

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0043968</u></p> <p>Facility Name: <u>ASTA CARE CENTER OF PONTIAC</u></p> <p>Address: <u>300 WEST LOWELL</u> <u>PONTIAC</u> <u>61764</u> Number City Zip Code</p> <p>County: <u>LIVINGTON</u></p> <p>Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u></p> <p>HFS ID Number: <u>36-4228801</u></p> <p>Date of Initial License for Current Owners: <u>8/17/1998</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MICHAEL GILLMAN</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MICHAEL GILLMAN</u> (Date) _____		(Title) <u>MEMBER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																	
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																	
	<input type="checkbox"/> "Sub-S" Corp.																																		
	<input checked="" type="checkbox"/> Limited Liability Co.																																		
	<input type="checkbox"/> Trust																																		
	<input type="checkbox"/> Other _____																																		
Officer or Administrator of Provider	(Signed) _____																																		
	(Type or Print Name) <u>MICHAEL GILLMAN</u> (Date) _____																																		
	(Title) <u>MEMBER</u>																																		
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____																																		
	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>																																		
	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>																																		
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																																		

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	<u>28</u>	Skilled (SNF)	<u>28</u>	<u>10,220</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>60</u>	Intermediate (ICF)	<u>60</u>	<u>21,900</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>88</u>	TOTALS	<u>88</u>	<u>32,120</u>	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	<u>853</u>	<u>134</u>	<u>3,493</u>	<u>4,480</u>	8
9	SNF/PED					9
10	ICF	<u>18,411</u>	<u>5,518</u>	<u>2,034</u>	<u>25,963</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,264</u>	<u>5,652</u>	<u>5,527</u>	<u>30,443</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.78%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 08/17/1998

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/17/1998 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 3,493

Medicare Intermediary ADMINISTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	184,867	18,071	7,411	210,349		210,349	0	210,349		1
2	Food Purchase		161,472		161,472	0	161,472	(1,644)	159,828		2
3	Housekeeping	153,791	24,587	0	178,378		178,378	0	178,378		3
4	Laundry	42,012	4,551	1	46,564	0	46,564	0	46,564		4
5	Heat and Other Utilities			99,133	99,133		99,133	0	99,133		5
6	Maintenance	38,977	11,972	33,398	84,347		84,347	(1,153)	83,194		6
7	Other (specify):*			6,940	6,940		6,940	0	6,940		7
8	TOTAL General Services	419,647	220,653	146,883	787,183	0	787,183	(2,797)	784,386		8
	B. Health Care and Programs										
9	Medical Director	0		6,500	6,500		6,500	0	6,500		9
10	Nursing and Medical Records	1,283,895	77,249	3,495	1,364,639		1,364,639	439	1,365,078		10
10a	Therapy	0	460	0	460		460	0	460		10a
11	Activities	183,449	7,229	0	190,678		190,678	0	190,678		11
12	Social Services	77,596		576	78,172		78,172	0	78,172		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			3,687	3,687		3,687	0	3,687		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,544,940	84,938	14,258	1,644,136	0	1,644,136	439	1,644,575		16
	C. General Administration										
17	Administrative	71,749		204,000	275,749		275,749	(60,947)	214,802		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			44,103	44,103		44,103	1,036	45,139		19
20	Dues, Fees, Subscriptions & Promotions			33,285	33,285		33,285	(20,507)	12,778		20
21	Clerical & General Office Expenses	105,704	22,391	22,469	150,564		150,564	(14,414)	136,150		21
22	Employee Benefits & Payroll Taxes			324,092	324,092	0	324,092	0	324,092		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			4,447	4,447		4,447	223	4,670		24
25	Other Admin. Staff Transportation			16,562	16,562		16,562	(1,698)	14,864		25
26	Insurance-Prop.Liab.Malpractice			76,884	76,884		76,884	2,202	79,086		26
27	Other (specify):*			25,999	25,999		25,999	(16,577)	9,422		27
28	TOTAL General Administration	177,453	22,391	751,841	951,685	0	951,685	(110,682)	841,003		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,142,040	327,982	912,982	3,383,004	0	3,383,004	(113,040)	3,269,964		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	6,843
	REPAIRS & MAINTENANCE	568
		0
		7,411
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1
		0
		1
5	HEAT & OTHER UTILITIES	
	GAS HEAT	35,473
	ELECTRICITY	39,344
	WATER	21,754
	CABLE TV - LOBBY	2,562
		0
		99,133
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,701
	PAINTING & DECORATING	2,275
	BUILDING REPAIRS	5,476
	MAINTENANCE TRAVEL	70
	EQUIPMENT MAINTENANCE & REPAIR	20,182
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,025
	FIRE SERVICE	4,016
	REBILLED SALARIES	(2,347)
		0
		0
		0
		33,398
7	OTHER	
	SCAVENGER	6,552
	SECURITY SERVICE	388
		0
		0
		6,940
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,500
		6,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	90
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,605
	PHARMACY CONSULTANT XVIII B 39-2	1,800
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		3,495
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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT 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 CONSULTANT XVIII B 45-2	576
	SOCIAL WORKER XVIII B 45-2	0
		0
		576
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	3,687
		3,687
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	204,000
		204,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	15,737
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	28,366
		0
		44,103
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	20,573
	EMPLOYEE WANT ADS XIX F	2,948
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,793
	LICENSES & PERMITS XIX F	2,471
	PUBLIC RELATIONS-PATIENT RELATED XIX F	
	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	1,500
	PATIENT BACKGROUND CHECKS XIX F	0
		33,285
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,857
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,080
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,054
	MESSENGER SERVICE	478
		0
		22,469

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	161,804
	UNEMPLOYMENT COMPENSATION XIX D	49,371
	WORKERS COMPENSATION INSURANC XIX D	49,530
	HOSPITALIZATION INSURANCE XIX D	55,679
	EMPLOYEE BENEFITS - OTHER XIX D	5,419
	EMPLOYEE PHYSICAL EXAMS XIX D	2,289
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		324,092
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	4,447
	TRAVEL XIX G	0
		4,447
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	16,562
		16,562
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	76,884
		76,884
27	OTHER	
	BAD DEBTS VI 24	25,999
		25,999

GRAND TOTAL COLUMN 3 OTHER

912,982

ASTA CARE CENTER OF PONTIAC
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	161,472	PATIENT MEALS	91329
LESS SALES TAX	(1,644)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	159,828	TOTAL MEALS/YEAR	91329
TOTAL PATIENT CENSUS	30,443	NET FOOD	159828
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	91329

TOTAL PATIENT MEALS	91329	COST PER MEAL	1.75
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

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			7,829	7,829		7,829	108,999	116,828			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			58,764	58,764		58,764	135,036	193,800			32
33	Real Estate Taxes			44,493	44,493		44,493	0	44,493			33
34	Rent-Facility & Grounds			231,471	231,471		231,471	(231,471)	0			34
35	Rent-Equipment & Vehicles			14,340	14,340		14,340	0	14,340			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			356,897	356,897	0	356,897	12,564	369,461			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		106,543	540,024	646,567		646,567	0	646,567			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			48,180	48,180		48,180	0	48,180			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	106,543	588,204	694,747	0	694,747	0	694,747			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,142,040	434,525	1,858,083	4,434,648	0	4,434,648	(100,476)	4,334,172			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	5,169	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,644)	2		13
14	Non-Care Related Interest	(3,130)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(2,080)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,999)	27		24
25	Fund Raising, Advertising and Promotional	(20,573)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(29,646)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,903)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(22,573)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (22,573)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (100,476)		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: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (1,896)	6	1
2	MARKETING TRAVEL	(5,544)	25	2
3	MARKETING SALARY	(22,206)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(29,646)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,644)	0	0	0	0	0	0	0	0	0	0	(1,644)	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	(1,896)	743	0	0	0	0	0	0	0	0	0	(1,153)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,540)	743	0	(2,797)	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	439	0	0	0	0	0	0	0	0	0	439	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	439	0	439	16								
	C. General Administration													
17	Administrative	0	(60,947)	0	0	0	0	0	0	0	0	0	(60,947)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,036	0	0	0	0	0	0	0	0	0	1,036	19
20	Fees, Subscriptions & Promotions	(20,573)	66	0	0	0	0	0	0	0	0	0	(20,507)	20
21	Clerical & General Office Expenses	(24,286)	9,872	0	0	0	0	0	0	0	0	0	(14,414)	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	223	0	0	0	0	0	0	0	0	0	223	24
25	Other Admin. Staff Transportation	(5,544)	3,846	0	0	0	0	0	0	0	0	0	(1,698)	25
26	Insurance-Prop.Liab.Malpractice	0	2,202	0	0	0	0	0	0	0	0	0	2,202	26
27	Other (specify):*	(25,999)	9,422	0	0	0	0	0	0	0	0	0	(16,577)	27
28	TOTAL General Administration	(76,402)	(34,280)	0	(110,682)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(79,942)	(33,098)	0	(113,040)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,169	0	103,830	0	0	0	0	0	0	0	0	108,999	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,130)	0	138,166	0	0	0	0	0	0	0	0	135,036	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(231,471)	0	0	0	0	0	0	0	0	(231,471)	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	2,039	0	10,525	0	12,564	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)	(77,903)	(33,098)	10,525	0	(100,476)	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		
DARRYLE GILLMAN	25	SEE ATTACHED SCHEDULE		HEALTHCARE CO.	ELGIN	MANAGEMENT
BARRY KIRSCHENBAUM	25					
DIANE KIRSCHENBAUM	25			ASTA PONTIAC PROPERTIES	ELGIN	REAL ESTATE

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 204,000	ASTA HEALTHCARE COMPANY		\$	(204,000)	1
2	V	6 MAINTENANCE				743	743	2
3	V	10 NURSING SUPPLIES				439	439	3
4	V	17 ADMINISTRATIVE SALARIES				143,053	143,053	4
5	V	19 PROFESSIONAL FEES				1,036	1,036	5
6	V	20 LICENSE & PERMITS				66	66	6
7	V	21 OFFICE EXPENSE				9,872	9,872	7
8	V	24 SEMINARS				223	223	8
9	V	25 STAFF TRANS / TRAVEL				3,846	3,846	9
10	V	26 INSURANCE GEN / WC				2,202	2,202	10
11	V	27 PAYR. TAXES & GRP INS				9,422	9,422	11
12	V							12
13	V							13
14	Total		\$ 204,000			\$ 170,902	\$ * (33,098)	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	\$ 231,471	PONTIAC PROPERTIES		\$	(231,471)
16	V	30 DEPRECIATION				103,830	103,830
17	V	32 INTEREST				138,166	138,166
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		\$ 231,471			\$ 241,996	\$ * 10,525

* 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: 01/01/2006 Ending: 12/31/2006

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				SALARY	\$ 29,785	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$175,000										2
3	SETH GILLMAN										3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986							SALARY	24,677	17-7	4
5	SALARY FROM ASTA CARE OF TOLUCA \$23088 SALARY FROM ASTA CARE OF BLOOMINGTON \$6926										5
6	CRAIG FRANK										6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986							SALARY	24,677	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$30,014										8
9	DAVID MEISELMAN										9
10	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$141,842							SALARY	24,142	17-7	10
11	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,014										11
12	ALIZA FRANK - TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$32,583							SALARY	5,545	21-7	12
13								TOTAL	\$ 108,826		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:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PATIENT DAYS	178,865	6	\$ 4,363	\$ 30,443	\$ 743	1
2	10	NURSING SUPPLIES	PATIENT DAYS	178,865	6	2,577	30,443	439	2
3	17	OFFICER'S SALARY - MG	PATIENT DAYS	178,865	6	175,000	30,443	29,785	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	178,865	6	144,986	30,443	24,677	4
5	17	ADMIN. SALARY - CF	PATIENT DAYS	178,865	6	144,986	30,443	24,677	5
6	17	ADMIN. SALRY - DM	PATIENT DAYS	178,865	6	141,842	30,443	24,142	6
7	17	ADMIN. SALARY	PATIENT DAYS	178,865	6	233,674	30,443	39,772	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,865	6	6,085	30,443	1,036	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,865	6	389	30,443	66	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,865	6	58,004	30,443	9,872	10
11	24	SEMINARS	PATIENT DAYS	178,865	6	1,310	30,443	223	11
12	25	STAFF TRANS / TRAVEL	PATIENT DAYS	178,865	6	22,595	30,443	3,846	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,865	6	12,935	30,443	2,202	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,865	6	55,359	30,443	9,422	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,004,105	\$ 639,397	\$ 170,902	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COST		\$	\$		\$	1
2	32	INTEREST	DIRECT COST						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				\$	\$		\$	0

Facility Name & ID Number

ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10
		Related**					Purpose of Loan	Monthly Payment Required				
		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	\$ 1,694,110	3/1/23	0.0675	\$ 138,166	1
2												2
3												3
4												4
5												5
	Working Capital											
6	S.I. CREDIT CORP		X	INSURANCE POLICIES							1,563	6
7	ALBANY BANK		X	WORKING CAPITAL	INTEREST	REVOLV	150,000	495,146	REVOLV	PRIME +	34,071	7
8	BARRY KIRSCHENBAUM	X		WORKING CAPITAL	INTEREST		100,000	100,000			20,000	8
9	TOTAL Facility Related				\$14,494.84		\$ 2,130,000	\$ 2,289,256			\$ 193,800	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11	ILL DEPT OF PUBLIC AID		X	BED TAX							3,130	11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 3,130	14
15	TOTALS (line 9+line14)						\$ 2,130,000	\$ 2,289,256			\$ 196,930	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 2005 report.	\$	41,943	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.)	\$	43,218	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,275	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	43,218	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.	\$	44,493	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	36,945	8
	2002	38,186	9
	2003	39,973	10
	2004	41,943	11
	2005	43,218	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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 2005 TAX BILL.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF PONTIAC COUNTY LIVINGTON

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 2005 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 2005.

	(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>43,218.30</u>	\$ <u>43,218.30</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>43,218.30</u>	\$ <u>43,218.30</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 PONTIAC

0043968

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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).

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	<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:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	85	1998	1961	\$ 1,438,473	\$ 52,308	27.5	\$ 52,308	\$	\$ 438,079	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		54,194	9
10	WATER HEATERS & PLUMBING (PROP)	1999		14,502	527	27.5	527		3,974	10
11	BOILER & A/C (PROP)	1999		14,240	518	27.5	518		3,906	11
12	ELECTRONIC DOOR LOCKS (PROP)	1999		3,974	145	27.5	145		1,093	12
13	FENCE (PROP)	1999		1,155	77	15	77		581	13
14	REMODELING ROOMS & BATHROOMS (PROP)	2000		47,944	1,743	27.5	1,743		11,402	14
15	AIR CONDITIONER (PROP)	2000		5,569	203	27.5	203		1,328	15
16	FIRE PANEL (PROP)	2000		2,730	99	27.5	99		1,134	16
17	FURNISHING	2000		2,839	254	7	254		2,714	17
18	WATER SOFTENER (PROP)	2001		4,013	146	27.5	146		809	18
19	CONDENSER (PROP)	2001		3,100	113	27.5	113		626	19
20	HEATER AND A/C UNITS (PROP)	2001		5,100	186	27.5	186		1,030	20
21	GREASE TRAP (PROP)	2001		1,300	47	27.5	47		261	21
22	3 DOORS (PROP)	2001		4,000	145	27.5	145		804	22
23	FENCE (PROP)	2001		2,564	171	15	171		947	23
24	SIDEWALK (PROP)	2001		1,850	123	15	123		682	24
25	CONCRETE WORK (PROP)	2002		3,938	263	15	263		1,184	25
26	FIRE ALARM SYSTEM (PROP)	2002		40,476	1,472	27.5	1,472		6,685	26
27	RESIDENT SECURITY SYSTEM (PROP)	2002		11,930	434	27.5	434		1,971	27
28	FIRE DOORS (PROP)	2002		6,016	219	27.5	219		995	28
29	REMODELING 8 ROOMS (PROP)	2002		46,151	1,678	27.5	1,678		7,621	29
30	SPRINKLER HEADS (PROP)	2002		3,635	132	27.5	132		600	30
31	WATER LINE (PROP)	2002		3,002	109	27.5	109		495	31
32	BACK FLOW PREVENTER (PROP)	2002		3,300	120	27.5	120		545	32
33	NEW FLOOR DRAIN (PROP)	2003		1,726	63	27.5	63		223	33
34	LIGHTING (PROP)	2003		1,350	49	27.5	49		174	34
35	ELECTRICAL WORK (PROP)	2003		1,371	49	27.5	49		174	35
36	TELEPHONE WIRING (PROP)	2003		5,242	191	27.5	191		676	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	P-TAC UNITS(PROP)	2004	\$ 3,750	\$ 136	27.5	\$ 136	\$	\$ 346	37
38	ELECTRICAL WORK (PROP)	2005	5,435	198	27.5	198		305	38
39	AIR COMPRESSOR (PROP)	2005	5,791	211	27.5	211		325	39
40	FIRE SYSTEM (PROP)	2005	26,366	959	27.5	959		1,479	40
41	SPRINKLER HEADS (PROP)	2005	3,308	120	27.5	120		185	41
42	CIRCULATING (PROP)]	2005	2,077	75	27.5	75		116	42
43	DOOR ALARM (PROP)	2006	3,639	72	27.5	72		72	43
44	EXHAUST FAN (PROP)	2006	1,700	34	27.5	34		34	44
45	PTAC UNITS (PROP)	2006	2,717	53	27.5	53		53	45
46	OUTPATIENT THERAPY REMODELING (PROP)	2006	8,682	171	27.5	171		171	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)		\$ 1,842,013	\$ 70,084		\$ 70,084	\$ 0	\$ 547,993	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	\$ 124,310	\$ 6,323	\$ 12,431	\$ 6,108	10 YRS	\$ 68,800	71
72	Current Year Purchases	6,261	1,252	313	(939)	10 YRS	313	72
73	Fully Depreciated Assets				0			73
74	REL PARTY	340,000	34,000	34,000	0		286,906	74
75	TOTALS	\$ 470,571	\$ 41,575	\$ 46,744	\$ 5,169		\$ 356,019	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 FLD. VAN	1999	\$ 43,112	\$	\$	\$ 0		\$ 43,112	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 43,112	\$ 0	\$ 0	\$ 0		\$ 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)	\$ 2,455,696	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 111,659	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 116,828	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,169	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 947,124	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>231,471</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>231,471</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: \$ 14,340 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. 12/31/2007 \$ 231,471

13. 12/31/2008 \$ 231,471

14. 12/31/2009 \$ 231,471

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 75,252	\$		\$ 75,252	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			52,850			52,850	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			380,144			380,144	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 prescripts				85,172		85,172	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 Other (specify): Outside Services	39-8				31,778	21,371		53,149	13
14	TOTAL			\$		\$ 540,024	\$ 106,543		\$ 646,567	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: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,028	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	736,214		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,566		6
7	Other Prepaid Expenses	2,019		7
8	Accounts Receivable (owners or related parties)	677,986		8
9	Other(specify): <u>R.E. TAX ESCROW</u>	14,196		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,476,009	\$ 0	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	187,972		16
17	Accumulated Depreciation (book methods)	(176,098)		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)	\$ 11,874	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,487,883	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 630,389	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	695,146		29
30	Accrued Salaries Payable	89,128		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,774		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,218		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)	\$ 1,473,655	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,473,655	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 14,228	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,487,883	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 242,129	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 242,129	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(19,345)	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	(208,556)	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)	\$ (227,901)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 14,228	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	\$ 4,151,665	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,151,665	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	256,364	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 256,364	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	52	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSE ADJ	7,222	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,222	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,415,303	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	787,183	31
32	Health Care	1,644,136	32
33	General Administration	951,685	33
	B. Capital Expense		
34	Ownership	356,897	34
	C. Ancillary Expense		
35	Special Cost Centers	646,567	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)*	\$ 4,434,648	40
41	Income before Income Taxes (line 30 minus line 40)**	(19,345)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (19,345)	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: 01/01/2006

Ending: 12/31/2006

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	1,686	1,872	\$ 59,354	\$ 31.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,432	10,091	236,169	23.40	3
4	Licensed Practical Nurses	17,092	18,130	407,086	22.45	4
5	CNAs & Orderlies	52,533	55,083	557,836	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,354	2,575	46,180	17.93	9
10	Activity Assistants	17,160	18,360	137,269	7.48	10
11	Social Service Workers	5,268	5,622	77,596	13.80	11
12	Dietician					12
13	Food Service Supervisor	2,279	2,458	28,378	11.55	13
14	Head Cook	9,745	10,533	96,660	9.18	14
15	Cook Helpers/Assistants	8,221	8,503	59,829	7.04	15
16	Dishwashers					16
17	Maintenance Workers	1,985	2,188	38,977	17.81	17
18	Housekeepers	19,558	20,711	153,791	7.43	18
19	Laundry	3,660	4,003	42,012	10.50	19
20	Administrator	1,568	1,706	71,749	42.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,793	6,257	105,704	16.89	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	2,029	2,150	23,450	10.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,363	170,242	\$ 2,142,040 *	\$ 12.58	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	\$ 6,843	1-3	35
36	Medical Director	O	6,500	9-3	36
37	Medical Records Consultant	N	1,605	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,800	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	576	12-3	45
46	Other(specify)	S			46
47	Psycho Social Consultant		90	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,414		49

C. CONTRACT NURSES

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

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

1	Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010	14 FY2011
					1	PAINT/DECORATING	6/00	\$ 9,939	3 YRS	\$ 1,656	\$	\$	\$
2	PAINT/DECORATING	6/01	2,075	3 YRS	692	345							
3	PAINT/DECORATING	6/06	2,275	3 YRS				379	759	759	378		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 14,289		\$ 2,348	\$ 345	\$	\$ 379	\$ 759	\$ 759	\$ 378	\$	\$

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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. \$4,453
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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 _____ 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? YES Indicate the amount. \$ 730
- (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