		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

I. IDPH License ID Number: 0043968

Facility Name: ASTA CARE CENTER OF PONTIAC

Address: 300 WEST LOWELL (Number) PONTIAC (City) 61764 (Zip Code)

County: LIVINGSTON

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

HFS ID Number:

Date of Initial License for Current Owners: 08/17/98

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) ____ (Date)
	(Type or Print Name) MICHAEL GILLMAN
	(Title) MEMBER
Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
	(Print Name and Title) BOB KAGDA / VICE PRESIDENT
	(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD / 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
	(Telephone) (847) 675-3585 Fax # (847) 675-5777

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2	466	6,141	6,609	8
9	SNF/PED					9
10	ICF	17,525	5,850	602	23,977	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,527	6,316	6,743	30,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.22%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/17/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 5,698

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	212,740	14,360	10,897	237,997		237,997		237,997			1
2	Food Purchase		146,451		146,451		146,451	(2,553)	143,898			2
3	Housekeeping	151,595	23,503		175,098		175,098		175,098			3
4	Laundry	87,469	22,360	247	110,076		110,076		110,076			4
5	Heat and Other Utilities			102,163	102,163		102,163		102,163			5
6	Maintenance	43,656	27,659	36,413	107,728		107,728		107,728			6
7	Other (specify):*			15,988	15,988		15,988		15,988			7
8	**TOTAL General Services**	495,460	234,333	165,708	895,501		895,501	(2,553)	892,948			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,455,216	72,597	4,904	1,532,717	3,825	1,536,542	8,418	1,544,960			10
10a	Therapy		332		332		332		332			10a
11	Activities	271,712	12,584	923	285,219		285,219		285,219			11
12	Social Services	105,851			105,851		105,851		105,851			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,832,779	85,513	11,327	1,929,619	3,825	1,933,444	8,418	1,941,862			16
	C. General Administration											
17	Administrative	125,195		395,963	521,158		521,158	(309,068)	212,090			17
18	Directors Fees											18
19	Professional Services			40,424	40,424	(3,825)	36,599	712	37,311			19
20	Dues, Fees, Subscriptions & Promotions			25,762	25,762		25,762	(17,880)	7,882			20
21	Clerical & General Office Expenses	79,118	24,170	69,328	172,616		172,616	(7,512)	165,104			21
22	Employee Benefits & Payroll Taxes			316,510	316,510		316,510		316,510			22
23	Inservice Training & Education			4,323	4,323		4,323		4,323			23
24	Travel and Seminar							416	416			24
25	Other Admin. Staff Transportation			10,751	10,751		10,751	895	11,646			25
26	Insurance-Prop.Liab.Malpractice			45,369	45,369		45,369	1,268	46,637			26
27	Other (specify):*			80,714	80,714		80,714	(72,377)	8,337			27
28	**TOTAL General Administration**	204,313	24,170	989,144	1,217,627	(3,825)	1,213,802	(403,546)	810,256			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,532,552	344,016	1,166,179	4,042,747		4,042,747	(397,681)	3,645,066			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: **ASTA CARE CENTER OF PONTIAC** #0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,240	
	REPAIRS & MAINTENANCE		1,657	
			0	10,897
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		247	
			0	247
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		24,820	
	ELECTRICITY		44,024	
	WATER		31,707	
	CABLE TV - LOBBY		1,612	
			0	102,163
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		619	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		8,999	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		19,271	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,050	
	FIRE SERVICE		6,474	
			0	
			0	
			0	
			0	36,413
7	**OTHER**			
	SCAVENGER		15,988	
	SECURITY SERVICE		0	
			0	
			0	15,988
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 CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,904	
	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	4,904
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	923	
			0	923
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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC #0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	395,963	395,963
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,618	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	25,806	
			0	40,424
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	13,911	
	EMPLOYEE WANT ADS	XIX F	602	
	CONTRIBUTIONS	VI 20 XIX F	3,300	
	DUES & SUBSCRIPTIONS	XIX F	3,759	
	LICENSES & PERMITS	XIX F	750	
	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	1,500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	720	
	PATIENT BACKGROUND CHECKS	XIX F	1,220	
				25,762
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,310	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	42,661	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,357	
	MESSENGER SERVICE		0	
			0	69,328

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	188,289	
	UNEMPLOYMENT COMPENSATION	XIX D	18,444	
	WORKERS COMPENSATION INSURANC	XIX D	68,259	
	HOSPITALIZATION INSURANCE	XIX D	39,436	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,350	
	EMPLOYEE PHYSICAL EXAMS	XIX D	732	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	316,510
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,323	
				4,323
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,751	
				10,751
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		45,369	
				45,369
27	**OTHER**			
	BAD DEBTS	VI 24	80,714	
				80,714

GRAND TOTAL COLUMN 3 OTHER **1,166,179**

ASTA CARE CENTER OF PONTIAC
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	146,451
LESS SALES TAX	(2,553)
NET FOOD	143,898
TOTAL PATIENT CENSUS	30,586
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	91,758
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	91,758
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	91,758
NET FOOD	143,898
DIVIDE TOTAL MEALS/YEAR	91,758
COST PER MEAL	1.57
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,258	18,258		18,258	67,370	85,628			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,451	56,451		56,451	63,491	119,942			32
33	Real Estate Taxes			48,580	48,580		48,580		48,580			33
34	Rent-Facility & Grounds			359,000	359,000		359,000	(359,000)				34
35	Rent-Equipment & Vehicles			12,082	12,082		12,082		12,082			35
36	Other (specify):*											36
37	**TOTAL Ownership**			494,371	494,371		494,371	(228,139)	266,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		227,784	853,031	1,080,815		1,080,815		1,080,815			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**		227,784	901,211	1,128,995		1,128,995		1,128,995			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,532,552	571,800	2,561,761	5,666,113		5,666,113	(625,820)	5,040,293			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: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,355)	30		9
10	Interest and Other Investment Income	(974)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,553)	2		13
14	Non-Care Related Interest	(5,184)	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	(42,661)	21		18
19	Entertainment		20		19
20	Contributions	(4,800)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(275)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,714)	27		24
25	Fund Raising, Advertising and Promotional	(13,911)	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	(5,783)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (163,210)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(462,610)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (462,610)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (625,820)		37

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

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

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

STATE OF ILLINOIS

ASTA CARE CENTER OF PONTIAC

ID# 0043968

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3	NON- ALLOWABLE TRAVEL	(5,783)	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**	(5,783)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,553)	0	0	0	0	0	0	0	0	0	0	(2,553)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,553)	0	0	0	0	0	0	0	0	0	0	(2,553)	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	8,418	0	0	0	0	0	0	0	0	0	8,418	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	8,418	0	0	0	0	0	0	0	0	0	8,418	16
	C. General Administration													
17	Administrative	0	(309,068)	0	0	0	0	0	0	0	0	0	(309,068)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(275)	987	0	0	0	0	0	0	0	0	0	712	19
20	Fees, Subscriptions & Promotions	(18,711)	831	0	0	0	0	0	0	0	0	0	(17,880)	20
21	Clerical & General Office Expenses	(42,661)	35,149	0	0	0	0	0	0	0	0	0	(7,512)	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	416	0	0	0	0	0	0	0	0	0	416	24
25	Other Admin. Staff Transportation	(5,783)	6,678	0	0	0	0	0	0	0	0	0	895	25
26	Insurance-Prop.Liab.Malpractice	0	1,268	0	0	0	0	0	0	0	0	0	1,268	26
27	Other (specify):*	(80,714)	8,337	0	0	0	0	0	0	0	0	0	(72,377)	27
28	**TOTAL General Administration**	(148,144)	(255,402)	0	0	0	0	0	0	0	0	0	(403,546)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(150,697)	(246,984)	0	0	0	0	0	0	0	0	0	(397,681)	29

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	(6,355)	0	73,725	0	0	0	0	0	0	0	0	67,370	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,158)	0	69,649	0	0	0	0	0	0	0	0	63,491	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(359,000)	0	0	0	0	0	0	0	0	(359,000)	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**	(12,513)	0	(215,626)	0	0	0	0	0	0	0	0	(228,139)	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)**	(163,210)	(246,984)	(215,626)	0	0	0	0	0	0	0	0	(625,820)	45

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 LLC	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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 395,963	ASTA HEALTHCARE COMPANY		$	$ (395,963)	1
2	V	10	NURSING				8,418	8,418	2
3	V	17	ADMINISTRATIVE				86,895	86,895	3
4	V	19	PROFESSIONAL FEES				987	987	4
5	V	20	LICENSES & PERMITS				831	831	5
6	V	21	OFFICE EXPENSE				35,149	35,149	6
7	V	24	SEMINARS				416	416	7
8	V	25	STAFF TRANS/ TRAVEL				6,678	6,678	8
9	V	26	INSURANCE GEN / WC				1,268	1,268	9
10	V	27	PAYR. TAXES & GRP INS				8,337	8,337	10
11	V								11
12	V								12
13	V								13
14	Total			$ 395,963			$ 148,979	$ * (246,984)	14

* 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: 01/01/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 359,000	ASTA PONTIAC PROPERTIES, LLC		$	$ (359,000)	15
16	V	30	DEPRECIATION				73,725	73,725	16
17	V	32	INTEREST				69,649	69,649	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 359,000			$ 143,374	$ * (215,626)	39

* 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: 01/01/2010 Ending: 12/31/2010

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 Hours	 Percent	7 Compensation Included in Costs for this Reporting Period** Description	 Amount	8 Schedule V. Line & Column Reference	
1	MICHAEL GILLMAN							SALARY	$ 33,082	17*7	1
2											2
3											3
4					SEE	SEE					4
5	CRAIG FRANK				ATTACHED	ATTACHED		SALARY	33,824	17-7	5
6	SALARY FROM ASTA CARE OF FORD COUNTY $43,541				SCHEDULE	SCHEDULE					6
7	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $25,000										7
8											8
9	ALIZA FRANK		PAYROLL					SALARY	6,008	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 72,914		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: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	180,290	7	$ 49,619	$ 49,619	30,586	$ 8,418	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	180,290	7	195,000	195,000	30,586	33,082	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	180,290	7	199,375	199,375	30,586	33,824	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	180,290	7	35,417	35,417	30,586	6,008	4
5	17	ADMIN. SALARY- JS	PATIENT DAYS	180,290	7	82,414	82,414	30,586	13,981	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	180,290	7	5,819		30,586	987	6
7	20	LICENSES & PERMITS	PATIENT DAYS	180,290	7	4,897		30,586	831	7
8	21	OFFICE EXPENSE	PATIENT DAYS	180,290	7	207,187	169,766	30,586	35,149	8
9	24	SEMINARS	PATIENT DAYS	180,290	7	2,453		30,586	416	9
10	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	180,290	7	39,363		30,586	6,678	10
11	26	INSURANCE GEN / WC	PATIENT DAYS	180,290	7	7,472		30,586	1,268	11
12	27	PAYR. TAXES & GRP INS	PATIENT DAYS	180,290	7	49,140		30,586	8,337	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					$ 878,156	$ 731,591		$ 148,979	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	ASTA PONTIAC PROPERTIES, LLC						$	$			$	1
2	ALBANK		X	MORTGAGE	$14,494.84	2/14/03	1,880,000	1,414,949	3/1/23	0.0675	69,649	2
3	TCF		X	AUTO LOAN	$476.89	2009	24,275	18,771	10/18/2014	0.0716	1,510	3
4												4
5	KIRSCHENBAUM	X		WORKING CAPITAL							20,000	5
	Working Capital											
6	ALBANY BANK		X	WORKING CAPITAL	INTEREST	REVOLV		583,306	REVOLV	PRIME+	22,085	6
7			X	INSURANCE FEES							5,185	7
8	GILMAN										2,487	8
9	TOTAL Facility Related				$14,971.73		$ 1,904,275	$ 2,017,026			$ 120,916	9
	B. Non-Facility Related*											
10	IRS		X	LATE FEES							366	10
11				BED TAX							4,818	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 5,184	14
15	TOTALS (line 9+line14)						$ 1,904,275	$ 2,017,026			$ 126,100	15

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

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

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 2009 report.	$	47,044	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.)	$	47,812	2
3. Under or (over) accrual (line 2 minus line 1).	$	768	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	47,812	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.	$	48,580	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	43,218	8
2006	45,234	9
2007	45,342	10
2008	47,044	11
2009	47,812	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED
ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF PONTIAC COUNTY LIVINGSTON

FACILITY IDPH LICENSE NUMBER 0043968

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-27-255-014	NURSING HOME	$ 47,812.24	$ 47,812.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,812.24	$ 47,812.24

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	NURSING HOME		1998	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	85		1998	1961	$ 1,438,473	$ 52,308	27.5	$ 52,308	$	$ 647,311	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		80,078	9
10	WATER HEATERS & PLUMBING (PROP)			1999	14,502	527	27.5	527		6,082	10
11	BOILER & A/C (PROP)			1999	14,240	518	27.5	518		5,978	11
12	ELECTRONIC DOOR LOCKS (PROP)			1999	3,974	145	27.5	145		1,673	12
13	FENCE (PROP)			1999	1,155	77	15	77		889	13
14	REMODELING ROOMS & BATHROOMS (PROP)			2000	47,944	1,743	27.5	1,743		18,374	14
15	AIR CONDITIONER (PROP)			2000	5,569	203	27.5	203		2,140	15
16	FIRE PANEL (PROP)			2000	2,730	99	27.5	99		1,530	16
17	FURNISHING			2000	2,839		7			2,839	17
18	WATER SOFTENER (PROP)			2001	4,013	146	27.5	146		1,393	18
19	CONDENSER (PROP)			2001	3,100	113	27.5	113		1,078	19
20	HEATER AND A/C UNITS (PROP)			2001	5,100	186	27.5	186		1,774	20
21	GREASE TRAP (PROP)			2001	1,300	47	27.5	47		449	21
22	3 DOORS (PROP)			2001	4,000	145	27.5	145		1,384	22
23	FENCE (PROP)			2001	2,564	171	15	171		1,631	23
24	SIDEWALK (PROP)			2001	1,850	123	15	123		1,174	24
25	CONCRETE WORK(PROP)			2002	3,938	263	15	263		2,236	25
26	FIRE ALARM SYSTEM(PROP)			2002	40,476	1,472	27.5	1,472		12,573	26
27	RESIDENT SECURITY SYSTEM(PROP)			2002	11,930	434	27.5	434		3,707	27
28	FIRE DOORS(PROP)			2002	6,016	219	27.5	219		1,871	28
29	REMODELING 8 ROOMS(PROP)			2002	46,151	1,678	27.5	1,678		14,333	29
30	SPRINKLER HEADS(PROP)			2002	3,635	132	27.5	132		1,128	30
31	WATER LINE(PROP)			2002	3,002	109	27.5	109		931	31
32	BACK FLOW PREVENTER(PROP)			2002	3,300	120	27.5	120		1,025	32
33	NEW FLOOR DRAIN(PROP)			2003	1,726	63	27.5	63		475	33
34	LIGHTING(PROP)			2003	1,350	49	27.5	49		370	34
35	ELECTRICAL WORK(PROP)			2003	1,371	49	27.5	49		370	35
36	TELEPHONE WIRING(PROP)			2003	5,242	191	27.5	191		1,440	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	P-TAC UNITS(PROP)	2004	$ 3,750	$ 136	27.5	$ 136	$	$ 890	37
38	ELECTRICAL WORK (PROP)	2005	5,435	198	27.5	198		1,097	38
39	AIR COMPRESSOR (PROP)	2005	5,791	211	27.5	211		1,169	39
40	FIRE SYSTEM (PROP)	2005	26,366	959	27.5	959		5,315	40
41	SPRINKLER HEADS (PROP)	2005	3,308	120	27.5	120		665	41
42	CIRCULATING (PROP)]	2005	2,077	75	27.5	75		416	42
43	DOOR ALARM (PROP)	2006	3,639	132	27.5	132		600	43
44	EXHAUST FAN (PROP)	2006	1,700	62	27.5	62		282	44
45	PTAC UNITS (PROP)	2006	2,717	99	27.5	99		449	45
46	OUTPATIENT THERAPY REMODELING (PROP)	2006	8,682	316	27.5	316		1,435	46
47	WATER HEATER (PROP)	2008	6,179	225	27.5	225		647	47
48	10 FOOT ADDITION FOR DIALYSIS TRTMNT ROOM(PROP)	2008	55,988	2,036	27.5	2,036		5,005	48
49	WATER SOFTENER (PROP)	2008	7,022	255	27.5	255		563	49
50	4 TON A/C AND FILTER DRYER (PROP)	2008	2,979	108	27.5	108		239	50
51	3 TON A/C AND DRYER (PROP)	2008	2,550	93	27.5	93		205	51
52	WATER HEATER (PROP)	2008	3,897	142	27.5	142		314	52
53	SPRINKLER HEADS (PROP)	2009	20,820	757	27.5	757		1,356	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	$ 73,725		$ 73,725	$	$ 836,883	70

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 106,061	$ 3,597	$ 10,606	$ 7,009	10 YRS	$ 71,093	71
72	Current Year Purchases	13,477	13,477	674	(12,803)	10 YRS	1,348	72
73	Fully Depreciated Assets	45,166					45,166	73
74								74
75	TOTALS	$ 164,704	$ 17,074	$ 11,280	$ (5,794)		$ 117,607	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	$ 24,275	$ 1,184	$ 623	$ (561)	5 YRS	$ 1,246	76
77										77
78										78
79										79
80	TOTALS			$ 24,275	$ 1,184	$ 623	$ (561)		$ 1,246	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)	$ 2,230,427	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 91,983	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 85,628	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,355)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 955,736	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
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:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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: *

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.		$
13.		$
14.		$

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: $ 12,082 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: 01/01/2010 Ending: 12/31/2010

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

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

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

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 114,320	$		$ 114,320	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			67,637			67,637	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			656,404			656,404	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				216,253		216,253	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					14,670	11,531		14,670 11,531	13
14	TOTAL			$		$ 853,031	$ 227,784		$ 1,080,815	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.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,537	$	1
2	Cash-Patient Deposits	1,466		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,000))	570,104		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,723		6
7	Other Prepaid Expenses	4,939		7
8	Accounts Receivable (owners or related parties)	2,049,096		8
9	Other(specify): REAL ESTATE ESCROW	47,812		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,721,677	$	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	164,704		15
16	Equipment, at Historical Cost	5,956		16
17	Accumulated Depreciation (book methods)	(164,288)		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): SECURITY DEPOSIT	23,235		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 29,607	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,751,284	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 992,638	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	787,831		29
30	Accrued Salaries Payable	44,702		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,589		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,812		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)**	$ 1,882,572	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,246		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)**	$ 14,246	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,896,818	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 854,466	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,751,284	$	48

*(See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 697,573	1
2	Restatements (describe):		2
3	ROUNDING	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 697,569	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	601,265	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	(444,368)	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)**	$ 156,897	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)**	$ 854,466	24 *

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,936,831	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,936,831	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	334,821	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 334,821	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***	974	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 974	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)**	$ 6,272,626	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	895,501	31
32	Health Care	1,929,619	32
33	General Administration	1,217,627	33
	B. Capital Expense		
34	Ownership	494,371	34
	C. Ancillary Expense		
35	Special Cost Centers	1,080,815	35
36	Provider Participation Fee	48,180	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(6,371)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,659,742	40
41	**Income before Income Taxes (line 30 minus line 40)****	612,884	41
42	**Income Taxes**	(11,619)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 601,265	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: 01/01/2010 Ending: 12/31/2010

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	2,424	2,698	$ 103,443	$ 38.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,600	8,132	228,952	28.15	3
4	Licensed Practical Nurses	19,107	21,061	466,126	22.13	4
5	CNAs & Orderlies	52,603	56,844	623,535	10.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,443	2,915	60,137	20.63	9
10	Activity Assistants	21,253	23,219	211,575	9.11	10
11	Social Service Workers	5,552	6,249	105,851	16.94	11
12	Dietician					12
13	Food Service Supervisor	2,029	2,215	37,248	16.82	13
14	Head Cook	10,400	11,757	111,299	9.47	14
15	Cook Helpers/Assistants	7,524	7,901	64,193	8.12	15
16	Dishwashers					16
17	Maintenance Workers	1,971	2,166	43,656	20.16	17
18	Housekeepers	14,643	16,316	151,595	9.29	18
19	Laundry	8,184	9,329	87,469	9.38	19
20	Administrator	2,585	2,960	125,195	42.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,269	5,778	79,118	13.69	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	1,951	2,199	33,160	15.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,538	181,739	$ 2,532,552 *	$ 13.94	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	$ 9,240	1-3	35
36	Medical Director	O	5,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,904	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	923	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)		$ 20,567		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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LORRIE STOGSDILL	ADMINISTRATOR	0	$ 125,195
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 125,195

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE COMPANY	$ 395,963
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 395,963

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		40,424
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 40,424

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 68,259
Unemployment Compensation Insurance		18,444
FICA Taxes		188,289
Employee Health Insurance		39,436
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,350
EMPLOYEE PHYSICAL EXAMS		732
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 316,510

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		602
Health Care Worker Background Check		720
(Indicate # of checks performed 60)		
Patient Background Checks	1220	1,220
TRUST/FRANCHISE/CONTRIB/ETC		4,800
MARKETING/ADV/PROMO		13,911
LICENSES/DUES/SUBSCRIPTIONS		4,509
MGMT CO ALLOC		831
TRUST/FRANCHISE/CONTRIB/ETC		(4,800)
Less: Public Relations Expense		(0)
Non-allowable advertising		(13,911)
Yellow page advertising		(0)
TOTAL (agree to Sch. V, line 20, col. 8)		$ 7,882

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
MGMT CO ALLOC	416
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 416

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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. $4,858**

(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. $ **1,408** 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 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.