICHAEL GILLMAN
(Title) MEMBER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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: 01/01/2013 Ending: 12/31/2013

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	178		2,888	3,066	8
9	SNF/PED					9
10	ICF	22,780	348	708	23,836	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,958	348	3,596	26,902	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.87%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [x] Date 07/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 65 and days of care provided 2,855

Medicare Intermediary CGA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	240,857	23,051	6,956	270,864		270,864		270,864			1
2	Food Purchase		168,416		168,416	(350)	168,066	(559)	167,507			2
3	Housekeeping	103,608	29,050		132,658		132,658		132,658			3
4	Laundry	66,722	15,140	2,224	84,086		84,086		84,086			4
5	Heat and Other Utilities			98,711	98,711		98,711		98,711			5
6	Maintenance	60,203	36,387	42,175	138,765		138,765		138,765			6
7	Other (specify):*			31,328	31,328		31,328		31,328			7
8	TOTAL General Services	471,390	272,044	181,394	924,828	(350)	924,478	(559)	923,919			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,303,051	123,621	8,206	1,434,878		1,434,878	3,994	1,438,872			10
10a	Therapy	4,441			4,441		4,441		4,441			10a
11	Activities	94,909	3,478		98,387		98,387		98,387			11
12	Social Services	29,127			29,127		29,127		29,127			12
13	CNA Training											13
14	Program Transportation			4,527	4,527		4,527		4,527			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,431,528	127,099	24,733	1,583,360		1,583,360	3,994	1,587,354			16
	C. General Administration											
17	Administrative	106,424		309,079	415,503		415,503	(252,624)	162,879			17
18	Directors Fees											18
19	Professional Services			52,172	52,172		52,172	5,906	58,078			19
20	Dues, Fees, Subscriptions & Promotions			17,554	17,554		17,554	(8,423)	9,131			20
21	Clerical & General Office Expenses	52,946	25,737	40,037	118,720		118,720	23,921	142,641			21
22	Employee Benefits & Payroll Taxes			344,677	344,677	350	345,027		345,027			22
23	Inservice Training & Education			326	326		326		326			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			13,166	13,166		13,166	4,012	17,178			25
26	Insurance-Prop.Liab.Malpractice			75,209	75,209		75,209		75,209			26
27	Other (specify):*			76,702	76,702		76,702	(71,407)	5,295			27
28	TOTAL General Administration	159,370	25,737	928,922	1,114,029	350	1,114,379	(298,615)	815,764			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,062,288	424,880	1,135,049	3,622,217		3,622,217	(295,180)	3,327,037			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.

Facility Name & ID#: ASTA CARE CENTER OF TOLUCA #0042796 **Report Period Beginning: 01/01/2013** **Ending: 12/31/2013**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,956	
	REPAIRS & MAINTENANCE		0	
			0	6,956
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,224	
			0	2,224
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		12,183	
	ELECTRICITY		51,893	
	WATER		27,820	
	CABLE TV - LOBBY		6,815	
			0	98,711
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,325	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		30,200	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		255	
	FIRE SERVICE		9,395	
			0	
			0	
			0	
			0	42,175
7	**OTHER**			
	SCAVENGER		31,328	
	SECURITY SERVICE		0	
			0	
			0	31,328
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

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	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,806	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	3,400	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	8,206
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA **#0042796** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		4,527	4,527
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	309,079	309,079
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	26,420	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	25,752	
			0	52,172
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,351	
	EMPLOYEE WANT ADS	XIX F	2,990	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	1,515	
	LICENSES & PERMITS	XIX F	3,093	
	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	500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	450	
	PATIENT BACKGROUND CHECKS	XIX F	655	
				17,554
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		12,944	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,463	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		24,630	
	MESSENGER SERVICE		0	
			0	40,037

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	154,667	
	UNEMPLOYMENT COMPENSATION	XIX D	56,110	
	WORKERS COMPENSATION INSURANC	XIX D	102,601	
	HOSPITALIZATION INSURANCE	XIX D	30,995	
	EMPLOYEE BENEFITS - OTHER	XIX D	304	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	344,677
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		326	
				326
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		13,166	
				13,166
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		75,209	
				75,209
27	**OTHER**			
	BAD DEBTS	VI 24	76,702	
				76,702

GRAND TOTAL COLUMN 3 OTHER **1,135,049**

ASTA CARE CENTER OF TOLUCA
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	168,416
LESS SALES TAX	(559)
NET FOOD	167,857
TOTAL PATIENT CENSUS	26,902
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	80,706
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	80,706
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	80,706
NET FOOD	167,857
DIVIDE TOTAL MEALS/YEAR	80,706
COST PER MEAL	2.08
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**350**

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA #0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,266	30,266		30,266	2,993	33,259			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			247,620	247,620		247,620	(13,599)	234,021			32
33	Real Estate Taxes			18,242	18,242		18,242		18,242			33
34	Rent-Facility & Grounds			447,252	447,252		447,252		447,252			34
35	Rent-Equipment & Vehicles			9,397	9,397		9,397		9,397			35
36	Other (specify):* Amortization			16,840	16,840		16,840		16,840			36
37	TOTAL Ownership			769,617	769,617		769,617	(10,606)	759,011			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150,490	363,264	513,754		513,754	(75,602)	438,152			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			197,801	197,801		197,801		197,801			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		150,490	561,065	711,555		711,555	(75,602)	635,953			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,062,288	575,370	2,465,731	5,103,389		5,103,389	(381,388)	4,722,001			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: 01/01/2013 Ending: 12/31/2013

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	2,993	30		9
10	Interest and Other Investment Income	(4,436)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(559)	2		13
14	Non-Care Related Interest	(9,163)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,463)	21		18
19	Entertainment		20		19
20	Contributions	(500)	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	(76,702)	27		24
25	Fund Raising, Advertising and Promotional	(8,351)	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	(81,706)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (180,887)		$	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 Amount	2 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)	(200,501)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (200,501)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (381,388)		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 Yes	2 No	3 Amount	4 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: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON-ALLOWABLE TRAVEL	$ (1,593)	25	1
2	NON ALLOWABLE PROFESSIONAL FEES		19	2
3	MARKETING SALARY	(4,511)	21	3
4	RELATED PARTY THERAPY ADJUSTMENT	(75,602)	39	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**	(81,706)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA **#** 0042796 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(559)	0	0	0	0	0	0	0	0	0	0	(559)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(559)	0	0	0	0	0	0	0	0	0	0	(559)	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	3,994	0	0	0	0	0	0	0	0	0	3,994	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	3,994	0	0	0	0	0	0	0	0	0	3,994	16
	C. General Administration													
17	Administrative	0	(252,624)	0	0	0	0	0	0	0	0	0	(252,624)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,906	0	0	0	0	0	0	0	0	0	5,906	19
20	Fees, Subscriptions & Promotions	(8,851)	428	0	0	0	0	0	0	0	0	0	(8,423)	20
21	Clerical & General Office Expenses	(6,974)	30,895	0	0	0	0	0	0	0	0	0	23,921	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,593)	5,605	0	0	0	0	0	0	0	0	0	4,012	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(76,702)	5,295	0	0	0	0	0	0	0	0	0	(71,407)	27
28	**TOTAL General Administration**	(94,120)	(204,495)	0	0	0	0	0	0	0	0	0	(298,615)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(94,679)	(200,501)	0	0	0	0	0	0	0	0	0	(295,180)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA **#** 0042796 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	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)	
30	Depreciation	2,993	0	0	0	0	0	0	0	0	0	0	2,993	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,599)	0	0	0	0	0	0	0	0	0	0	(13,599)	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**	(10,606)	0	0	0	0	0	0	0	0	0	0	(10,606)	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	(75,602)	0	0	0	0	0	0	0	0	0	0	(75,602)	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**	(75,602)	0	0	0	0	0	0	0	0	0	0	(75,602)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(180,887)	(200,501)	0	0	0	0	0	0	0	0	0	(381,388)	45

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL GILLMAN	50	ASTA CARE CENTER OF BLOOMINGTON	BLOOMINGTON	ASTA		
DENNIS RUBEN	50	ASTA CARE CENTER OF COLFAX	COLFAX	HEALTHCARE CO.	ELGIN	MANAGEMENT
		ASTA CARE CENTER OF ELGIN	ELGIN			
		ASTA CARE CENTER OF FORD COUNTY	PAXTON	ASTA THERAPY		THERAPY
		ASTA CARE CENTER OF PONTIAC	PONTIAC			
		ASTA CARE CENTER OF ROCKFORD	ROACKFORD			

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. [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 309,079	ASTA HEALTHCARE COMPANY, INC.		$	$ (309,079)	1
2	V	10	NURSING		ASTA HEALTHCARE COMPANY, INC.		3,994	3,994	2
3	V	17	OFFICER'S SALARY -MG		ASTA HEALTHCARE COMPANY, INC.		28,122	28,122	3
4	V	17	ADMIN. SALARY -CF		ASTA HEALTHCARE COMPANY, INC.		23,552	23,552	4
5	V	17	ADMIN. SALARY -AF		ASTA HEALTHCARE COMPANY, INC.		4,781	4,781	5
6	V	19	PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY, INC.		5,906	5,906	6
7	V	20	LICENSES & PERMITS		ASTA HEALTHCARE COMPANY, INC.		428	428	7
8	V	21	OFFICE EXPENSE		ASTA HEALTHCARE COMPANY, INC.		30,895	30,895	8
9	V	25	STAFF TRANS/ TRAVEL		ASTA HEALTHCARE COMPANY, INC.		5,605	5,605	9
10	V	27	PAYR. TAXES & W/C		ASTA HEALTHCARE COMPANY, INC.		5,295	5,295	10
11	V								11
12	V								12
13	V								13
14	Total			$ 309,079			$ 108,578	$ * (200,501)	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: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN	PRESIDENT	administrative/					SALARY	$ 28,122	17-7	1
2			management								2
3	CRAIG FRANK	CFO	finance manage.		SEE	SEE		SALARY	23,552	17-7	3
4					ATTACHED	ATTACHED					4
5	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $97,500				SCHEDULE	SCHEDULE					5
6	MANAGEMENT FEE FROM ASTA CARE OF COLFAX $30,000				SCHEDULE	SCHEDULE					6
7											7
8	ALIZA FRANK	PAYROLL CLERK	PAYROLL					SALARY	4,781	17-7	8
9											9
10	DAVID MEISELMAN	THERAPY MGMNT	management					SALARY	23,036	39-4	10
11											11
12											12
13								TOTAL	$ 79,491		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: 01/01/2013 Ending: 2/31/2013

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	191,321	7	$ 28,405	$ 28,303	26,902	$ 3,994	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	191,321	7	200,000	200,000	26,902	28,122	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	191,321	7	167,500	167,500	26,902	23,552	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	191,321	7	34,000	34,000	26,902	4,781	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	191,321	7	42,001		26,902	5,906	5
6	20	LICENSES & PERMITS	PATIENT DAYS	191,321	7	3,043		26,902	428	6
7	21	OFFICE EXPENSE	PATIENT DAYS	191,321	7	219,718	184,734	26,902	30,895	7
8	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	191,321	7	39,861		26,902	5,605	8
9	27	PAYR. TAXES & W/C	PATIENT DAYS	191,321	7	37,656		26,902	5,295	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	TOTALS					$ 772,184	$ 614,537		$ 108,578	25

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MIDCAP FINANCIAL		X	L.O.C.				1,034,110			72,638	6
7	ENLOE			TRADE PAYABLE FIN			345,083	345,083			18,047	7
8												8
9	TOTAL Facility Related						$ 345,083	$ 1,379,193			$ 90,685	9
	B. Non-Facility Related*											
10	ASTA MANAGEMENT										133,928	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 133,928	14
15	TOTALS (line 9+line14)						$ 345,083	$ 1,379,193			$ 224,613	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ N/A** **Line # 36**

*** 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.)**

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	GLAUBACH			WORKING CAPITAL			200,000	200,000			9,000	6
7			X	INSURANCE POLICIES							2,890	7
8	MEMBER LOAN	X		WORKING CAPITAL							1,954	8
9	TOTAL Facility Related						$ 200,000	$ 200,000			$ 13,844	9
	B. Non-Facility Related*											
10	IDPA			BED TAX							9,163	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 9,163	14
15	TOTALS (line 9+line14)						$ 200,000	$ 200,000			$ 23,007	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

*** 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.)**

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 21,572	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.)		$ 19,907	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,665)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 19,907	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.		$ 18,242	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	21,170	8
	2009	23,003	9
	2010	21,980	10
	2011	21,572	11
	2012	19,907	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-206-001	NURSING HOME	$ 19,906.98	$ 19,906.98
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,906.98	$ 19,906.98

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. [x] (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. [x] (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGN			1997	950	24	39	24		389	9
10	WATER HEATER			1997	2,824	73	39	73		1,183	10
11	NURSES STATION			1998	6,622	170	39	170		2,571	11
12	ELECTRICAL WATER HEATER			1998	3,400	87	39	87		1,316	12
13	HANDRAILS			1998	4,445	114	39	114		1,724	13
14	LAUNDRY BUILDING			1999	69,014	2,510	27.5	2,510		35,872	14
15	DOORS			2000	3,400	124	27.5	124		1,679	15
16	REKEY LOCKS			2000	1,672	61	27.5	61		826	16
17	DOORS			2000	10,080	366	27.5	366		4,957	17
18	BUSHES			2000	2,493	166	15	166		2,248	18
19	ROOF			2000	16,511	600	27.5	600		8,125	19
20	FENCE			2000	2,981	199	15	199		2,695	20
21	FURNISHING			2000	2,271		7			2,271	21
22	ROOF			2001	6,500	236	27.5	236		2,960	22
23	DOOR ACCESS SYSTEM			2001	2,825	103	27.5	103		1,292	23
24	FLASHING			2001	1,250	46	27.5	46		577	24
25	DOOR SYSTEM			2002	2,461	89	27.5	89		1,027	25
26	GAS/ELECTRIC ROOFTOP UNIT			2002	10,997	400	27.5	400		4,617	26
27	AIR HANDLER			2002	2,237	81	27.5	81		935	27
28	CODE ALERT RESIDENT SECURITY SYSTEM			2002	2,561	93	27.5	93		1,073	28
29	WATER HEATER			2002	5,490	200	27.5	200		2,308	29
30	FURNISHING - CARPETING			2003	907		5			907	30
31	AWNING			2003	2,010	73	27.5	73		769	31
32	SINKS			2003	619	22	27.5	22		232	32
33	5 TON AIR CONDITIONER FOR KITCHEN			2003	1,700	62	27.5	62		654	33
34	FIRE DAMPERS			2004	5,542	202	27.5	202		1,860	34
35	ASPHALTING DRIVEWAY			2005	5,700	380	15	380		3,119	35
36	WATER HEATER			2005	4,509	164	27.5	164		1,401	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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SEWER LINE	2005	$ 1,811	$ 66	27.5	$ 66	$	$ 563	37
38	ROOF TOP UNIT	2005	3,745	136	27.5	136		1,162	38
39	GENERATOR	2006	19,135	696	27.5	696		4,901	39
40	SIDEWALKS	2006	6,000	400	15	400		2,850	40
41	SIDEWALKS	2007	7,020	468	15	468		3,023	41
42	PHOTOELECTRIC SMOKE DETECTORS WITH PANEL	2007	2,510	91	27.5	91		580	42
43	ACCESS DOORS IN DUCTS ABOVE DOORS	2007	2,766	101	27.5	101		644	43
44	FIRE ALARM ANNUNCIATOR	2007	3,689	134	27.5	134		854	44
45	CHECK VALVE & MIXING VALVE	2007	6,254	228	27.5	228		1,454	45
46	COIL & LOW AMBIENT CONTROLS	2007	3,228	117	27.5	117		746	46
47	WATER HEATER	2007	4,100	149	27.5	149		950	47
48	CUBICLE CURTAINS	2008	4,429	128	5	886	758	2,216	48
49	SIDEWALKS	2008	5,250	350	15	350		1,925	49
50	EMERGENCY LIGHTS	2008	3,641	132	27.5	132		732	50
51	SMOKE DAMPERS	2008	7,758	282	27.5	282		1,563	51
52	REHAB FIREDOORS	2008	3,080	112	27.5	112		621	52
53	CEILING TILE	2008	3,540	129	27.5	129		715	53
54	EMERGENCY PANEL & ANNUNCIATOR	2008	4,504	164	27.5	164		908	54
55	WATER HEATER	2009	5,395	196	27.5	196		841	55
56	NEW COPING METAL	2010	19,850	722	27.5	722		2,316	56
57	WATER HEATER	2011	4,650	169	27.5	169		429	57
58	WATER HEATER	2011	6,495	236	27.5	236		600	58
59	REPLACE EVAPORATOR COIL ON 5 TON PACKAGE UNIT	2012	2,795	102	27.5	102		123	59
60	GENERATOR REPAIR	2012	4,072	148	27.5	148		179	60
61	NEW WALK IN COOLER	2013	14,895	302	27.5	302		302	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 332,583	$ 12,403		$ 13,161	$ 758	$ 120,784	70

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 183,030	$ 1,268	$ 17,884	$ 16,616		$ 126,756	71
72	Current Year Purchases	25,964	14,837	1,298	(13,539)		1,298	72
73	Fully Depreciated Assets	156,697					156,697	73
74								74
75	TOTALS	$ 365,691	$ 16,105	$ 19,182	$ 3,077		$ 284,751	75

D. Vehicle Costs. (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	RESIDENT TRANSPORT	2002 FORD E350	2011	$ 9,158	$ 1,758	$ 916	$ (842)	5 YRS	$ 2,748	76
77										77
78										78
79										79
80	TOTALS			$ 9,158	$ 1,758	$ 916	$ (842)		$ 2,748	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)	$ 707,432	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,266	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,259	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,993	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 408,283	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.

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MONTE CASINO
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. [X] 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	$ 447,252	30		3
4	Additions							4
5								5
6								6
7	TOTAL		104		$ 447,252 **			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: [X] YES [ ] NO Terms: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 9,397 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.

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 78,842	$		$ 78,842	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,452			7,452	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			257,508			257,508	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				103,399		103,399	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology,Lab,I.V. therapy, Other Service Other (specify): Medical Supplies					19,462	47,091		19,462 47,091	13
14	TOTAL			$		$ 363,264	$ 150,490		$ 513,754	14

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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,330	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (81,000))	1,556,021		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,930		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	552,147		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,156,428	$	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	324,976		15
16	Equipment, at Historical Cost	382,456		16
17	Accumulated Depreciation (book methods)	(483,737)		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): Deferred Loan Costs	32,277		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 255,972	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,412,400	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,273,628	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,717,599		29
30	Accrued Salaries Payable	69,099		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,084		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,907		32
33	Accrued Interest Payable	133,928		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)**	$ 4,224,245	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	353,463		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)**	$ 353,463	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,577,708	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,165,308)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,412,400	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,918,199)	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)**	$ (1,918,195)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(247,113)	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)**	$ (247,113)	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)**	$ (2,165,308)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,568,311	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,568,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,560	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 173,560	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***	4,436	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,436	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,746,307	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	924,828	31
32	Health Care	1,583,360	32
33	General Administration	1,114,029	33
	B. Capital Expense		
34	Ownership	769,617	34
	C. Ancillary Expense		
35	Special Cost Centers	513,754	35
36	Provider Participation Fee	197,801	36
	D. Other Expenses (specify):		
37			37
38	PENALTY ABATEMENT	(47,759)	38
39	OUT OF PERIOD EXPENSE ADJUSTMENT	(62,210)	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,993,420	40
41	**Income before Income Taxes (line 30 minus line 40)****	(247,113)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (247,113)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,293,453	44
45	Private Pay - Net Inpatient Revenue	62,549	45
46	Medicare - Net Inpatient Revenue	1,073,983	46
47	Other-(specify) INSURANCE	138,326	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,568,311	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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: 01/01/2013 Ending: 12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,963	2,193	$ 68,604	$ 31.28	1
2	Assistant Director of Nursing	2,702	2,995	53,387	17.83	2
3	Registered Nurses	10,078	11,307	262,292	23.20	3
4	Licensed Practical Nurses	10,647	11,411	249,020	21.82	4
5	CNAs & Orderlies	49,716	53,289	630,647	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	200	205	4,441	21.66	8
9	Activity Director	3,199	3,422	43,449	12.70	9
10	Activity Assistants	3,503	4,509	51,460	11.41	10
11	Social Service Workers	2,000	2,150	29,127	13.55	11
12	Dietician					12
13	Food Service Supervisor	1,949	2,109	44,553	21.13	13
14	Head Cook	7,324	8,183	94,400	11.54	14
15	Cook Helpers/Assistants	9,135	10,098	101,904	10.09	15
16	Dishwashers					16
17	Maintenance Workers	4,165	4,565	60,203	13.19	17
18	Housekeepers	8,207	8,909	103,608	11.63	18
19	Laundry	4,996	5,097	66,722	13.09	19
20	Administrator	2,051	2,211	106,424	48.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,565	3,925	52,946	13.49	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	1,994	2,154	39,101	18.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,394	138,732	$ 2,062,288 *	$ 14.87	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,956	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,806	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	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,762		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JENIFER DIAZ	ADMINISTRATOR		$ 106,424
			0
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,424

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE COMPANY-MANAGEMENT FEES	$ 309,079
TOTAL (agree to Schedule V, line 17, col. 3)	$ 309,079
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		52,172
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 52,172

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,601
Unemployment Compensation Insurance	56,110
FICA Taxes	154,667
Employee Health Insurance	30,995
Employee Meals	350
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	304
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 345,027

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,990
Health Care Worker Background Check	450
(Indicate # of checks performed 45)	
Patient Background Checks 65	655
TRUST/FRANCHISE/CONTRIB/ETC	500
MARKETING/ADV/PROMO	8,351
LICENSES/DUES/SUBSCRIPTIONS	4,608
MGMT CO ALLOC	428
TRUST/FRANCHISE/CONTRIB/ETC	(500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(8,351)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,131

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
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: 01/01/2013 Ending: 12/31/2013

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. HEALTHCARE ASSOC. $1,514**

(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. $ **31,160** 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. $ **197,801**
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. $ **350** 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 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.