

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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 License 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>LIVINGSTON</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>08/17/98</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> Email Address: _____</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>01/01/2009</u> to <u>12/31/2009</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: 20%;">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">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>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>
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Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		260	4,912	5,172	8
9	SNF/PED					9
10	ICF	17,580	6,562	1,518	25,660	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,580	6,822	6,430	30,832	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.99%

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 4,912

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	204,784	19,544	6,687	231,015		231,015		231,015		1
2	Food Purchase		161,060		161,060		161,060	(1,679)	159,381		2
3	Housekeeping	151,271	28,222		179,493		179,493		179,493		3
4	Laundry	75,924	12,033		87,957		87,957		87,957		4
5	Heat and Other Utilities			92,867	92,867		92,867		92,867		5
6	Maintenance	44,265	19,458	28,138	91,861		91,861	1,260	93,121		6
7	Other (specify):*			15,048	15,048		15,048		15,048		7
8	TOTAL General Services	476,244	240,317	142,740	859,301		859,301	(419)	858,882		8
	B. Health Care and Programs										
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	1,396,419	78,053	2,722	1,477,194		1,477,194	2,246	1,479,440		10
10a	Therapy		1,236		1,236		1,236		1,236		10a
11	Activities	251,443	13,120		264,563		264,563		264,563		11
12	Social Services	100,631			100,631		100,631		100,631		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,748,493	92,409	9,222	1,850,124		1,850,124	2,246	1,852,370		16
	C. General Administration										
17	Administrative	118,354		364,208	482,562		482,562	(275,371)	207,191		17
18	Directors Fees										18
19	Professional Services			51,464	51,464		51,464	262	51,726		19
20	Dues, Fees, Subscriptions & Promotions			23,709	23,709		23,709	(10,887)	12,822		20
21	Clerical & General Office Expenses	68,977	19,059	87,163	175,199		175,199	(29,375)	145,824		21
22	Employee Benefits & Payroll Taxes			300,639	300,639		300,639		300,639		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,356	1,356		1,356	48	1,404		24
25	Other Admin. Staff Transportation			5,157	5,157		5,157	5,992	11,149		25
26	Insurance-Prop.Liab.Malpractice			47,192	47,192		47,192	1,593	48,785		26
27	Other (specify):*			142,766	142,766		142,766	(134,963)	7,803		27
28	TOTAL General Administration	187,331	19,059	1,023,654	1,230,044		1,230,044	(442,701)	787,343		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,412,068	351,785	1,175,616	3,939,469		3,939,469	(440,874)	3,498,595		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	6,322
	REPAIRS & MAINTENANCE	365
		0
		6,687
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	19,988
	ELECTRICITY	42,280
	WATER	30,599
	CABLE TV - LOBBY	0
		0
		92,867
6	MAINTENANCE	
	GROUNDS MAINTENANCE	475
	PAINTING & DECORATING	0
	BUILDING REPAIRS	8,836
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	13,181
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	901
	FIRE SERVICE	4,745
		0
		0
		0
		0
		28,138
7	OTHER	
	SCAVENGER	14,060
	SECURITY SERVICE	988
		0
		0
		15,048
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	652
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	270
	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
		2,722
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	364,208
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,318
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	35,146
		0
		51,464
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	10,448
	EMPLOYEE WANT ADS XIX F	1,900
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	4,154
	LICENSES & PERMITS XIX F	3,085
	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	1,579
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	972
	PATIENT BACKGROUND CHECKS XIX F	1,571
		23,709
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,513
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	64,397
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,253
	MESSENGER SERVICE	0
		0
		87,163

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	182,894
	UNEMPLOYMENT COMPENSATION XIX D	24,354
	WORKERS COMPENSATION INSURANC XIX D	47,995
	HOSPITALIZATION INSURANCE XIX D	44,503
	EMPLOYEE BENEFITS - OTHER XIX D	893
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		300,639
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,356
	TRAVEL XIX G	0
		1,356
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	5,157
		5,157
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	47,192
		47,192
27	OTHER	
	BAD DEBTS VI 24	142,766
		142,766

GRAND TOTAL COLUMN 3 OTHER **1,175,616**

ASTA CARE CENTER OF PONTIAC
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	161,060
LESS SALES TAX	<u>(1,679)</u>
NET FOOD	159,381

TOTAL PATIENT CENSUS	30,832
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	92,496

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

PATIENT MEALS	92,496
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	92,496

NET FOOD	159,381
DIVIDE TOTAL MEALS/YEAR	<u>92,496</u>

COST PER MEAL	1.72
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

ASTA CARE CENTER OF PONTIAC

#0043968

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,683	9,683		9,683	75,096	84,779			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,013	54,013		54,013	71,194	125,207			32
33	Real Estate Taxes			48,746	48,746		48,746		48,746			33
34	Rent-Facility & Grounds			262,000	262,000		262,000	(262,000)				34
35	Rent-Equipment & Vehicles			12,337	12,337		12,337		12,337			35
36	Other (specify):*											36
37	TOTAL Ownership			386,779	386,779		386,779	(115,710)	271,069			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,228	838,241	1,026,469		1,026,469		1,026,469			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		188,228	886,421	1,074,649		1,074,649		1,074,649			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,412,068	540,013	2,448,816	5,400,897		5,400,897	(556,584)	4,844,313			45

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,529	30		9
10	Interest and Other Investment Income	(7,096)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,679)	2		13
14	Non-Care Related Interest	(6,032)	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	(64,397)	21		18
19	Entertainment		20		19
20	Contributions	(1,579)	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	(142,766)	27		24
25	Fund Raising, Advertising and Promotional	(10,448)	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	(3,847)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (236,315)		\$	30

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)	(320,269)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (320,269)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (556,584)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

ASTA CARE CENTER OF PONTIAC

ID# 0043968

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 378	6	1
2	MARKETING SALARY	(2,750)	21	2
3	MARKETING TRAVEL	(1,475)	25	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		(3,847)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,679)	0	0	0	0	0	0	0	0	0	0	(1,679)	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	378	882	0	0	0	0	0	0	0	0	0	1,260	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,301)	882	0	(419)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,246	0	0	0	0	0	0	0	0	0	2,246	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	2,246	0	2,246	16								
	C. General Administration													
17	Administrative	0	(275,371)	0	0	0	0	0	0	0	0	0	(275,371)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	262	0	0	0	0	0	0	0	0	0	262	19
20	Fees, Subscriptions & Promotions	(12,027)	1,140	0	0	0	0	0	0	0	0	0	(10,887)	20
21	Clerical & General Office Expenses	(67,147)	37,772	0	0	0	0	0	0	0	0	0	(29,375)	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	48	0	0	0	0	0	0	0	0	0	48	24
25	Other Admin. Staff Transportation	(1,475)	7,467	0	0	0	0	0	0	0	0	0	5,992	25
26	Insurance-Prop.Liab.Malpractice	0	1,593	0	0	0	0	0	0	0	0	0	1,593	26
27	Other (specify):*	(142,766)	7,803	0	0	0	0	0	0	0	0	0	(134,963)	27
28	TOTAL General Administration	(223,415)	(219,286)	0	(442,701)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(224,716)	(216,158)	0	(440,874)	29								

STATE OF ILLINOIS

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

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	1,529	0	73,567	0	0	0	0	0	0	0	0	75,096	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,128)	0	84,322	0	0	0	0	0	0	0	0	71,194	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(262,000)	0	0	0	0	0	0	0	0	(262,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,599)	0	(104,111)	0	(115,710)	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)	(236,315)	(216,158)	(104,111)	0	(556,584)	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 364,208	ASTA HEALTHCARE COMPANY		\$	\$ (364,208)	1
2	V	6 MAINTENANCE				882	882	2
3	V	10 NURSING				2,246	2,246	3
4	V	17 ADMINISTRATIVE				88,837	88,837	4
5	V	19 PROFESSIONAL FEES				262	262	5
6	V	20 LICENSES & PERMITS				1,140	1,140	6
7	V	21 OFFICE EXPENSE				37,772	37,772	7
8	V	24 SEMINARS				48	48	8
9	V	25 STAFF TRANS/ TRAVEL				7,467	7,467	9
10	V	26 INSURANCE GEN / WC				1,593	1,593	10
11	V	27 PAYR. TAXES & GRP INS				7,803	7,803	11
12	V							12
13	V							13
14	Total		\$ 364,208			\$ 148,050	\$ * (216,158)	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	\$ 262,000	PONTIAC PROPERTIES		\$	(262,000)
16	V	30 DEPRECIATION				73,567	73,567
17	V	32 INTEREST				84,322	84,322
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		\$ 262,000			\$ 157,889	\$ * (104,111)

* 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: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN							SALARY	\$ 33,694	17-7	1
2											2
3	SETH GILLMAN							SALARY	1,167	17-7	3
4											4
5					SEE		SEE				5
6					ATTACHED		ATTACHED				6
7	CRAIG FRANK				SCHEDULE		SCHEDULE	SALARY	28,403	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,333										8
9											9
10											10
11											11
12	ALIZA FRANK							SALARY	5,875	17-7	12
13								TOTAL	\$ 69,139		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:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PATIENT DAYS	178,434	6	\$ 5,107	30,832	\$ 882	1
2	10	NURSING	PATIENT DAYS	178,434	6	13,000	13,000	2,246	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	178,434	6	195,000	195,000	33,694	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	178,434	6	6,755	6,755	1,167	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	178,434	6	164,375	164,375	28,403	5
6	17	ADMIN. SALARY -AF	PATIENT DAYS	178,434	6	34,000	34,000	5,875	6
7	17	ADMIN. SALARY- JS	PATIENT DAYS	178,434	6	114,000	114,000	19,698	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,434	6	1,518	30,832	262	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,434	6	6,596	30,832	1,140	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,434	6	218,597	139,019	37,772	10
11	24	SEMINARS	PATIENT DAYS	178,434	6	275	30,832	48	11
12	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	178,434	6	43,211	30,832	7,467	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,434	6	9,222	30,832	1,593	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,434	6	45,157	30,832	7,803	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 856,813	\$ 666,149	\$ 148,050	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ASTA 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

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	30	DEPRECIATION	DIRECT COST	1	1	\$ 73,567	\$ 1	\$ 73,567	1
2	32	INTEREST	DIRECT COST	1	1	84,322	1	84,322	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				\$ 157,889	\$		\$ 157,889	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	\$ 1,503,101	3/1/23	0.0675	\$ 84,322	1						
2												2						
3	TCF		X	AUTO LOAN	\$476.89	2009	24,275	22,984	10/18/2014	0.0716	139	3						
4			X									4						
5	KIRCHENBAUM	X		WORKING CAPITAL				100,000			20,000	5						
Working Capital																		
6	ALBANY BANK		X	WORKING CAPITAL	INTEREST	REVOLV		589,123	REVOLV	PRIME +	22,196	6						
7			X	INSURANCE FEES							4,320	7						
8	GILMAN	X		WORKING CAPITAL				100,000			1,326	8						
9	TOTAL Facility Related				\$14,971.73		\$ 1,904,275	\$ 2,315,208			\$ 132,303	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11				BED TAX							6,032	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 6,032	14						
15	TOTALS (line 9+line14)						\$ 1,904,275	\$ 2,315,208			\$ 138,335	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2008 report.	\$	45,342	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.)	\$	47,044	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,702	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	47,044	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.	\$	48,746	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	41,943	8
	2005	43,218	9
	2006	45,234	10
	2007	45,342	11
	2008	47,044	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>47,044.10</u>	\$ <u>47,044.10</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

X. BUILDING AND GENERAL INFORMATION:

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC

0043968

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	85		1998	1961	\$ 1,438,473	\$ 52,308	27.5	\$ 52,308	\$	\$ 595,003	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		73,607	9
10		WATER HEATERS & PLUMBING (PROP)	1999		14,502	527	27.5	527		5,555	10
11		BOILER & A/C (PROP)	1999		14,240	518	27.5	518		5,460	11
12		ELECTRONIC DOOR LOCKS (PROP)	1999		3,974	145	27.5	145		1,528	12
13		FENCE (PROP)	1999		1,155	77	15	77		812	13
14		REMODELING ROOMS & BATHROOMS (PROP)	2000		47,944	1,743	27.5	1,743		16,631	14
15		AIR CONDITIONER (PROP)	2000		5,569	203	27.5	203		1,937	15
16		FIRE PANEL (PROP)	2000		2,730	99	27.5	99		1,431	16
17		FURNISHING	2000		2,839		7			2,839	17
18		WATER SOFTENER (PROP)	2001		4,013	146	27.5	146		1,247	18
19		CONDENSER (PROP)	2001		3,100	113	27.5	113		965	19
20		HEATER AND A/C UNITS (PROP)	2001		5,100	186	27.5	186		1,588	20
21		GREASE TRAP (PROP)	2001		1,300	47	27.5	47		402	21
22		3 DOORS (PROP)	2001		4,000	145	27.5	145		1,239	22
23		FENCE (PROP)	2001		2,564	171	15	171		1,460	23
24		SIDEWALK (PROP)	2001		1,850	123	15	123		1,051	24
25		CONCRETE WORK (PROP)	2002		3,938	263	15	263		1,973	25
26		FIRE ALARM SYSTEM (PROP)	2002		40,476	1,472	27.5	1,472		11,101	26
27		RESIDENT SECURITY SYSTEM (PROP)	2002		11,930	434	27.5	434		3,273	27
28		FIRE DOORS (PROP)	2002		6,016	219	27.5	219		1,652	28
29		REMODELING 8 ROOMS (PROP)	2002		46,151	1,678	27.5	1,678		12,655	29
30		SPRINKLER HEADS (PROP)	2002		3,635	132	27.5	132		996	30
31		WATER LINE (PROP)	2002		3,002	109	27.5	109		822	31
32		BACK FLOW PREVENTER (PROP)	2002		3,300	120	27.5	120		905	32
33		NEW FLOOR DRAIN (PROP)	2003		1,726	63	27.5	63		412	33
34		LIGHTING (PROP)	2003		1,350	49	27.5	49		321	34
35		ELECTRICAL WORK (PROP)	2003		1,371	49	27.5	49		321	35
36		TELEPHONE WIRING (PROP)	2003		5,242	191	27.5	191		1,249	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	P-TAC UNITS(PROP)	2004	\$ 3,750	\$ 136	27.5	\$ 136	\$	\$ 754	37
38	ELECTRICAL WORK (PROP)	2005	5,435	198	27.5	198		899	38
39	AIR COMPRESSOR (PROP)	2005	5,791	211	27.5	211		958	39
40	FIRE SYSTEM (PROP)	2005	26,366	959	27.5	959		4,356	40
41	SPRINKLER HEADS (PROP)	2005	3,308	120	27.5	120		545	41
42	CIRCULATING (PROP)]	2005	2,077	75	27.5	75		341	42
43	DOOR ALARM (PROP)	2006	3,639	132	27.5	132		468	43
44	EXHAUST FAN (PROP)	2006	1,700	62	27.5	62		220	44
45	PTAC UNITS (PROP)	2006	2,717	99	27.5	99		350	45
46	OUTPATIENT THERAPY REMODELING (PROP)	2006	8,682	316	27.5	316		1,119	46
47	WATER HEATER (PROP)	2008	6,179	225	27.5	225		422	47
48	10 FOOT ADDITION FOR DIALYSIS TRTMNT ROOM(PROP)	2008	55,988	2,036	27.5	2,036		2,969	48
49	WATER SOFTENER (PROP)	2008	7,022	255	27.5	255		308	49
50	4 TON A/C AND FILTER DRYER (PROP)	2008	2,979	108	27.5	108		131	50
51	3 TON A/C AND DRYER (PROP)	2008	2,550	93	27.5	93		112	51
52	WATER HEATER (PROP)	2008	3,897	142	27.5	142		172	52
53	SPRINKLER HEADS (PROP)	2009	20,820	599	27.5	599		599	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)		\$ 1,941,448	\$ 73,567		\$ 73,567	\$	\$ 763,158	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	\$ 105,661	\$ 3,615	\$ 10,096	\$ 6,481	10 YRS	\$ 69,447	71
72	Current Year Purchases	9,853	5,912	493	(5,419)	10 YRS	493	72
73	Fully Depreciated Assets	35,713				10 YRS	35,713	73
74	REL PARTY	340,000					340,000	74
75	TOTALS	\$ 491,227	\$ 9,527	\$ 10,589	\$ 1,062		\$ 445,653	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	2004 FORD TURTLE	2009	\$ 3,117	\$ 156	\$ 623	\$ 467	5 YRS	\$ 623	76
77										77
78										78
79										79
80	TOTALS			\$ 3,117	\$ 156	\$ 623	\$ 467		\$ 623	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)	\$ 2,535,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,250	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 84,779	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,529	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,209,434	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:				\$ 262,000			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 262,000			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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: \$ 12,337 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8			
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
			Units	Cost			Units	Cost										
1	Licensed Occupational Therapist	39-3	hrs	\$				\$	123,237	\$						\$	123,237	1
2	Licensed Speech and Language Development Therapist	39-3	hrs						53,882								53,882	2
3	Licensed Recreational Therapist		hrs															3
4	Licensed Physical Therapist	39-3	hrs						642,365								642,365	4
5	Physician Care		visits						281								281	5
6	Dental Care		visits															6
7	Work Related Program		hrs															7
8	Habilitation		hrs															8
9	Pharmacy	39-2	# of prescripts							175,084							175,084	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs															10
11	Academic Education		hrs															11
12	Other (specify): <u>i.v. therapy, radiology</u>	39-2							18,476								18,476	12
13	Other (specify): <u>supplies,lab</u>	39-2								13,144							13,144	13
14	TOTAL			\$				\$	838,241	\$	188,228					\$	1,026,469	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: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 43,436	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	726,699		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	39,338		7
8	Accounts Receivable (owners or related parties)	1,996,257		8
9	Other(specify): <u>REAL ESTATE ESCROW</u>	13,292		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,819,022	\$	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	157,183		16
17	Accumulated Depreciation (book methods)	(146,030)		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>UTILITY SECURITY DEP</u>	542		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,695	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,830,717	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,029,722	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	812,107		29
30	Accrued Salaries Payable	130,372		30
31	Accrued Taxes Payable (excluding real estate taxes)	113,899		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,044		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,133,144	\$	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)	\$ 2,133,144	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 697,573	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,830,717	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 324,253	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 324,252	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	467,310	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	(93,989)	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)	\$ 373,321	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)	\$ 697,573	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	\$ 5,506,259	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,506,259	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	325,522	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 325,522	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***	7,096	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,096	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	OTHER EXPENSE ADJ PRIOR PERIOD	38,391	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38,391	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,877,268	30	

		2		
Expenses		Amount		
A. Operating Expenses				
31	General Services	859,301	31	
32	Health Care	1,850,124	32	
33	General Administration	1,230,044	33	
B. Capital Expense				
34	Ownership	386,779	34	
C. Ancillary Expense				
35	Special Cost Centers	1,026,469	35	
36	Provider Participation Fee	48,180	36	
D. Other Expenses (specify):				
37	OUT-OF-PERIOD EXPENSES		37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,400,897	40	
41	Income before Income Taxes (line 30 minus line 40)**	476,371	41	
42	Income Taxes	(9,061)	42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 467,310	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: 01/01/2009

Ending: 12/31/2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,329	2,513	\$ 94,333	\$ 37.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,785	8,293	229,630	27.69	3
4	Licensed Practical Nurses	18,239	19,620	431,550	22.00	4
5	CNAs & Orderlies	52,089	55,393	608,071	10.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,434	2,554	53,185	20.82	9
10	Activity Assistants	20,872	22,378	198,258	8.86	10
11	Social Service Workers	5,702	6,302	100,631	15.97	11
12	Dietician					12
13	Food Service Supervisor	2,029	2,150	36,115	16.80	13
14	Head Cook	8,983	10,002	95,209	9.52	14
15	Cook Helpers/Assistants	8,705	9,200	73,460	7.98	15
16	Dishwashers					16
17	Maintenance Workers	1,932	2,208	44,265	20.05	17
18	Housekeepers	15,976	17,245	151,271	8.77	18
19	Laundry	6,388	7,521	75,924	10.09	19
20	Administrator	2,606	2,798	118,354	42.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,913	5,377	68,977	12.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,950	2,183	32,835	15.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,932	175,737	\$ 2,412,068 *	\$ 13.73	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	\$ 6,322	1-3	35
36	Medical Director	O	6,500	9-3	36
37	Medical Records Consultant	N	270	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	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,892		49

C. CONTRACT NURSES

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

XIX. 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	
LORRIE STOGSDILL	ADMINISTRATOR	0	\$ 118,354	Workers' Compensation Insurance	\$ 47,995	IDPH License Fee	\$ 1,990	
			0	Unemployment Compensation Insurance	24,354	Advertising: Employee Recruitment	1,900	
			0	FICA Taxes	182,894	Health Care Worker Background Check	972	
				Employee Health Insurance	44,503	(Indicate # of checks performed <u>49</u>)		
				Employee Meals	0	Patient Background Checks	109	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,571	
				EMPLOYEE BENEFITS - OTHER	893	MARKETING/ADV/PROMO	10,448	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	5,249	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,140	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,579)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(10,448)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 118,354	TOTAL (agree to Schedule V, line 22, col.8)	\$ 300,639	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,822	
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			\$ 364,208				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)			\$ 364,208				Seminar Expense	1,356
							MGMT CO ALLOC	48
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,404
SEE SCHEDULE ATTACHED			51,464					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 51,464	TOTAL		\$		

* 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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	6/06	\$ 2,275	3 YRS	\$ 379	\$ 759	\$ 759	\$ 378	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
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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

0043968

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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 HEALTHCARE ASSOC \$3746
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,348 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,180
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.