FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0043968

Facility Name: ASTA CARE CENTER OF PONTIAC, LLC

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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 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

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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	28	Skilled (SNF)	37	11,975	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	97	33,875	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1	349	5,821	6,171	8
9	SNF/PED					9
10	ICF	16,847	7,336	307	24,490	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,848	7,685	6,128	30,661	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.51%

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 37 and days of care provided 5,821

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	217,016	18,759	8,757	244,532		244,532		244,532			1
2	Food Purchase		169,197		169,197		169,197	(2,983)	166,214			2
3	Housekeeping	144,540	30,767		175,307		175,307		175,307			3
4	Laundry	69,912	27,219	2,963	100,094		100,094		100,094			4
5	Heat and Other Utilities			103,782	103,782		103,782		103,782			5
6	Maintenance	46,886	18,576	29,032	94,494		94,494		94,494			6
7	Other (specify):*			19,884	19,884		19,884		19,884			7
8	TOTAL General Services	478,354	264,518	164,418	907,290		907,290	(2,983)	904,307			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,549,654	69,244	5,238	1,624,136		1,624,136	9,736	1,633,872			10
10a	Therapy											10a
11	Activities	283,099	5,999	800	289,898		289,898		289,898			11
12	Social Services	31,140			31,140		31,140		31,140			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,863,893	75,243	12,038	1,951,174		1,951,174	9,736	1,960,910			16
	C. General Administration											
17	Administrative	139,548		421,279	560,827		560,827	(356,406)	204,421			17
18	Directors Fees											18
19	Professional Services			61,400	61,400		61,400	5,383	66,783			19
20	Dues, Fees, Subscriptions & Promotions			18,607	18,607		18,607	(6,979)	11,628			20
21	Clerical & General Office Expenses	171,747	28,045	70,508	270,300		270,300	(23,924)	246,376			21
22	Employee Benefits & Payroll Taxes			333,226	333,226		333,226		333,226			22
23	Inservice Training & Education			2,387	2,387		2,387		2,387			23
24	Travel and Seminar			425	425		425		425			24
25	Other Admin. Staff Transportation			8,779	8,779		8,779	(11)	8,768			25
26	Insurance-Prop.Liab.Malpractice			36,308	36,308		36,308		36,308			26
27	Other (specify):*			84,699	84,699		84,699	(77,350)	7,349			27
28	TOTAL General Administration	311,295	28,045	1,037,618	1,376,958		1,376,958	(459,287)	917,671			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,653,542	367,806	1,214,074	4,235,422		4,235,422	(452,534)	3,782,888			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, LLC #0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,368	
	REPAIRS & MAINTENANCE		1,389	
			0	8,757
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,963	
			0	2,963
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,562	
	ELECTRICITY		42,390	
	WATER		32,559	
	CABLE TV - LOBBY		3,271	
			0	103,782
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,645	
	PAINTING & DECORATING		560	
	BUILDING REPAIRS		1,642	
	MAINTENANCE TRAVEL		437	
	EQUIPMENT MAINTENANCE & REPAIR		16,428	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		985	
	FIRE SERVICE		6,335	
			0	
			0	
			0	
			0	29,032
7	**OTHER**			
	SCAVENGER		18,619	
	SECURITY SERVICE		1,265	
			0	
			0	19,884
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	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	5,238	
	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	5,238
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	800	
			0	800
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC **#0043968** **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	421,279	421,279
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,431	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	39,969	
			0	61,400
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,916	
	EMPLOYEE WANT ADS	XIX F	950	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,357	
	LICENSES & PERMITS	XIX F	2,717	
	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	1,457	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	550	
	PATIENT BACKGROUND CHECKS	XIX F	1,660	
				18,607
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		8,103	
	EQUIPMENT REPAIR & MAINTENANCE		158	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	38,336	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		23,911	
	MESSENGER SERVICE		0	
			0	70,508

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	199,618	
	UNEMPLOYMENT COMPENSATION	XIX D	25,404	
	WORKERS COMPENSATION INSURANC	XIX D	88,800	
	HOSPITALIZATION INSURANCE	XIX D	18,717	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	687	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	333,226
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,387	
				2,387
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	425	
				425
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,779	
				8,779
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		36,308	
				36,308
27	**OTHER**			
	BAD DEBTS	VI 24	84,699	
				84,699

GRAND TOTAL COLUMN 3 OTHER **1,214,074**

ASTA CARE CENTER OF PONTIAC, LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	169,197
LESS SALES TAX	(2,983)
NET FOOD	166,214
TOTAL PATIENT CENSUS	30,661
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	91,983
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	91,983
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	91,983
NET FOOD	166,214
DIVIDE TOTAL MEALS/YEAR	91,983
COST PER MEAL	1.81
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC #0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			128,560	128,560		128,560	(12,087)	116,473			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,669	53,669		53,669	88,788	142,457			32
33	Real Estate Taxes			43,841	43,841		43,841		43,841			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			15,908	15,908		15,908		15,908			35
36	Other (specify):*											36
37	**TOTAL Ownership**			721,978	721,978		721,978	(403,299)	318,679			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		237,975	931,505	1,169,480		1,169,480	(301,051)	868,429			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,902	128,902		128,902		128,902			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		237,975	1,060,407	1,298,382		1,298,382	(301,051)	997,331			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,653,542	605,781	2,996,459	6,255,782		6,255,782	(1,156,884)	5,098,898			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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Reference	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	(110,526)	30		9
10	Interest and Other Investment Income	(1,344)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,983)	2		13
14	Non-Care Related Interest	(4,942)	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	(38,336)	21		18
19	Entertainment		20		19
20	Contributions	(1,457)	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	(84,699)	27		24
25	Fund Raising, Advertising and Promotional	(5,916)	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	(327,527)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (577,730)		$	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)	(579,154)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (579,154)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,156,884)		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.		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

STATE OF ILLINOIS

ASTA CARE CENTER OF PONTIAC, LLC

ID# 0043968

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	NON-ALLOWABLE TRAVEL	(4,920)	25	2
3	RELATED PARTY THERAPY ADJUSTMENT	(301,051)	39	3
4	MARKETING SALARY	(21,556)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(327,527)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,983)	0	0	0	0	0	0	0	0	0	0	(2,983)	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**	(2,983)	0	0	0	0	0	0	0	0	0	0	(2,983)	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	9,736	0	0	0	0	0	0	0	0	0	9,736	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	9,736	0	0	0	0	0	0	0	0	0	9,736	16
	C. General Administration													
17	Administrative	0	(356,406)	0	0	0	0	0	0	0	0	0	(356,406)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,383	0	0	0	0	0	0	0	0	0	5,383	19
20	Fees, Subscriptions & Promotions	(7,373)	394	0	0	0	0	0	0	0	0	0	(6,979)	20
21	Clerical & General Office Expenses	(59,892)	35,968	0	0	0	0	0	0	0	0	0	(23,924)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,920)	4,909	0	0	0	0	0	0	0	0	0	(11)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(84,699)	7,349	0	0	0	0	0	0	0	0	0	(77,350)	27
28	**TOTAL General Administration**	(156,884)	(302,403)	0	0	0	0	0	0	0	0	0	(459,287)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(159,867)	(292,667)	0	0	0	0	0	0	0	0	0	(452,534)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(110,526)	0	98,439	0	0	0	0	0	0	0	0	(12,087)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,286)	0	95,074	0	0	0	0	0	0	0	0	88,788	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(480,000)	0	0	0	0	0	0	0	0	(480,000)	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	(116,812)	0	(286,487)	0	0	0	0	0	0	0	0	(403,299)	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	(301,051)	0	0	0	0	0	0	0	0	0	0	(301,051)	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	(301,051)	0	0	0	0	0	0	0	0	0	0	(301,051)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(577,730)	(292,667)	(286,487)	0	0	0	0	0	0	0	0	(1,156,884)	45

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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	$ 421,279	ASTA HEALTHCARE COMPANY		$	$ (421,279)	1
2	V	10	NURSING				9,736	9,736	2
3	V	17	ADMINISTRATIVE				64,873	64,873	3
4	V	19	PROFESSIONAL FEES				5,383	5,383	4
5	V	20	LICENSES & PERMITS				394	394	5
6	V	21	OFFICE EXPENSE				35,968	35,968	6
7	V	25	STAFF TRANS/ TRAVEL				4,909	4,909	7
8	V	27	PAYR TAXES & W/C INS				7,349	7,349	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 421,279			$ 128,612	$ * (292,667)	14

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 480,000	ASTA PONTIAC PROPERTIES, LLC		$	$ (480,000)	15
16	V	30	DEPRECIATION				98,439	98,439	16
17	V	32	INTEREST				95,074	95,074	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			$ 480,000			$ 193,513	$ * (286,487)	39

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MICHAEL GILLMAN	PRESIDENT	administrative/	25.00				SALARY	$ 32,315	17-7	1
2			management								2
3					SEE	SEE					3
4	CRAIG FRANK	CFO	finance manage.		ATTACHED	ATTACHED		SALARY	27,064	17-7	4
5	SALARY FROM ASTA CARE OF FORD COUNTY $				SCHEDULE	SCHEDULE					5
6	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $										6
7											7
8											8
9	DAVID MEISELMAN	THERAPY MGMNT	management					SALARY	39,286	39	9
10											10
11	ALIZA FRANK	PAYROLL CLERK	PAYROLL					SALARY			11
12									5,494	17-7	12
13								TOTAL	$ 104,159		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	189,761	7	$ 60,259	$ 57,558	30,661	$ 9,736	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	189,761	7	200,000	200,000	30,661	32,315	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	189,761	7	167,500	167,500	30,661	27,064	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	189,761	7	34,000	34,000	30,661	5,494	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	189,761	7	33,313		30,661	5,383	5
6	20	LICENSES & PERMITS	PATIENT DAYS	189,761	7	2,436		30,661	394	6
7	21	OFFICE EXPENSE	PATIENT DAYS	189,761	7	222,607	160,308	30,661	35,968	7
8	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	189,761	7	30,383		30,661	4,909	8
9	27	PAYR. TAXES & W/C	PATIENT DAYS	189,761	7	45,486		30,661	7,349	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					$ 795,984	$ 619,366		$ 128,612	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 PONTIAC PROPERTIES
Street Address: 300 WEST LOWELL
City / State / Zip Code: PONTIAC, ILL 61764
Phone Number: (847) 742 - 8822
Fax Number: (847) 742 - 9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 98,439	$	1	$ 98,439	1
2	32	INTEREST	DIRECT	1	1	95,074		1	95,074	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					$ 193,513	$		$ 193,513	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	REL PARTY:						$	$			$	1
2	ALBANY BANK		X	MORTGAGE	$14,495.00	2/14/03	1,880,000	1,325,880	3/1/23	0.0675	66,750	2
3	ALBANY BANK		X	BUILDING ADDITION	$5,937.02	6/15/11	900,000	892,405		0.0625	28,324	3
4	TCF		X	AUTO LOAN	$476.89	2009	24,275	14,246	10/14/2014	0.0716	1,198	4
5	KIRSCHENBAUM	X		WORKING CAPITAL							15,000	5
	Working Capital											
6	ALBANY BANK		X	WORKING CAPITAL	INTEREST	REVOLV		581,003	REVOLV	PRIME+	29,005	6
7	INSURANCE POLICIES		X	INSURANCE POLICIES FIN.							1,202	7
8	GILLMAN	X		WORKING CAPITAL							2,322	8
9	TOTAL Facility Related				$20,908.91		$ 2,804,275	$ 2,813,534			$ 143,801	9
	B. Non-Facility Related*											
10												10
11				BED TAX							4,942	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,942	14
15	TOTALS (line 9+line14)						$ 2,804,275	$ 2,813,534			$ 148,743	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, LLC # 0043968 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 47,812	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 45,827	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,986)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 45,827	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 43,841	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	45,234	8
	2007	45,342	9
	2008	47,044	10
	2009	47,812	11
	2010	45,827	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 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF PONTIAC, LLC COUNTY LIVINGSTON

FACILITY IDPH LICENSE NUMBER 0043968

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-27-255-014	NURSING HOME	$ 45,826.52	$ 45,826.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,826.52	$ 45,826.52

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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? [X] (a) Own the Facility [ ] (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 [ ] (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).

N/A

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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 699,619	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		86,549	9
10	WATER HEATERS & PLUMBING (PROP)			1999	14,502	527	27.5	527		6,609	10
11	BOILER & A/C (PROP)			1999	14,240	518	27.5	518		6,496	11
12	ELECTRONIC DOOR LOCKS (PROP)			1999	3,974	145	27.5	145		1,818	12
13	FENCE (PROP)			1999	1,155	77	15	77		966	13
14	REMODELING ROOMS & BATHROOMS (PROP)			2000	47,944	1,743	27.5	1,743		20,117	14
15	AIR CONDITIONER (PROP)			2000	5,569	203	27.5	203		2,343	15
16	FIRE PANEL (PROP)			2000	2,730	99	27.5	99		1,629	16
17	FURNISHING			2000	2,839		7			2,839	17
18	WATER SOFTENER (PROP)			2001	4,013	146	27.5	146		1,539	18
19	CONDENSER (PROP)			2001	3,100	113	27.5	113		1,191	19
20	HEATER AND A/C UNITS (PROP)			2001	5,100	186	27.5	186		1,960	20
21	GREASE TRAP (PROP)			2001	1,300	47	27.5	47		496	21
22	3 DOORS (PROP)			2001	4,000	145	27.5	145		1,529	22
23	FENCE (PROP)			2001	2,564	171	15	171		1,802	23
24	SIDEWALK (PROP)			2001	1,850	123	15	123		1,297	24
25	CONCRETE WORK(PROP)			2002	3,938	263	15	263		2,499	25
26	FIRE ALARM SYSTEM(PROP)			2002	40,476	1,472	27.5	1,472		14,045	26
27	RESIDENT SECURITY SYSTEM(PROP)			2002	11,930	434	27.5	434		4,141	27
28	FIRE DOORS(PROP)			2002	6,016	219	27.5	219		2,090	28
29	REMODELING 8 ROOMS(PROP)			2002	46,151	1,678	27.5	1,678		16,011	29
30	SPRINKLER HEADS(PROP)			2002	3,635	132	27.5	132		1,260	30
31	WATER LINE(PROP)			2002	3,002	109	27.5	109		1,040	31
32	BACK FLOW PREVENTER(PROP)			2002	3,300	120	27.5	120		1,145	32
33	NEW FLOOR DRAIN(PROP)			2003	1,726	63	27.5	63		538	33
34	LIGHTING(PROP)			2003	1,350	49	27.5	49		419	34
35	ELECTRICAL WORK(PROP)			2003	1,371	49	27.5	49		419	35
36	TELEPHONE WIRING(PROP)			2003	5,242	191	27.5	191		1,631	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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 1,026	37
38	ELECTRICAL WORK (PROP)	2005	5,435	198	27.5	198		1,295	38
39	AIR COMPRESSOR (PROP)	2005	5,791	211	27.5	211		1,380	39
40	FIRE SYSTEM (PROP)	2005	26,366	959	27.5	959		6,274	40
41	SPRINKLER HEADS (PROP)	2005	3,308	120	27.5	120		785	41
42	CIRCULATING (PROP)]	2005	2,077	75	27.5	75		491	42
43	DOOR ALARM (PROP)	2006	3,639	132	27.5	132		732	43
44	EXHAUST FAN (PROP)	2006	1,700	62	27.5	62		344	44
45	PTAC UNITS (PROP)	2006	2,717	99	27.5	99		548	45
46	OUTPATIENT THERAPY REMODELING (PROP)	2006	8,682	316	27.5	316		1,751	46
47	WATER HEATER (PROP)	2008	6,179	225	27.5	225		872	47
48	10 FOOT ADDITION FOR DIALYSIS TRTMNT ROOM(PROP)	2008	55,988	2,036	27.5	2,036		7,041	48
49	WATER SOFTENER (PROP)	2008	7,022	255	27.5	255		818	49
50	4 TON A/C AND FILTER DRYER (PROP)	2008	2,979	108	27.5	108		347	50
51	3 TON A/C AND DRYER (PROP)	2008	2,550	93	27.5	93		298	51
52	WATER HEATER (PROP)	2008	3,897	142	27.5	142		456	52
53	SPRINKLER HEADS (PROP)	2009	20,820	757	27.5	757		2,113	53
54									54
55									55
56									56
57									57
58	NEW 9 BED WING (PROP)	2011	1,101,458	21,695	27.5	21,695		21,695	58
59	ELECTRIC SERVICE FOR 9 BED WING (PROP)	2011	5,300	104	27.5	104		104	59
60	PARKING DRAIN DONE BECAUSE OF 9 BED WING (PROP)	2011	6,500	128	27.5	128		128	60
61	ARCHITECT FEES FOR 9 BED WING (PROP)	2011	73,280	1,444	27.5	1,444		1,444	61
62	PHONE SYSTEM FOR 9 BED WING (PROP)	2011	3,490	69	27.5	69		69	62
63	INTERIOR DESIGN WORK FOR 9 BED WING	2011	18,104	18,104	5	1,810	(16,294)	1,810	63
64	CONSTRUCTION INTEREST PAID FOR 9 BED WING PROP)	2011	23,661	466	27.5	466		466	64
65	BANK SERVICE FEE PAID FOR 9 BED WING (PROP)	2011	9,000	177	27.5	177		177	65
66	APPRAISAL REPORTS DONE FOR 9 BED WING (PROP)	2011	4,500	89	27.5	89		89	66
67	escrow fee and title charges paid for 9 bed wing (prop)	2011	3,003	59	27.5	59		59	67
68	bank charged architect fees for 9 bed wing (prop)	2011	3,600	71	27.5	71		71	68
69	ENGINEERING FEES FOR 9 BED WING (PROP)	2011	9,568	189	27.5	189		189	69
70	TOTAL (lines 4 thru 69)		$ 3,202,912	$ 116,320		$ 100,026	$ (16,294)	$ 936,909	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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12A, Carried Forward		$ 3,202,912	$ 116,320		$ 100,026	$ (16,294)	$ 936,909	1
2	FEE PAID TO IDPA FOR 9 BED WING (PROP)	2011	8,140	160	27.5	160		8,140	2
3	CUSTOM HOOD AND FIRD SUPRESIION (PROP)	2011	8,320	63	27.5	63		8,320	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	TOTAL (lines 1 thru 33)		$ 3,219,372	$ 116,543		$ 100,249	$ (16,294)	$ 953,369	34

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 103,204	$ 2,552	$ 10,241	$ 7,689	10 YRS	$ 65,535	71
72	Current Year Purchases	107,193	107,193	5,360	(101,833)	10 YRS	5,360	72
73	Fully Depreciated Assets	61,500					61,500	73
74								74
75	TOTALS	$ 271,897	$ 109,745	$ 15,601	$ (94,144)		$ 132,395	75

D. Vehicle Costs. (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	$ 711	$ 623	$ (88)		$ 1,869	76
77										77
78										78
79										79
80	TOTALS			$ 3,117	$ 711	$ 623	$ (88)		$ 1,869	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)	$ 3,594,386	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 226,999	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 116,473	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (110,526)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,087,633	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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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:				$ 480,000			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 480,000 **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 15,908 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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 143,113	$		$ 143,113	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			82,956			82,956	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			686,380			686,380	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				232,804		232,804	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology,Lab,Physician.I.V. Therapy					19,056			19,056	13
	Other (specify): Med. Supplies, Rentals						5,171		5,171	
14	TOTAL			$		$ 931,505	$ 237,975		$ 1,169,480	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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 47,125	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (35,000))	1,585,610		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,965		6
7	Other Prepaid Expenses	1,990		7
8	Accounts Receivable (owners or related parties)	2,772,299		8
9	Other(specify): Real Estate Escrow Deposit	25,318		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,458,307	$	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	271,897		15
16	Equipment, at Historical Cost	24,060		16
17	Accumulated Depreciation (book methods)	(292,848)		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)**	$ 26,344	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,484,651	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,991,855	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	785,863		29
30	Accrued Salaries Payable	53,660		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,001		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,827		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)**	$ 2,878,206	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,386		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)**	$ 9,386	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,887,592	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,597,059	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,484,651	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 854,466	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 854,469	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	501,241	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	(10,243)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) CAPITAL CONTR. DURING YEAR	251,592	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 742,590	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)**	$ 1,597,059	24 *

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 6,403,315	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,403,315	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,702	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 362,702	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***	1,344	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,344	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)**	$ 6,767,361	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	907,290	31
32	Health Care	1,951,174	32
33	General Administration	1,376,958	33
	B. Capital Expense		
34	Ownership	721,978	34
	C. Ancillary Expense		
35	Special Cost Centers	1,169,480	35
36	Provider Participation Fee	128,902	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,255,782	40
41	**Income before Income Taxes (line 30 minus line 40)****	511,579	41
42	**Income Taxes**	(10,338)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 501,241	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,251	2,504	$ 103,527	$ 41.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,096	9,763	271,366	27.80	3
4	Licensed Practical Nurses	19,320	21,690	474,595	21.88	4
5	CNAs & Orderlies	56,355	61,025	666,445	10.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,448	3,048	62,821	20.61	9
10	Activity Assistants	22,123	24,020	220,278	9.17	10
11	Social Service Workers	2,487	2,755	31,140	11.30	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,248	38,989	17.34	13
14	Head Cook	11,445	12,741	118,703	9.32	14
15	Cook Helpers/Assistants	6,731	7,154	59,324	8.29	15
16	Dishwashers					16
17	Maintenance Workers	1,992	2,295	46,886	20.43	17
18	Housekeepers	13,588	15,136	144,540	9.55	18
19	Laundry	6,907	7,643	69,912	9.15	19
20	Administrator	2,592	2,928	139,548	47.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,705	8,400	171,747	20.45	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	1,996	2,172	33,721	15.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,068	185,522	$ 2,653,542 *	$ 14.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,368	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,238	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	800	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)		$ 19,406		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LORRIE STOGSDILL	ADMINISTRATOR	0	$ 139,548
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 139,548

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE COMPANY	$ 421,279
TOTAL (agree to Schedule V, line 17, col. 3)	$ 421,279
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		61,400
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 61,400

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,800
Unemployment Compensation Insurance	25,404
FICA Taxes	199,618
Employee Health Insurance	18,717
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	687
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)	$ 333,226

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	$ 3,980
Advertising: Employee Recruitment	950
Health Care Worker Background Check	550
(Indicate # of checks performed 16)	
Patient Background Checks 160	1,660
TRUST/FRANCHISE/CONTRIB/ETC	1,457
MARKETING/ADV/PROMO	5,916
LICENSES/DUES/SUBSCRIPTIONS	4,094
MGMT CO ALLOC	394
TRUST/FRANCHISE/CONTRIB/ETC	(1,457)
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,916)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,628

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	425
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 425

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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.$ 4,822

(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. $ 3,563 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. $ 128,902
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.