

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	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			3,766	3,766	8
9	SNF/PED					9
10	ICF	16,621	5,746	2,793	25,160	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,621	5,746	6,559	28,926	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.06%

D. How many bed-hold days during this year were paid by the Department? NONE (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 08/17/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/17/98 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 28 and days of care provided 3,766

Medicare Intermediary ADMINASTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	184,781	16,555	7,142	208,478		208,478		208,478		1
2	Food Purchase		150,760		150,760		150,760	(2,652)	148,108		2
3	Housekeeping	133,402	26,249		159,651		159,651		159,651		3
4	Laundry	44,993	2,740	34	47,767		47,767		47,767		4
5	Heat and Other Utilities			101,619	101,619		101,619		101,619		5
6	Maintenance	36,527	8,308	38,552	83,387		83,387		83,387		6
7	Other (specify):*			5,968	5,968		5,968		5,968		7
8	TOTAL General Services	399,703	204,612	153,315	757,630		757,630	(2,652)	754,978		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,128,404	83,712	162,798	1,374,914		1,374,914		1,374,914		10
10a	Therapy		1,698		1,698		1,698		1,698		10a
11	Activities	124,073	9,634	599	134,306		134,306		134,306		11
12	Social Services	66,895		144	67,039		67,039		67,039		12
13	CNA Training										13
14	Program Transportation			1,145	1,145	2,794	3,939		3,939		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,319,372	95,044	170,686	1,585,102	2,794	1,587,896		1,587,896		16
	C. General Administration										
17	Administrative	67,220		231,950	299,170		299,170	(95,695)	203,475		17
18	Directors Fees										18
19	Professional Services			37,407	37,407		37,407	1,285	38,692		19
20	Dues, Fees, Subscriptions & Promotions			27,264	27,264		27,264	(15,526)	11,738		20
21	Clerical & General Office Expenses	102,676	19,982	20,028	142,686		142,686	(11,397)	131,289		21
22	Employee Benefits & Payroll Taxes			288,100	288,100		288,100		288,100		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,144	4,144		4,144		4,144		24
25	Other Admin. Staff Transportation			9,287	9,287	(2,794)	6,493	65	6,558		25
26	Insurance-Prop.Liab.Malpractice			78,160	78,160		78,160	649	78,809		26
27	Other (specify):*							8,841	8,841		27
28	TOTAL General Administration	169,896	19,982	696,340	886,218	(2,794)	883,424	(111,778)	771,646		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,888,971	319,638	1,020,341	3,228,950		3,228,950	(114,430)	3,114,520		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	6,904
	REPAIRS & MAINTENANCE	238
		0
		7,142
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	34
		0
		34
5	HEAT & OTHER UTILITIES	
	GAS HEAT	36,569
	ELECTRICITY	42,775
	WATER	20,553
	CABLE TV - LOBBY	1,722
		0
		101,619
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,523
	PAINTING & DECORATING	837
	BUILDING REPAIRS	14,269
	MAINTENANCE TRAVEL	179
	EQUIPMENT MAINTENANCE & REPAIR	15,390
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,792
	FIRE SERVICE	3,562
		0
		0
		0
		38,552
7	OTHER	
	SCAVENGER	5,607
	SECURITY SERVICE	361
		5,968
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	155,464
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	642
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,440
	PHARMACY CONSULTANT XVIII B 39-2	1,291
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	3,490
	DENTAL	471
		162,798
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	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	599
		0
		599
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	144
	SOCIAL WORKER XVIII B 45-2	0
		0
		144
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	1,145
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	231,950
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	9,297
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	28,110
		0
		37,407
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	16,686
	EMPLOYEE WANT ADS XIX F	2,468
	CONTRIBUTIONS VI 20 XIX F	25
	DUES & SUBSCRIPTIONS XIX F	3,852
	LICENSES & PERMITS XIX F	2,980
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,253
		27,264
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,751
	EQUIPMENT REPAIR & MAINTENANCE	681
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,155
	MESSENGER SERVICE	441
		0
		20,028

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	142,273
	UNEMPLOYMENT COMPENSATION XIX D	49,571
	WORKERS COMPENSATION INSURANCE XIX D	39,573
	HOSPITALIZATION INSURANCE XIX D	44,681
	EMPLOYEE BENEFITS - OTHER XIX D	9,209
	EMPLOYEE PHYSICAL EXAMS XIX D	2,793
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		288,100
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	4,144
	TRAVEL XIX G	0
		0
		0
		4,144
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,287
		9,287
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	78,160
		78,160
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,020,341

ASTA CARE CENTER OF PONTIAC
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	150,760	PATIENT MEALS	86778
LESS SALES TAX	(2,652)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	148,108	TOTAL MEALS/YEAR	86778
TOTAL PATIENT CENSUS	28,926	NET FOOD	148108
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	86778

TOTAL PATIENT MEALS	86778	COST PER MEAL	1.71
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

#0043968

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,586	11,586		11,586	103,834	115,420			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,512	48,512		48,512	119,805	168,317			32
33	Real Estate Taxes			43,913	43,913		43,913		43,913			33
34	Rent-Facility & Grounds			223,355	223,355		223,355	(223,355)				34
35	Rent-Equipment & Vehicles			11,842	11,842		11,842	1,255	13,097			35
36	Other (specify):* amort computer software			267	267		267		267			36
37	TOTAL Ownership			339,475	339,475		339,475	1,539	341,014			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,788	673,797	754,585		754,585		754,585			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		80,788	721,977	802,765		802,765		802,765			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,888,971	400,426	2,081,793	4,371,190		4,371,190	(112,891)	4,258,299			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,050	30		9
10	Interest and Other Investment Income	(17)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,652)	2		13
14	Non-Care Related Interest		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		21		18
19	Entertainment		20		19
20	Contributions	(25)	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		27		24
25	Fund Raising, Advertising and Promotional	(16,686)	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	(26,924)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,254)		\$	30

OHF 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)	(67,637)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (67,637)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (112,891)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

ASTA CARE CENTER OF PONTIAC

ID# 0043968

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0		1
2	BANK CHARGES	(2,751)	21	2
3	PROFESSIONAL FEES SPECIAL DELIVERIES	(430)	19	3
4	MARKETING TRAVEL	(3,997)	25	4
5	MARKETING SALARY	(19,746)	21	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	(26,924)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC# 0043968

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(2,652)	0	0	0	0	0	0	0	0	0	0	(2,652)	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	(2,652)	0	0	0	0	0	0	0	0	0	0	(2,652)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(95,695)	0	0	0	0	0	0	0	0	0	(95,695)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(430)	1,715	0	0	0	0	0	0	0	0	0	1,285	19
20	Fees, Subscriptions & Promotions	(16,711)	1,185	0	0	0	0	0	0	0	0	0	(15,526)	20
21	Clerical & General Office Expenses	(22,497)	11,100	0	0	0	0	0	0	0	0	0	(11,397)	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	(3,997)	4,062	0	0	0	0	0	0	0	0	0	65	25
26	Insurance-Prop.Liab.Malpractice	0	649	0	0	0	0	0	0	0	0	0	649	26
27	Other (specify):*	0	8,841	0	0	0	0	0	0	0	0	0	8,841	27
28	TOTAL General Administration	(43,635)	(68,143)	0	(111,778)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,287)	(68,143)	0	(114,430)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,050	0	102,784	0	0	0	0	0	0	0	0	103,834	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17)	0	119,822	0	0	0	0	0	0	0	0	119,805	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(223,355)	0	0	0	0	0	0	0	0	(223,355)	34
35	Rent-Equipment & Vehicles	0	1,255	0	0	0	0	0	0	0	0	0	1,255	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,033	1,255	(749)	0	1,539	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(45,254)	(66,888)	(749)	0	(112,891)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL GILLMAN	25			ASTA HEALTHCARE		
DARRYLE GILLMAN	25			COMPANY	ELGIN	MANAGEMENT
BARRY KIRSCHBAUM	25	SEE ATTACHED SCHEDULE				
DIANR KIRSCHENBAUM	25			ASTA PONTIAC	ELGIN	REAL ESTATE
				PROPERTIES		

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	\$ 231,950	ASTA HEALTHCARE COMPANY			\$(231,950)	1
2	V	17	OFFICERS SALARY-MG			35,094		35,094	2
3	V	17	OFFICERS SALARY-SETH			28,239		28,239	3
4	V	17	ADMIN. SALARY-CF			24,156		24,156	4
5	V	17	ADMIN. SALARY-DM			24,649		24,649	5
6	V	17	ADMIN. SALARY			24,117		24,117	6
7	V	19	PROFESSIONAL FEES			1,715		1,715	7
8	V	20	DUES & SUBSCRIPTIONS			1,185		1,185	8
9	V	21	OFFICE EXPENSE			11,100		11,100	9
10	V	25	AUTO & TRAVEL			4,062		4,062	10
11	V	26	INSURANCE GEN & W/C			649		649	11
12	V	27	PAYROLL TAX & EMPL BEN			8,841		8,841	12
13	V	35	EQUIPMENT RENTAL			1,255		1,255	13
14	Total		\$ 231,950			\$ 165,062	\$ *	(66,888)	14

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

VII. RELATED PARTIES (continued)

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)
15	V	34 RENT	\$ 223,355	PONTIAC PROPERTIES		\$	(223,355)
16	V	30 DEPRECIATION				102,784	102,784
17	V	32 INTEREST				119,822	119,822
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 223,355			\$ 222,606	\$ * (749)

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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			25.00					\$		1
2	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$210,000							SALARY	35,094	17-7	2
3											3
4	SETH GILLMAN										4
5	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$168,982							SALARY	28,239	17-7	5
6											6
7	CRAIG FRANK										7
8	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$144,547							SALARY	24,156	17-7	8
9											9
10	DAVID MEISELMAN										10
11	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$147,499							SALARY	24,649	17-7	11
12	ALIZA FRANK-TOTAL SAL. RECEIVED FR ASTA HEALTH \$27,096							SALARY	4,528	21-7	12
13								TOTAL	\$ 116,666		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 PONTIAC

0043968

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 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	17	OFFICERS SALARY-MG	PATIENT DAYS	173,090	6	\$ 210,000	\$ 210,000	28,926	\$ 35,094	1
2	17	OFFICERS SALARY-SETH	PATIENT DAYS	173,090	6	168,982	168,982	28,926	28,239	2
3	17	ADMIN. SALARY-CF	PATIENT DAYS	173,090	6	144,547	144,547	28,926	24,156	3
4	17	ADMIN. SALARY-DM	PATIENT DAYS	173,090	6	147,499	147,499	28,926	24,649	4
5	17	ADMIN. SALARY	PATIENT DAYS	173,090	6	144,315	144,315	28,926	24,117	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	173,090	6	10,265		28,926	1,715	6
7	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	173,090	6	7,090		28,926	1,185	7
8	21	OFFICE EXPENSE	PATIENT DAYS	173,090	6	66,421	27,096	28,926	11,100	8
9	25	AUTO & TRAVEL	PATIENT DAYS	173,090	6	24,306		28,926	4,062	9
10	26	INSURANCE GEN & W/C	PATIENT DAYS	173,090	6	3,885		28,926	649	10
11	27	PAYROLL TAX & EMPL BEN	PATIENT DAYS	173,090	6	52,906		28,926	8,841	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	173,090	6	7,509		28,926	1,255	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					\$ 987,725	\$ 842,439		\$ 165,062	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning: 01/01/2005

Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization ASTA PONTIAC PROPERTIES
 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	30	DEPRECIATION	DIRECT COST	1	1	\$ 102,784	\$ 1	\$ 102,784	1
2	32	INTEREST	DIRECT COST	1	1	119,822	1	119,822	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	TOTALS					\$ 222,606	\$	\$ 222,606	25

Facility Name & ID Number

ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
A. Directly Facility Related												
Long-Term												
1	REL PARTY-ALBANK		X	MORTGAGE	\$14,494.84	2/14/03	\$ 1,880,000	\$ 1,745,527	3/1/23	0.0675	\$ 119,822	1
2												2
3												3
4												4
5			X	BEDTAX							3,616	5
Working Capital												
6	ALBANY BANK		X	WORKING CAPITAL	INTEREST	REVOLV	150,000	420,146	REVOLV	PRIME+	27,470	6
7	BARRY KIRSCHENBAUM	X		WORKING CAPITAL	INTEREST		100,000	100,000			15,000	7
8	S.I. CREDIT CORP		X	INSURANCE POLICIES							2,426	8
9	TOTAL Facility Related				\$14,494.84		\$ 2,130,000	\$ 2,265,673			\$ 168,334	9
B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,130,000	\$ 2,265,673			\$ 168,334	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 must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	\$	39,973	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.)	\$	41,943	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,970	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	41,943	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.	\$	43,913	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	37,072	8
	2001	36,945	9
	2002	38,186	10
	2003	39,973	11
	2004	41,943	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2004 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF PONTIAC COUNTY LIVINGSTON

FACILITY IDPH LICENSE NUMBER 0043968

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-27-255-001</u>	<u>NURSING HOME</u>	\$ <u>41,943.06</u>	\$ <u>41,943.06</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>41,943.06</u>	\$ <u>41,943.06</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,600 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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).

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>1998</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 100,000	3

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	85	1998	1961	\$ 1,438,473	\$ 52,308	27.5	\$ 52,308	\$	\$ 385,771	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LAND IMPROVEMENTS - PURCHASE ALLOCATION (PROP)	1998		97,058	6,471	15	6,471		47,723	9
10	WATER HEATERS & PLUMBING (PROP)	1999		14,502	527	27.5	527		3,447	10
11	BOILER & A/C (PROP)	1999		14,240	518	27.5	518		3,388	11
12	ELECTRONIC DOOR LOCKS (PROP)	1999		3,974	145	27.5	145		948	12
13	FENCE (PROP)	1999		1,155	77	15	77		504	13
14	REMODELING ROOMS & BATHROOMS (PROP)	2000		47,944	1,743	27.5	1,743		9,659	14
15	AIR CONDITIONER (PROP)	2000		5,569	203	27.5	203		1,125	15
16	FIRE PANEL (PROP)	2000		2,730	99	27.5	99		1,035	16
17	FURNISHING	2000		2,839	253	7	253		2,460	17
18	WATER SOFTENER (PROP)	2001		4,013	146	27.5	146		663	18
19	CONDENSER (PROP)	2001		3,100	113	27.5	113		513	19
20	HEATER AND A/C UNITS (PROP)	2001		5,100	186	27.5	186		844	20
21	GREASE TRAP (PROP)	2001		1,300	47	27.5	47		214	21
22	3 DOORS (PROP)	2001		4,000	145	27.5	145		659	22
23	FENCE (PROP)	2001		2,564	171	15	171		776	23
24	SIDEWALK (PROP)	2001		1,850	123	15	123		559	24
25	CONCRETE WORK (PROP)	2002		3,938	263	15	263		921	25
26	FIRE ALARM SYSTEM (PROP)	2002		40,476	1,472	27.5	1,472		5,213	26
27	RESIDENT SECURITY SYSTEM (PROP)	2002		11,930	434	27.5	434		1,537	27
28	FIRE DOORS (PROP)	2002		6,016	219	27.5	219		776	28
29	REMODELING 8 ROOMS (PROP)	2002		46,151	1,678	27.5	1,678		5,943	29
30	SPRINKLER HEADS (PROP)	2002		3,635	132	27.5	132		468	30
31	WATER LINE (PROP)	2002		3,002	109	27.5	109		386	31
32	BACK FLOW PREVENTER (PROP)	2002		3,300	120	27.5	120		425	32
33	NEW FLOOR DRAIN (PROP)	2003		1,726	63	27.5	63		160	33
34	LIGHTING (PROP)	2003		1,350	49	27.5	49		125	34
35	ELECTRICAL WORK (PROP)	2003		1,371	49	27.5	49		125	35
36	TELEPHONE WIRING (PROP)	2003		5,242	191	27.5	191		485	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	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 P-TAC UNITS(PROP)	2004	\$ 3,750	\$ 136	27.5	\$ 136	\$	\$ 210	37
38 ELECTRICAL WORK (PROP)	2005	5,435	107	27.5	107		107	38
39 AIR COMPRESSOR (PROP)	2005	5,791	114	27.5	114		114	39
40 FIRE SYSTEM (PROP)	2005	26,366	520	27.5	520		520	40
41 SPRINKLER HEADS (PROP)	2005	3,308	65	27.5	65		65	41
42 CIRCULATING (PROP)]	2005	2,077	41	27.5	41		41	42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,825,275	\$ 69,037		\$ 69,037	\$	\$ 477,909	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	\$ 123,353	\$ 11,142	\$ 12,335	\$ 1,193	10 YRS	\$ 56,321	71
72	Current Year Purchases	957	191	48	(143)	10 YRS	48	72
73	Fully Depreciated Assets							73
74	REL PARTY	340,000	34,000	34,000		10 YRS	252,906	74
75	TOTALS	\$ 464,310	\$ 45,333	\$ 46,383	\$ 1,050		\$ 309,275	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	FACILITY VAN	1999 FORD ELD. VAN	1999	\$ 43,112	\$	\$	\$	5	\$ 43,112	76
77										77
78										78
79										79
80	TOTALS			\$ 43,112	\$	\$	\$		\$ 43,112	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)	\$ 2,432,697	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 114,370	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 115,420	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,050	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 830,296	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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>223,355</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>223,355</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 11,842 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 159,204	\$		\$ 159,204	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			38,832			38,832	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			443,346			443,346	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				74,335		74,335	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Supplies, Radiology, Lab, nursing services, Other (specify): <u>rentals, outside services</u>	39-8				32,415	6,453		38,868	13
14	TOTAL			\$		\$ 673,797	\$ 80,788		\$ 754,585	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 PONTIAC

0043968

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(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	\$ 21,119	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	675,136		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	25,771		7
8	Accounts Receivable (owners or related parties)	673,328		8
9	Other(specify): <u>RE TAX ESCROW</u>	74,606		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,469,960	\$	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			15
16	Equipment, at Historical Cost	181,711		16
17	Accumulated Depreciation (book methods)	(168,269)		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)	\$ 13,442	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,483,402	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 482,175	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	620,146		29
30	Accrued Salaries Payable	79,383		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,626		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,943		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,241,273	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,241,273	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 242,129	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,483,402	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 131,023	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 131,028	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	111,101	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)	\$ 111,101	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)	\$ 242,129	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	\$ 4,020,036	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,020,036	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	432,654	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 432,654	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***	17	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSES	35,174	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35,174	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,487,881	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	757,630	31
32	Health Care	1,585,102	32
33	General Administration	886,218	33
B. Capital Expense			
34	Ownership	339,475	34
C. Ancillary Expense			
35	Special Cost Centers	754,585	35
36	Provider Participation Fee	48,180	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,371,190	40
41	Income before Income Taxes (line 30 minus line 40)**	116,691	41
42	Income Taxes	(5,590)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 111,101	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 PONTIAC

0043968

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	2,042	2,292	\$ 68,663	\$ 29.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,382	9,847	243,377	24.72	3
4	Licensed Practical Nurses	12,933	13,761	302,856	22.01	4
5	CNAs & Orderlies	48,713	50,892	493,412	9.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,422	2,575	43,527	16.90	9
10	Activity Assistants	10,196	11,061	80,546	7.28	10
11	Social Service Workers	4,578	4,994	66,895	13.40	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,268	29,426	12.97	13
14	Head Cook	8,358	8,979	77,476	8.63	14
15	Cook Helpers/Assistants	10,517	10,869	77,879	7.17	15
16	Dishwashers					16
17	Maintenance Workers	1,978	2,157	36,527	16.93	17
18	Housekeepers	17,595	18,502	133,402	7.21	18
19	Laundry	3,903	4,508	44,993	9.98	19
20	Administrator	1,497	1,669	67,220	40.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,252	6,784	102,676	15.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,061	2,172	20,096	9.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,491	153,330	\$ 1,888,971 *	\$ 12.32	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 6,904	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,440	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,291	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	599	11-3	44
45	Social Service Consultant	E	144	12-3	45
46	Other(specify) <u>PROGRAM</u>	S	3,490	10-3	46
47	<u>PSYCHO-SOCIAL</u>		642	10-3	47
48	<u>DENTAL</u>		471	10-3	48
49	TOTAL (lines 35 - 48)		\$ 20,981		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	747	\$ 29,885	10-3	50
51	Licensed Practical Nurses	1,703	59,622	10-3	51
52	Certified Nurse Assistants/Aides	2,837	65,957	10-3	52
53	TOTAL (lines 50 - 52)	5,287	\$ 155,464		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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005
1	PAIN/DECORATING	6/00	\$ 9,939	3 YRS	\$ 3,313	\$ 1,656														
2	PAIN/DECORATING	6/01	2,075	3 YRS	692	692	345													
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 12,014		\$ 4,005	\$ 2,348	\$ 345	\$	\$	\$	\$	\$								

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (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, \$3,230
- (3) Did the nursing home make political contributions or payments to a political action organization? _____ If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ 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. \$ _____ 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? _____ YES X 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. \$ 48,180
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? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees