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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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	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: SANFORD BOKOR **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 01/01/2013 to 12/31/2013 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) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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 # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	37	Skilled (SNF)	37	13,505	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	97	TOTALS	97	35,405	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	84	326	6,533	6,943	8
9	SNF/PED					9
10	ICF	16,245	5,787	732	22,764	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,329	6,113	7,265	29,707	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.91%

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 5,717

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	244,573	21,990	6,456	273,019		273,019		273,019			1
2	Food Purchase		181,595		181,595	(6,500)	175,095	(1,432)	173,663			2
3	Housekeeping	138,769	33,426		172,195		172,195		172,195			3
4	Laundry	43,316	12,033	407	55,756		55,756		55,756			4
5	Heat and Other Utilities			109,504	109,504		109,504		109,504			5
6	Maintenance	42,244	12,716	35,259	90,219		90,219		90,219			6
7	Other (specify):*			19,293	19,293		19,293		19,293			7
8	**TOTAL General Services**	468,902	261,760	170,919	901,581	(6,500)	895,081	(1,432)	893,649			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,561,267	77,752	8,059	1,647,078		1,647,078	4,411	1,651,489			10
10a	Therapy											10a
11	Activities	274,825	6,384	268	281,477		281,477		281,477			11
12	Social Services	23,752			23,752		23,752		23,752			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,859,844	84,136	14,327	1,958,307		1,958,307	4,411	1,962,718			16
	C. General Administration											
17	Administrative	166,504		391,405	557,909		557,909	(329,063)	228,846			17
18	Directors Fees											18
19	Professional Services			53,397	53,397		53,397	6,522	59,919			19
20	Dues, Fees, Subscriptions & Promotions			25,015	25,015		25,015	(8,555)	16,460			20
21	Clerical & General Office Expenses	127,520	30,920	36,066	194,506		194,506	22,507	217,013			21
22	Employee Benefits & Payroll Taxes			397,134	397,134	6,500	403,634		403,634			22
23	Inservice Training & Education			1,405	1,405		1,405		1,405			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			15,184	15,184		15,184	6,189	21,373			25
26	Insurance-Prop.Liab.Malpractice			77,578	77,578		77,578		77,578			26
27	Other (specify):*			82,835	82,835		82,835	(76,988)	5,847			27
28	**TOTAL General Administration**	294,024	30,920	1,080,019	1,404,963	6,500	1,411,463	(379,388)	1,032,075			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,622,770	376,816	1,265,265	4,264,851		4,264,851	(376,409)	3,888,442			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: 01/01/2013** **Ending: 12/31/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,456	
	REPAIRS & MAINTENANCE		0	
			0	6,456
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		407	
			0	407
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,005	
	ELECTRICITY		46,599	
	WATER		32,300	
	CABLE TV - LOBBY		5,600	
			0	109,504
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		8,876	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		22,530	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,140	
	FIRE SERVICE		1,713	
			0	
			0	
			0	
			0	35,259
7	**OTHER**			
	SCAVENGER		19,293	
	SECURITY SERVICE		0	
			0	
			0	19,293
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 CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	8,059	
	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	8,059
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	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	268	
			0	268
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 **#0043968** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	391,405	391,405
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,111	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	28,286	
			0	53,397
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,531	
	EMPLOYEE WANT ADS	XIX F	4,287	
	CONTRIBUTIONS	VI 20 XIX F	632	
	DUES & SUBSCRIPTIONS	XIX F	3,394	
	LICENSES & PERMITS	XIX F	4,637	
	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	864	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,670	
	PATIENT BACKGROUND CHECKS	XIX F	2,000	
				25,015
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		12,879	
	EQUIPMENT REPAIR & MAINTENANCE		362	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,324	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,501	
	MESSENGER SERVICE		0	
			0	36,066

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	195,209	
	UNEMPLOYMENT COMPENSATION	XIX D	40,185	
	WORKERS COMPENSATION INSURANC	XIX D	121,508	
	HOSPITALIZATION INSURANCE	XIX D	39,067	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,165	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	397,134
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,405	
				1,405
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		15,184	
				15,184
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		77,578	
				77,578
27	**OTHER**			
	BAD DEBTS	VI 24	82,835	
				82,835

GRAND TOTAL COLUMN 3 OTHER **1,265,265**

ASTA CARE CENTER OF PONTIAC
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	181,595
LESS SALES TAX	(1,432)
NET FOOD	180,163
TOTAL PATIENT CENSUS	29,707
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	89,121
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	89,121
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	89,121
NET FOOD	180,163
DIVIDE TOTAL MEALS/YEAR	89,121
COST PER MEAL	2.02
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**6,500**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC #0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			908	908		908	139,259	140,167			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			175,854	175,854		175,854	(13,108)	162,746			32
33	Real Estate Taxes			78,461	78,461		78,461		78,461			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)				34
35	Rent-Equipment & Vehicles			19,616	19,616		19,616		19,616			35
36	Other (specify):* **Amortization**			15,708	15,708		15,708		15,708			36
37	**TOTAL Ownership**			650,547	650,547		650,547	(233,849)	416,698			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		276,881	684,585	961,466		961,466	(129,051)	832,415			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			203,012	203,012		203,012		203,012			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		276,881	887,597	1,164,478		1,164,478	(129,051)	1,035,427			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,622,770	653,697	2,803,409	6,079,876		6,079,876	(739,309)	5,340,567			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: 01/01/2013 Ending: 12/31/2013

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	21,885	30		9
10	Interest and Other Investment Income	(97,107)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,432)	2		13
14	Non-Care Related Interest	(26,691)	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	(1,324)	21		18
19	Entertainment		20		19
20	Contributions	(1,496)	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	(82,835)	27		24
25	Fund Raising, Advertising and Promotional	(7,531)	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	(139,336)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (335,867)		$	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)	(403,442)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (403,442)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (739,309)		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

ID# 0043968

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (10,285)	21	1
2				2
3				3
4	RELATED PARTY THERAPY ADJUSTMENT	(129,051)	39	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**	(139,336)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(1,432)	0	0	0	0	0	0	0	0	0	0	(1,432)	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**	(1,432)	0	0	0	0	0	0	0	0	0	0	(1,432)	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	4,411	0	0	0	0	0	0	0	0	0	4,411	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	4,411	0	0	0	0	0	0	0	0	0	4,411	16
	C. General Administration													
17	Administrative	0	(329,063)	0	0	0	0	0	0	0	0	0	(329,063)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,522	0	0	0	0	0	0	0	0	0	6,522	19
20	Fees, Subscriptions & Promotions	(9,027)	472	0	0	0	0	0	0	0	0	0	(8,555)	20
21	Clerical & General Office Expenses	(11,609)	34,116	0	0	0	0	0	0	0	0	0	22,507	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	0	6,189	0	0	0	0	0	0	0	0	0	6,189	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(82,835)	5,847	0	0	0	0	0	0	0	0	0	(76,988)	27
28	**TOTAL General Administration**	(103,471)	(275,917)	0	0	0	0	0	0	0	0	0	(379,388)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(104,903)	(271,506)	0	0	0	0	0	0	0	0	0	(376,409)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	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)	
30	Depreciation	21,885	0	117,374	0	0	0	0	0	0	0	0	139,259	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(123,798)	0	110,690	0	0	0	0	0	0	0	0	(13,108)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(360,000)	0	0	0	0	0	0	0	0	(360,000)	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**	(101,913)	0	(131,936)	0	0	0	0	0	0	0	0	(233,849)	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	(129,051)	0	0	0	0	0	0	0	0	0	0	(129,051)	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**	(129,051)	0	0	0	0	0	0	0	0	0	0	(129,051)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(335,867)	(271,506)	(131,936)	0	0	0	0	0	0	0	0	(739,309)	45

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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
MICHAEL GILLMAN	25	ASTA CARE CENTER OF BLOOMINGTON	BLOOMINGTON	ASTA		
DARYLE GILLMAN	25	ASTA CARE CENTER OF ELGIN	ELGIN	HEALTHCARE CO.	ELGIN	MANAGEMENT
BARRY KIRSCHENBAUM	25	ASTA CARE CENTER OF FORD COUNTY	PAXTON			
DIANE KIRSCHENBAUM	25	ASTA CARE CENTER OF COLFAX	COLFAX			
		ASTA CARE CENTER OF ROCKFORD	ROCKFORD	ASTA THERAPY	ELGIN	THERAPY
		ASTA CARE CENTER OF TOLUCA	TOLUCA			

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	$ 391,405	ASTA HEALTHCARE COMPANY, INC.		$	$ (391,405)	1
2	V	10	NURSING		ASTA HEALTHCARE COMPANY, INC.		4,411	4,411	2
3	V	17	OFFICER'S SALARY -MG		ASTA HEALTHCARE COMPANY, INC.		31,055	31,055	3
4	V	17	ADMIN. SALARY -CF		ASTA HEALTHCARE COMPANY, INC.		26,008	26,008	4
5	V	17	ADMIN. SALARY -AF		ASTA HEALTHCARE COMPANY, INC.		5,279	5,279	5
6	V	19	PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY, INC.		6,522	6,522	6
7	V	20	LICENSES & PERMITS		ASTA HEALTHCARE COMPANY, INC.		472	472	7
8	V	21	OFFICE EXPENSE		ASTA HEALTHCARE COMPANY, INC.		34,116	34,116	8
9	V	25	STAFF TRANS/ TRAVEL		ASTA HEALTHCARE COMPANY, INC.		6,189	6,189	9
10	V	27	PAYR. TAXES & W/C		ASTA HEALTHCARE COMPANY, INC.		5,847	5,847	10
11	V				ASTA HEALTHCARE COMPANY, INC.				11
12	V								12
13	V								13
14	Total			$ 391,405			$ 119,899	$ * (271,506)	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: 01/01/2013 Ending: 12/31/2013

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	$ 360,000	ASTA PONTIAC PROPERTIES,LLC		$	$ (360,000)	15
16	V	30	DEPRECIATION		ASTA PONTIAC PROPERTIES,LLC		117,374	117,374	16
17	V	32	INTEREST		ASTA PONTIAC PROPERTIES,LLC		110,690	110,690	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			$ 360,000			$ 228,064	$ * (131,936)	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: 01/01/2013 Ending: 12/31/2013

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 # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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					SALARY	$ 31,055	17-7	1
2			MANAGEMENT	25.00							2
3					SEE	SEE					3
4	CRAIG FRANK	CFO	FINANCE MGMT		ATTACHED	ATTACHED		SALARY	26,008	17-7	4
5	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $97,500				SCHEDULE	SCHEDULE					5
6	MANAGEMENT FEE FROM ASTA CARE OF COLFAX $30,000										6
7											7
8	ALIZA FRANK		PAYROLL					SALARY	5,279	17-7	8
9											9
10	DAVID MEISELMAN	THERAPY MGMNT	management					SALARY	29,036	39-3	10
11											11
12											12
13								TOTAL	$ 91,378		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: 01/01/2013 Ending: 2/31/2013

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	191,321	7	$ 28,405	$ 28,303	29,707	$ 4,411	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	191,321	7	200,000	200,000	29,707	31,055	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	191,321	7	167,500	167,500	29,707	26,008	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	191,321	7	34,000	34,000	29,707	5,279	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	191,321	7	42,001		29,707	6,522	5
6	20	LICENSES & PERMITS	PATIENT DAYS	191,321	7	3,043		29,707	472	6
7	21	OFFICE EXPENSE	PATIENT DAYS	191,321	7	219,718	184,734	29,707	34,116	7
8	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	191,321	7	39,861		29,707	6,189	8
9	27	PAYR. TAXES & W/C	PATIENT DAYS	191,321	7	37,656		29,707	5,847	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					$ 772,184	$ 614,537		$ 119,899	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	MIDCAP FINANCIAL		X	LINE OF CREDIT		11/29/12	$	$ 185,051	REVOLV	0.0700	$ 67,755	1
2	ENLOE		X	TRADE PAYABLE FIN	$17,521.08	7/31/12	921,482	854,326	6/30/17	0.0550	44,096	2
3	TCF		X	VAN PURCHASE	$476.89	11/18/09	25,275	4,167	9/18/14		503	3
4	KIRSCHENBAUM	X		WORKING CAPITAL							10,000	4
5												5
	Working Capital											
6												6
7	INSURANCE POLICIES										2,451	7
8	GILLMAN	X		WORKING CAPITAL							24,358	8
9	TOTAL Facility Related				$17,997.97		$ 946,757	$ 1,043,544			$ 149,163	9
	B. Non-Facility Related*											
10	HEALTHCARE FAMILY SVC			BED TAX INTEREST							26,580	10
11	ILL DEPT OF REV			MISC							111	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 26,691	14
15	TOTALS (line 9+line14)						$ 946,757	$ 1,043,544			$ 175,854	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: 01/01/2013 Ending: 12/31/2013

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: ALBANY BANK		X	MORTGAGE	$20,432.02		$ 2,780,000	$ 1,994,019			$ 110,690	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$20,432.02		$ 2,780,000	$ 1,994,019			$ 110,690	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,780,000	$ 1,994,019			$ 110,690	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: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 46,309	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.)		$ 62,385	2
3. Under or (over) accrual (line 2 minus line 1).		$ 16,076	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 62,385	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.		$ 78,461	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	47,044	8
	2009	47,812	9
	2010	45,827	10
	2011	46,309	11
	2012	62,385	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 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-15-27-255-014	NURSING HOME	$ 62,384.66	$ 62,384.66
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,384.66	$ 62,384.66

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. [ ] (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 # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$	$ 804,235	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS - PURCHASE ALLOCATION (PROP)			1998	97,058	4,038	15	4,038		97,058	9
10	WATER HEATERS & PLUMBING (PROP)			1999	14,502	527	27.5	527		7,663	10
11	BOILER & A/C (PROP)			1999	14,240	518	27.5	518		7,532	11
12	ELECTRONIC DOOR LOCKS (PROP)			1999	3,974	145	27.5	145		2,108	12
13	FENCE (PROP)			1999	1,155	77	15	77		1,120	13
14	REMODELING ROOMS & BATHROOMS (PROP)			2000	47,944	1,743	27.5	1,743		23,603	14
15	AIR CONDITIONER (PROP)			2000	5,569	203	27.5	203		2,749	15
16	FIRE PANEL (PROP)			2000	2,730	99	27.5	99		1,827	16
17	FURNISHING			2000	2,839		7			2,839	17
18	WATER SOFTENER (PROP)			2001	4,013	146	27.5	146		1,831	18
19	CONDENSER (PROP)			2001	3,100	113	27.5	113		1,417	19
20	HEATER AND A/C UNITS (PROP)			2001	5,100	186	27.5	186		2,332	20
21	GREASE TRAP (PROP)			2001	1,300	47	27.5	47		590	21
22	3 DOORS (PROP)			2001	4,000	145	27.5	145		1,819	22
23	FENCE (PROP)			2001	2,564	171	15	171		2,144	23
24	SIDEWALK (PROP)			2001	1,850	123	15	123		1,543	24
25	CONCRETE WORK(PROP)			2002	3,938	263	15	263		3,025	25
26	FIRE ALARM SYSTEM(PROP)			2002	40,476	1,472	27.5	1,472		16,989	26
27	RESIDENT SECURITY SYSTEM(PROP)			2002	11,930	434	27.5	434		5,009	27
28	FIRE DOORS(PROP)			2002	6,016	219	27.5	219		2,528	28
29	REMODELING 8 ROOMS(PROP)			2002	46,151	1,678	27.5	1,678		19,367	29
30	SPRINKLER HEADS(PROP)			2002	3,635	132	27.5	132		1,524	30
31	WATER LINE(PROP)			2002	3,002	109	27.5	109		1,258	31
32	BACK FLOW PREVENTER(PROP)			2002	3,300	120	27.5	120		1,385	32
33	NEW FLOOR DRAIN(PROP)			2003	1,726	63	27.5	63		664	33
34	LIGHTING(PROP)			2003	1,350	49	27.5	49		517	34
35	ELECTRICAL WORK(PROP)			2003	1,371	49	27.5	49		517	35
36	TELEPHONE WIRING(PROP)			2003	5,242	191	27.5	191		2,013	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: 01/01/2013 Ending: 12/31/2013

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	$	$ 1,298	37
38	ELECTRICAL WORK (PROP)	2005	5,435	198	27.5	198		1,691	38
39	AIR COMPRESSOR (PROP)	2005	5,791	211	27.5	211		1,802	39
40	FIRE SYSTEM (PROP)	2005	26,366	959	27.5	959		8,192	40
41	SPRINKLER HEADS (PROP)	2005	3,308	120	27.5	120		1,025	41
42	CIRCULATING (PROP)]	2005	2,077	75	27.5	75		641	42
43	DOOR ALARM (PROP)	2006	3,639	132	27.5	132		996	43
44	EXHAUST FAN (PROP)	2006	1,700	62	27.5	62		468	44
45	PTAC UNITS (PROP)	2006	2,717	99	27.5	99		746	45
46	OUTPATIENT THERAPY REMODELING (PROP)	2006	8,682	316	27.5	316		2,383	46
47	WATER HEATER (PROP)	2008	6,179	225	27.5	225		1,322	47
48	10 FOOT ADDITION FOR DIALYSIS TRTMNT ROOM(PROP)	2008	55,988	2,036	27.5	2,036		11,113	48
49	WATER SOFTENER (PROP)	2008	7,022	255	27.5	255		1,328	49
50	4 TON A/C AND FILTER DRYER (PROP)	2008	2,979	108	27.5	108		563	50
51	3 TON A/C AND DRYER (PROP)	2008	2,550	93	27.5	93		484	51
52	WATER HEATER (PROP)	2008	3,897	142	27.5	142		740	52
53	SPRINKLER HEADS (PROP)	2009	20,820	757	27.5	757		3,627	53
54									54
55									55
56									56
57									57
58	NEW 9 BED WING (PROP)	2011	1,101,458	40,053	27.5	40,053		101,801	58
59	ELECTRIC SERVICE FOR 9 BED WING (PROP)	2011	5,300	193	27.5	193		490	59
60	PARKING DRAIN DONE BECAUSE OF 9 BED WING (PROP)	2011	6,500	236	27.5	236		600	60
61	ARCHITECT FEES FOR 9 BED WING (PROP)	2011	73,280	2,665	27.5	2,665		6,774	61
62	PHONE SYSTEM FOR 9 BED WING (PROP)	2011	3,490	127	27.5	127		323	62
63	INTERIOR DESIGN WORK FOR 9 BED WING	2011	18,104		5	3,621	3,621	9,052	63
64	CONSTRUCTION INTEREST PAID FOR 9 BED WING PROP)	2011	23,661	860	27.5	860		2,186	64
65	BANK SERVICE FEE PAID FOR 9 BED WING (PROP)	2011	9,000	327	27.5	327		831	65
66	APPRAISAL REPORTS DONE FOR 9 BED WING (PROP)	2011	4,500	164	27.5	164		417	66
67	escrow fee and title charges paid for 9 bed wing (prop)	2011	3,003	109	27.5	109		277	67
68	bank charged architect fees for 9 bed wing (prop)	2011	3,600	131	27.5	131		333	68
69	ENGINEERING FEES FOR 9 BED WING (PROP)	2011	9,568	348	27.5	348		885	69
70	TOTAL (lines 4 thru 69)		$ 3,202,912	$ 116,505		$ 120,126	$ 3,621	$ 1,179,594	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: 01/01/2013 Ending: 12/31/2013

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	$ 116,505		$ 120,126	$ 3,621	$ 1,179,594	1
2	FEE PAID TO IDPA FOR 9 BED WING (PROP)	2011	8,140	296	27.5	296		752	2
3	CUSTOM HOOD AND FIRD SUPRESIION (PROP)	2011	8,320	303	27.5	303		669	3
4	COMPRESSOR	2012	7,415	270	27.5	270		349	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
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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)		$ 3,226,787	$ 117,374		$ 120,995	$ 3,621	$ 1,181,364	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 # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 197,792	$ 567	$ 18,549	$ 17,982		$ 96,498	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	74,105					74,105	73
74								74
75	TOTALS	$ 271,897	$ 567	$ 18,549	$ 17,982		$ 170,603	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	$ 341	$ 623	$ 282		$ 3,115	76
77										77
78										78
79										79
80	TOTALS			$ 3,117	$ 341	$ 623	$ 282		$ 3,115	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)	$ 3,601,801	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 118,282	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 140,167	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,885	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,355,082	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: 01/01/2013 Ending: 12/31/2013

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:				$ 360,000			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 360,000 **			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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 19,616 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: 01/01/2013 Ending: 12/31/2013

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	$		$ 91,394	$		$ 91,394	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			36,726			36,726	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			515,334			515,334	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				270,685		270,685	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology,EKG,Lab,I.V.Therapy,Physician Other (specify):					41,131	6,196		41,131 6,196	13
14	TOTAL			$		$ 684,585	$ 276,881		$ 961,466	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 2,705	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,000))	1,485,738		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,615		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,794,617		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,337,675	$	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)	(295,370)		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 (spe**Loan Cost**	30,106		22
23	Other(specify): **Security Deposit**	23,235		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 53,928	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,391,603	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 835,310	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	355,375		29
30	Accrued Salaries Payable	78,292		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,099		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,385		32
33	Accrued Interest Payable	22,500		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	RELATED PARTIES	288,944		36
37	MEMBER LOAN	200,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,850,905	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	688,169		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)**	$ 688,169	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,539,074	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,852,529	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,391,603	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,747,706	1	
2	Restatements (describe):		2	
3	POST CLOSING ADJ	(101)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,747,605	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	115,156	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	(10,232)	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)**	$ 104,924	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)**	$ 1,852,529	24	*

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

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,812,846	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,812,846	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	187,105	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 187,105	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***	97,107	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 97,107	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PENALTY ABATEMENT	59,320	28
28a	OUT OF PERIOD EXPENSE ADJ.	44,835	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 104,155	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,201,213	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	901,581	31
32	Health Care	1,958,307	32
33	General Administration	1,404,963	33
	B. Capital Expense		
34	Ownership	650,547	34
	C. Ancillary Expense		
35	Special Cost Centers	961,466	35
36	Provider Participation Fee	203,012	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,079,876	40
41	**Income before Income Taxes (line 30 minus line 40)****	121,337	41
42	**Income Taxes**	(6,181)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 115,156	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,199,622	44
45	Private Pay - Net Inpatient Revenue	1,089,869	45
46	Medicare - Net Inpatient Revenue	2,151,991	46
47	Other-(specify) INSURANCE	371,364	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,812,846	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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: 01/01/2013 Ending: 12/31/2013

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	2,038	2,198	$ 85,676	$ 38.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,089	11,621	330,501	28.44	3
4	Licensed Practical Nurses	17,990	18,384	438,148	23.83	4
5	CNAs & Orderlies	62,791	64,641	684,939	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,441	3,913	87,813	22.44	9
10	Activity Assistants	19,519	21,445	187,012	8.72	10
11	Social Service Workers	2,000	2,125	23,752	11.18	11
12	Dietician					12
13	Food Service Supervisor	2,023	2,183	40,641	18.62	13
14	Head Cook	9,918	11,245	117,641	10.46	14
15	Cook Helpers/Assistants	9,996	10,375	86,291	8.32	15
16	Dishwashers					16
17	Maintenance Workers	1,939	2,099	42,244	20.13	17
18	Housekeepers	14,153	15,796	138,769	8.79	18
19	Laundry	4,863	5,103	43,316	8.49	19
20	Administrator	2,087	2,267	166,504	73.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,247	7,806	127,520	16.34	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	1,807	2,045	22,003	10.76	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,901	183,246	$ 2,622,770 *	$ 14.31	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	$ 6,456	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	8,059	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	268	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)		$ 20,783		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 # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LORRIE STOGSDILL	ADMINISTRATOR		$ 166,504
			0
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 166,504

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE COMPANY	$ 391,405
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 391,405

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		53,397
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 53,397

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,508
Unemployment Compensation Insurance	40,185
FICA Taxes	195,209
Employee Health Insurance	39,067
Employee Meals	6,500
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	1,165
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)	$ 403,634

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	4,287
Health Care Worker Background Check	1,670
(Indicate # of checks performed 167)	
Patient Background Checks 200	2,000
TRUST/FRANCHISE/CONTRIB/ETC	1,496
MARKETING/ADV/PROMO	7,531
LICENSES/DUES/SUBSCRIPTIONS	8,031
MGMT CO ALLOC	472
TRUST/FRANCHISE/CONTRIB/ETC	(1,496)
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,531)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,460

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			$		$	$	$	$	$	$	$	$	$
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 # 0043968 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. IHCA 3,394

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 5,772 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. $ 203,012
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. $ 6,500 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.