

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0043968</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>ASTA CARE CENTER OF PONTIAC, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>300 WEST LOWELL</u> <u>PONTIAC</u> <u>61764</u>																									
Number City Zip Code																									
County: <u>LIVINGSTON</u>																									
Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>MICHAEL GILLMAN</u></td></tr><tr><td>(Title) <u>MEMBER</u></td></tr><tr><td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>BOB KAGDA</u> and Title) <u>VICE PRESIDENT</u></td></tr><tr><td>(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table> 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		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MICHAEL GILLMAN</u>	(Title) <u>MEMBER</u>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	Paid Preparer	(Date) _____	(Print Name <u>BOB KAGDA</u> and Title) <u>VICE PRESIDENT</u>	(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>												
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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																								
Date of Initial License for Current Owners: <u>08/17/98</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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In the event there are further questions about this report, please contact:																									
Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>28</u>	Skilled (SNF)	<u>37</u>	<u>11,975</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>60</u>	Intermediate (ICF)	<u>60</u>	<u>21,900</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>88</u>	TOTALS	<u>97</u>	<u>33,875</u>	7

B. Census-For the entire report period.

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

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 08/17/1998

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date 08/17/1998

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number of beds certified 37 and days of care provided 5,821

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	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.

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 CONSULTANT 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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT 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 CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	421,279
	DIRECTORS FEES	
18	DIRECTORS FEES	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	<u>(2,983)</u>
NET FOOD	166,214

TOTAL PATIENT CENSUS	30,661
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	91,983

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

PATIENT MEALS	91,983
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	91,983

NET FOOD	166,214
DIVIDE TOTAL MEALS/YEAR	<u>91,983</u>

COST PER MEAL	1.81
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			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.

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (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

Report Period Beginning: ID# 0043968

Ending: 01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	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

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

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.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 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.

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 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.

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN	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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	REL PARTY:						\$		\$			\$	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2010 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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>15-27-255-014</u>	<u>NURSING HOME</u>	\$ <u>45,826.52</u>	\$ <u>45,826.52</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>45,826.52</u>	\$ <u>45,826.52</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.**

X. BUILDING AND GENERAL INFORMATION:

A.

Square Feet:

33,600

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

E.

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

N/A

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	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	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	85		1998	1961	\$ 1,438,473	\$ 52,308	27.5	\$ 52,308		\$ 699,619
5										
6										
7										
8										
	Improvement Type**									
9	LAND IMPROVEMENTS - PURCHASE ALLOCATION (PROP)			1998	97,058	6,471	15	6,471		86,549
10	WATER HEATERS & PLUMBING (PROP)			1999	14,502	527	27.5	527		6,609
11	BOILER & A/C (PROP)			1999	14,240	518	27.5	518		6,496
12	ELECTRONIC DOOR LOCKS (PROP)			1999	3,974	145	27.5	145		1,818
13	FENCE (PROP)			1999	1,155	77	15	77		966
14	REMODELING ROOMS & BATHROOMS (PROP)			2000	47,944	1,743	27.5	1,743		20,117
15	AIR CONDITIONER (PROP)			2000	5,569	203	27.5	203		2,343
16	FIRE PANEL (PROP)			2000	2,730	99	27.5	99		1,629
17	FURNISHING			2000	2,839		7			2,839
18	WATER SOFTENER (PROP)			2001	4,013	146	27.5	146		1,539
19	CONDENSER (PROP)			2001	3,100	113	27.5	113		1,191
20	HEATER AND A/C UNITS (PROP)			2001	5,100	186	27.5	186		1,960
21	GREASE TRAP (PROP)			2001	1,300	47	27.5	47		496
22	3 DOORS (PROP)			2001	4,000	145	27.5	145		1,529
23	FENCE (PROP)			2001	2,564	171	15	171		1,802
24	SIDEWALK (PROP)			2001	1,850	123	15	123		1,297
25	CONCRETE WORK(PROP)			2002	3,938	263	15	263		2,499
26	FIRE ALARM SYSTEM(PROP)			2002	40,476	1,472	27.5	1,472		14,045
27	RESIDENT SECURITY SYSTEM(PROP)			2002	11,930	434	27.5	434		4,141
28	FIRE DOORS(PROP)			2002	6,016	219	27.5	219		2,090
29	REMODELING 8 ROOMS(PROP)			2002	46,151	1,678	27.5	1,678		16,011
30	SPRINKLER HEADS(PROP)			2002	3,635	132	27.5	132		1,260
31	WATER LINE(PROP)			2002	3,002	109	27.5	109		1,040
32	BACK FLOW PREVENTER(PROP)			2002	3,300	120	27.5	120		1,145
33	NEW FLOOR DRAIN(PROP)			2003	1,726	63	27.5	63		538
34	LIGHTING(PROP)			2003	1,350	49	27.5	49		419
35	ELECTRICAL WORK(PROP)			2003	1,371	49	27.5	49		419
36	TELEPHONE WIRING(PROP)			2003	5,242	191	27.5	191		1,631

*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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	P-TAC UNITS(PROP)	2004	\$ 3,750	\$ 136	27.5	\$ 136	\$	\$ 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.

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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 SUPRESHION (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.

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	2	
	Reference	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.

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: _____*

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

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	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

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

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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)	\$			

- (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.

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	

- (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		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 Other (specify): Med. Supplies, Rentals					19,056	5,171		<u>19,056</u> 5,171	13
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.

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.)

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.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 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

2			
	Expenses	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,251	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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 7,368	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	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC, LLC # 0043968 Report Period Beginning: 01/01/2011 Ending: 12/31/2011 Page 21

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) (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)	

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 (Indicate # of checks performed 16)	550
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)	

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

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.