

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC

0043968 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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>110</u>	<u>4,221</u>	<u>5,184</u>	8
9	SNF/PED					9
10	ICF	<u>18,104</u>	<u>4,793</u>	<u>2,713</u>	<u>25,610</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,957</u>	<u>4,903</u>	<u>6,934</u>	<u>30,794</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.87%

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

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

NONE

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

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

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 4,221

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	189,994	19,010	7,367	216,371		216,371		216,371		1
2	Food Purchase		194,657		194,657		194,657	(4,255)	190,402		2
3	Housekeeping	161,852	35,936		197,788		197,788		197,788		3
4	Laundry	48,026	5,064		53,090		53,090		53,090		4
5	Heat and Other Utilities			110,306	110,306		110,306	128	110,434		5
6	Maintenance	39,797	15,237	36,597	91,631		91,631	1,128	92,759		6
7	Other (specify):*			7,332	7,332		7,332		7,332		7
8	TOTAL General Services	439,669	269,904	161,602	871,175		871,175	(2,999)	868,176		8
	B. Health Care and Programs										
9	Medical Director			5,500	5,500		5,500		5,500		9
10	Nursing and Medical Records	1,307,697	53,664	5,657	1,367,018		1,367,018	556	1,367,574		10
10a	Therapy		831	180	1,011		1,011		1,011		10a
11	Activities	214,263	6,378	96	220,737		220,737		220,737		11
12	Social Services	88,705			88,705		88,705		88,705		12
13	CNA Training										13
14	Program Transportation			4,782	4,782		4,782		4,782		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,610,665	60,873	16,215	1,687,753		1,687,753	556	1,688,309		16
	C. General Administration										
17	Administrative	80,541		239,000	319,541		319,541	(86,377)	233,164		17
18	Directors Fees										18
19	Professional Services			46,022	46,022		46,022	1,601	47,623		19
20	Dues, Fees, Subscriptions & Promotions			46,413	46,413		46,413	(27,503)	18,910		20
21	Clerical & General Office Expenses	110,924	20,391	26,049	157,364		157,364	(17,318)	140,046		21
22	Employee Benefits & Payroll Taxes			328,623	328,623		328,623		328,623		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,948	2,948		2,948	549	3,497		24
25	Other Admin. Staff Transportation			15,233	15,233		15,233	5,688	20,921		25
26	Insurance-Prop.Liab.Malpractice			50,089	50,089		50,089	1,923	52,012		26
27	Other (specify):*			33,357	33,357		33,357	(23,538)	9,819		27
28	TOTAL General Administration	191,465	20,391	787,734	999,590		999,590	(144,975)	854,615		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,241,799	351,168	965,551	3,558,518		3,558,518	(147,418)	3,411,100		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	7,367
	REPAIRS & MAINTENANCE	0
		0
		7,367
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	25,477
	ELECTRICITY	59,352
	WATER	24,660
	CABLE TV - LOBBY	817
		0
		110,306
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,662
	PAINTING & DECORATING	938
	BUILDING REPAIRS	8,287
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	16,260
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,095
	FIRE SERVICE	7,355
		0
		0
		0
		0
		36,597
7	OTHER	
	SCAVENGER	6,537
	SECURITY SERVICE	795
		0
		0
		7,332
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,500
		5,500

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	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,215
	PHARMACY CONSULTANT XVIII B 39-2	3,300
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	PSYCHO-SOCIAL	192
	NURSES AIDE TRAINING	950
		5,657
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	180
	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
		180
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	96
		0
		96
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	4,782
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	239,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,455
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	29,567
		0
		46,022
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	27,419
	EMPLOYEE WANT ADS XIX F	2,190
	CONTRIBUTIONS VI 20 XIX F	1,000
	DUES & SUBSCRIPTIONS XIX F	5,834
	LICENSES & PERMITS XIX F	8,070
	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	600
	PATIENT BACKGROUND CHECKS XIX F	1,300
		46,413
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,015
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	5,950
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	15,805
	MESSENGER SERVICE	1,279
		0
		26,049

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	169,622
	UNEMPLOYMENT COMPENSATION XIX D	49,029
	WORKERS COMPENSATION INSURANC XIX D	67,723
	HOSPITALIZATION INSURANCE XIX D	36,900
	EMPLOYEE BENEFITS - OTHER XIX D	4,011
	EMPLOYEE PHYSICAL EXAMS XIX D	1,338
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		328,623
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,948
	TRAVEL XIX G	0
		2,948
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	15,233
		15,233
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	50,089
		50,089
27	OTHER	
	BAD DEBTS VI 24	33,357
		33,357

GRAND TOTAL COLUMN 3 OTHER

965,551

ASTA CARE CENTER OF PONTIAC, LLC
SCHEDULES
12/31/2007

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

TOTAL FOOD PURCHASE	194,657
LESS SALES TAX	<u>(4,255)</u>
NET FOOD	190,402

TOTAL PATIENT CENSUS	30,794
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	92,382

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

PATIENT MEALS	92,382
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	92,382

NET FOOD	190,402
DIVIDE TOTAL MEALS/YEAR	<u>92,382</u>

COST PER MEAL	2.06
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC

#0043968

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,862	7,862		7,862	110,007	117,869			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,111	71,111		71,111	108,414	179,525			32
33	Real Estate Taxes			47,250	47,250		47,250		47,250			33
34	Rent-Facility & Grounds			216,000	216,000		216,000	(216,000)				34
35	Rent-Equipment & Vehicles			13,985	13,985		13,985	530	14,515			35
36	Other (specify):*											36
37	TOTAL Ownership			356,208	356,208		356,208	2,951	359,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		158,923	600,141	759,064		759,064		759,064			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		158,923	648,321	807,244		807,244		807,244			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,241,799	510,091	1,970,080	4,721,970		4,721,970	(144,467)	4,577,503			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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,860	30		9
10	Interest and Other Investment Income	(72)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,255)	2		13
14	Non-Care Related Interest	(24,844)	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	(5,950)	21		18
19	Entertainment		20		19
20	Contributions	(1,000)	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	(33,357)	27		24
25	Fund Raising, Advertising and Promotional	(27,419)	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	(22,968)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (114,005)		\$	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)	(30,462)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (30,462)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (144,467)		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

ID# 0043968

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 759	6	1
2				2
3	STAFF TRANSPORTATION - MARKETING	(39)	25	3
4	MARKETING SALARIES	(23,688)	21	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	(22,968)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(4,255)	0	0	0	0	0	0	0	0	0	0	(4,255)	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	128	0	0	0	0	0	0	0	0	0	128	5
6	Maintenance	759	369	0	0	0	0	0	0	0	0	0	1,128	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,496)	497	0	(2,999)	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	556	0	0	0	0	0	0	0	0	0	556	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	556	0	556	16								
	C. General Administration													
17	Administrative	0	(86,377)	0	0	0	0	0	0	0	0	0	(86,377)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,601	0	0	0	0	0	0	0	0	0	1,601	19
20	Fees, Subscriptions & Promotions	(28,419)	916	0	0	0	0	0	0	0	0	0	(27,503)	20
21	Clerical & General Office Expenses	(29,638)	12,320	0	0	0	0	0	0	0	0	0	(17,318)	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	549	0	0	0	0	0	0	0	0	0	549	24
25	Other Admin. Staff Transportation	(39)	5,727	0	0	0	0	0	0	0	0	0	5,688	25
26	Insurance-Prop.Liab.Malpractice	0	1,923	0	0	0	0	0	0	0	0	0	1,923	26
27	Other (specify):*	(33,357)	9,819	0	0	0	0	0	0	0	0	0	(23,538)	27
28	TOTAL General Administration	(91,453)	(53,522)	0	(144,975)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(94,949)	(52,469)	0	(147,418)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	5,860	0	104,147	0	0	0	0	0	0	0	0	110,007	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,916)	0	133,330	0	0	0	0	0	0	0	0	108,414	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(216,000)	0	0	0	0	0	0	0	0	(216,000)	34
35	Rent-Equipment & Vehicles	0	530	0	0	0	0	0	0	0	0	0	530	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(19,056)	530	21,477	0	2,951	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)	(114,005)	(51,939)	21,477	0	(144,467)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ASTA		
				HEALTHCARE CO.	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		ASTA PONTIAC		
				PROPERTIES	ELGIN	REAL ESTATE
				ASTA THERAPY	ELGIN	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEES	\$ 239,000	ASTA HEALTHCARE COMPANY		\$	(239,000)	1
2	V	5	UTILITIES			128		128	2
3	V	6	MAINTENANCE			369		369	3
4	V	10	NURSING			556		556	4
5	V	17	ADMINISTRATIVE			152,623		152,623	5
6	V	19	PROFESSIONAL FEES			1,601		1,601	6
7	V	20	LICENSES & PERMITS			916		916	7
8	V	21	OFFICE EXPENSE			12,320		12,320	8
9	V	24	SEMINARS			549		549	9
10	V	25	STAFF TRANS/ TRAVEL			5,727		5,727	10
11	V	26	INSURANCE GEN / WC			1,923		1,923	11
12	V	27	PAYR. TAXES & GRP INS			9,819		9,819	12
13	V	35	EQUIPMENT RENTAL			530		530	13
14	Total		\$ 239,000			\$ 187,061	\$ *	(51,939)	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	\$ 216,000	PONTIAC PROPERTIES		\$	(216,000)
16	V	30 DEPRECIATION				104,147	104,147
17	V	32 INTEREST				133,330	133,330
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		\$ 216,000			\$ 237,477	\$ * 21,477

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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		LIST	ATTACHED	SALARY	\$ 27,302	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										2
3	SETH GILLMAN					LIST	ATTACHED	SALARY	27,302	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										4
5	SALARY FROM ASTA CARE OF TOLUCA \$30,097										5
6	CRAIG FRANK					LIST	ATTACHED	SALARY	27,302	17-7	6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$38,397										8
9	DAVID MEISELMAN-TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$153,958					LIST	ATTACHED	SALARY	25,475	17-7	9
10	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,159										10
11	ALIZA FRANK - TOTAL SALARY RECEIVED FROM					LIST	ATTACHED	SALARY	5,695	21-7	11
12	ASTA HEALTHCARE \$34,417										12
13								TOTAL	\$ 113,076		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, LLC

0043968

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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	5	UTILITIES	PATIENT DAYS	186,106	6	\$ 773	30,794	\$ 128	1
2	6	MAINTENANCE	PATIENT DAYS	186,106	6	2,228	30,794	369	2
3	10	NURSING	PATIENT DAYS	186,106	6	3,360	30,794	556	3
4	17	OFFICER'S SALARY -MG	PATIENT DAYS	186,106	6	165,000	30,794	27,302	4
5	17	OFFICER'S SALARY - SETH	PATIENT DAYS	186,106	6	165,000	30,794	27,302	5
6	17	ADMIN. SALARY -CF	PATIENT DAYS	186,106	6	165,000	30,794	27,302	6
7	17	ADMIN. SALARY - DM	PATIENT DAYS	186,106	6	153,958	30,794	25,475	7
8	17	ADMIN. SALARY	PATIENT DAYS	186,106	6	273,426	30,794	45,242	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	186,106	6	9,677	30,794	1,601	9
10	20	LICENSES & PERMITS	PATIENT DAYS	186,106	6	5,535	30,794	916	10
11	21	OFFICE EXPENSE	PATIENT DAYS	186,106	6	74,457	30,794	12,320	11
12	24	SEMINARS	PATIENT DAYS	186,106	6	3,319	30,794	549	12
13	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	186,106	6	34,613	30,794	5,727	13
14	26	INSURANCE GEN / WC	PATIENT DAYS	186,106	6	11,622	30,794	1,923	14
15	27	PAYR. TAXES & GRP INS	PATIENT DAYS	186,106	6	59,344	30,794	9,819	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	186,106	6	3,205	30,794	530	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,130,517	\$ 960,161	\$ 187,061	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC

0043968

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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	1	\$ 104,147	\$ 1	\$ 104,147	1
2	32	INTEREST	DIRECT COST	1	1	133,330	1	133,330	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					\$ 237,477	\$	\$ 237,477	25

Facility Name & ID Number

ASTA CARE CENTER OF PONTIAC, LLC

0043968

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	REL PARTY-ALBANK		X	MORTGAGE	\$14,494.84	2/14/03	\$ 1,880,000	\$ 1,638,368	3/1/23	0.0675	\$ 133,330	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	S.L. CREDIT CORP		X	INSURANCE POLICIES							884	6								
7	ALBANY BANK		X	WORKING CAPITAL	INTEREST	REVOLV	150,000	495,146	REVOLV	PRIME+	42,200	7								
8	MICHAEL GILLMAN	X		WORKING CAPITAL	INTEREST			100,000			3,183	8								
9	TOTAL Facility Related				\$14,494.84		\$ 2,030,000	\$ 2,233,514			\$ 179,597	9								
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES								10								
11	BARRY KIRCHENBAUM	X		WORKING CAPITAL	INTEREST			100,000			20,000	11								
12	IDPA		X	BED TAX							4,844	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$ 100,000			\$ 24,844	14								
15	TOTALS (line 9+line14)						\$ 2,030,000	\$ 2,333,514			\$ 204,441	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 2006 report.	\$	43,218	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.)	\$	45,234	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,016	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	45,234	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.	\$	47,250	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	38,186	8
	2003	39,973	9
	2004	41,943	10
	2005	43,218	11
	2006	45,234	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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 2006 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF PONTIAC, LLC 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 2006 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 2006.

	(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>45,234.24</u>	\$ <u>45,234.24</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>45,234.24</u>	\$ <u>45,234.24</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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, LLC

0043968

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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, LLC

0043968

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 490,387	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		60,665	9
10	WATER HEATERS & PLUMBING (PROP)	1999		14,502	527	27.5	527		4,501	10
11	BOILER & A/C (PROP)	1999		14,240	518	27.5	518		4,424	11
12	ELECTRONIC DOOR LOCKS (PROP)	1999		3,974	145	27.5	145		1,238	12
13	FENCE (PROP)	1999		1,155	77	15	77		658	13
14	REMODELING ROOMS & BATHROOMS (PROP)	2000		47,944	1,743	27.5	1,743		13,145	14
15	AIR CONDITIONER (PROP)	2000		5,569	203	27.5	203		1,531	15
16	FIRE PANEL (PROP)	2000		2,730	99	27.5	99		1,233	16
17	FURNISHING	2000		2,839	125	7	125		2,839	17
18	WATER SOFTENER (PROP)	2001		4,013	146	27.5	146		955	18
19	CONDENSER (PROP)	2001		3,100	113	27.5	113		739	19
20	HEATER AND A/C UNITS (PROP)	2001		5,100	186	27.5	186		1,216	20
21	GREASE TRAP (PROP)	2001		1,300	47	27.5	47		308	21
22	3 DOORS (PROP)	2001		4,000	145	27.5	145		949	22
23	FENCE (PROP)	2001		2,564	171	15	171		1,118	23
24	SIDEWALK (PROP)	2001		1,850	123	15	123		805	24
25	CONCRETE WORK (PROP)	2002		3,938	263	15	263		1,447	25
26	FIRE ALARM SYSTEM (PROP)	2002		40,476	1,472	27.5	1,472		8,157	26
27	RESIDENT SECURITY SYSTEM (PROP)	2002		11,930	434	27.5	434		2,405	27
28	FIRE DOORS (PROP)	2002		6,016	219	27.5	219		1,214	28
29	REMODELING 8 ROOMS (PROP)	2002		46,151	1,678	27.5	1,678		9,299	29
30	SPRINKLER HEADS (PROP)	2002		3,635	132	27.5	132		732	30
31	WATER LINE (PROP)	2002		3,002	109	27.5	109		604	31
32	BACK FLOW PREVENTER (PROP)	2002		3,300	120	27.5	120		665	32
33	NEW FLOOR DRAIN (PROP)	2003		1,726	63	27.5	63		286	33
34	LIGHTING (PROP)	2003		1,350	49	27.5	49		223	34
35	ELECTRICAL WORK (PROP)	2003		1,371	49	27.5	49		223	35
36	TELEPHONE WIRING (PROP)	2003		5,242	191	27.5	191		867	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	\$	\$ 482	37
38	ELECTRICAL WORK (PROP)	2005	5,435	198	27.5	198		503	38
39	AIR COMPRESSOR (PROP)	2005	5,791	211	27.5	211		536	39
40	FIRE SYSTEM (PROP)	2005	26,366	959	27.5	959		2,438	40
41	SPRINKLER HEADS (PROP)	2005	3,308	120	27.5	120		305	41
42	CIRCULATING (PROP)]	2005	2,077	75	27.5	75		191	42
43	DOOR ALARM (PROP)	2006	3,639	132	27.5	132		204	43
44	EXHAUST FAN (PROP)	2006	1,700	62	27.5	62		96	44
45	PTAC UNITS (PROP)	2006	2,717	99	27.5	99		152	45
46	OUTPATIENT THERAPY REMODELING (PROP)	2006	8,682	316	27.5	316		487	46
47	GENERATOR (PROP)	2007	3,566	38	27.5	38		38	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)		\$ 1,845,579	\$ 70,272		\$ 70,272	\$	\$ 618,265	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	\$ 130,571	\$ 5,576	\$ 13,057	\$ 7,481		\$ 82,170	71
72	Current Year Purchases	10,803	2,161	540	(1,621)		540	72
73	Fully Depreciated Assets							73
74	REL PARTY	340,000	34,000	34,000			320,906	74
75	TOTALS	\$ 481,374	\$ 41,737	\$ 47,597	\$ 5,860		\$ 403,616	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	\$	\$	\$		\$ 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)	\$ 2,470,065	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 112,009	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,869	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,860	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,064,993	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>216,000</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>216,000</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: \$ 13,985 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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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	39-3	hrs	\$		\$ 95,679	\$		\$ 95,679	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			50,962			50,962	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			449,932			449,932	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				142,734		142,734	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	inhalation therapy, other services Other (specify): <u>supplies, radiology, lab</u>	39-8 39-8				3,568	16,189		<u>3,568</u> 16,189	13
14	TOTAL			\$		\$ 600,141	\$ 158,923		\$ 759,064	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, LLC

0043968

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 7,581	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	921,075		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,530		6
7	Other Prepaid Expenses	870		7
8	Accounts Receivable (owners or related parties)	707,605		8
9	Other(specify): <u>REAL ESTATE TX ESCROW</u>	17,362		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,713,023	\$	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	187,325		16
17	Accumulated Depreciation (book methods)	(172,511)		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): <u>SECURITY DEPOSIT</u>	542		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,356	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,728,379	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 970,115	\$	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	100,152		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,101		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,234		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)	\$ 1,830,748	\$	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)	\$ 1,830,748	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (102,369)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,728,379	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 14,228	1
2	Restatements (describe):		2
3	ROUNDING	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,225	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(80,618)	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	(35,976)	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)	\$ (116,594)	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)	\$ (102,369)	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	\$ 4,448,898	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,448,898	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	192,709	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 192,709	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***	72	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 72	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,641,679	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	871,175	31
32	Health Care	1,687,753	32
33	General Administration	999,590	33
	B. Capital Expense		
34	Ownership	356,208	34
	C. Ancillary Expense		
35	Special Cost Centers	759,064	35
36	Provider Participation Fee	48,180	36
	D. Other Expenses (specify):		
37	<u>OUT-OF-PERIOD EXPENSES</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,721,970	40
41	Income before Income Taxes (line 30 minus line 40)**	(80,291)	41
42	Income Taxes	(327)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (80,618)	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, LLC

0043968

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	1,631	1,823	\$ 60,572	\$ 33.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,869	8,304	205,807	24.78	3
4	Licensed Practical Nurses	18,619	19,937	436,361	21.89	4
5	CNAs & Orderlies	53,691	56,164	576,007	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,428	2,575	50,029	19.43	9
10	Activity Assistants	18,914	20,381	164,234	8.06	10
11	Social Service Workers	5,606	6,087	88,705	14.57	11
12	Dietician					12
13	Food Service Supervisor	2,251	2,551	30,522	11.96	13
14	Head Cook	8,493	9,460	89,832	9.50	14
15	Cook Helpers/Assistants	9,097	9,547	69,640	7.29	15
16	Dishwashers					16
17	Maintenance Workers	1,948	2,140	39,797	18.60	17
18	Housekeepers	19,211	20,462	161,852	7.91	18
19	Laundry	4,333	4,693	48,026	10.23	19
20	Administrator	1,603	1,803	80,541	44.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,775	6,367	110,924	17.42	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	2,037	2,158	28,950	13.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,506	174,452	\$ 2,241,799 *	\$ 12.85	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	\$ 7,367	1-3	35
36	Medical Director	O	5,500	9-3	36
37	Medical Records Consultant	N	1,215	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,300	10-3	39
40	Physical Therapy Consultant	T	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	96	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,478		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LORI STROGSDILL	ADMINISTRATOR	0	\$ 80,541	Workers' Compensation Insurance	\$ 67,723	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	49,029	Advertising: Employee Recruitment	2,190	
			0	FICA Taxes	169,622	Health Care Worker Background Check	600	
				Employee Health Insurance	36,900	(Indicate # of checks performed 60)		
				Employee Meals	0	Patient Background Checks	130	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,000	
				EMPLOYEE BENEFITS - OTHER	4,011	MARKETING/ADV/PROMO	27,419	
				EMPLOYEE PHYSICAL EXAMS	1,338	LICENSES/DUES/SUBSCRIPTIONS	13,904	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	916	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,000)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(27,419)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 80,541	TOTAL (agree to Schedule V, line 22, col.8)	\$ 328,623	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,910	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
ASTA HEALTHCARE COMPANY, INC.			\$ 239,000			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 239,000				Seminar Expense	2,948
							MANGEMENT COMP ALLOCATION	549
							Entertainment Expense	()
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,497
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount			\$		
COMPUTER TECH	DATA PROCESSING		\$ 605					
HEALTH DATA SYSTEMS	DATA PROCESSING		11,224					
HEALTH DATA SOLUTION	DATA PROCESSING		2,700					
KRUPNICK, BOKOR, KAGDA	ACCOUNTING FEES		17,900					
OSTROW REISN BERK	ACCOUNTING FEES		1,250					
STONE,MCGUIRE, BENJAMIN	LEGAL FEES		5,992					
PERSONNEL PLANNERS	UC CONSULTANT		750					
RICHARD PEELO	MEDICARE COST REPORT		2,750					
ROBINSON & ASSOCIATES	COMUTER CONSULTING		2,851					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 46,022					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	PAINT/DECORATING	6/06	\$ 2,275	3 YRS	\$	\$	\$ 379	\$ 759	\$ 759	\$ 378	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,275		\$	\$	\$ 379	\$ 759	\$ 759	\$ 378	\$	\$	\$

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC

0043968

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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. ILLINOIS HEALTHCARE ASSOC \$4,048
- (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. \$ 15,000 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 _____ 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? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees