



Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

# 0041772 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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>72</u>	Skilled (SNF)	<u>72</u>	<u>26,280</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,170</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>47,450</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>1,007</u>	<u>448</u>	<u>2,716</u>	<u>4,171</u>	8
9	SNF/PED					9
10	ICF	<u>32,556</u>	<u>1,792</u>	<u>592</u>	<u>34,940</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>33,563</u>	<u>2,240</u>	<u>3,308</u>	<u>39,111</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.43%

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 06/01/96

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 06/01/96 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 28 and days of care provided 2,716

Medicare Intermediary ADMINISTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	186,815	13,959	12,743	213,517		213,517	0	213,517		1
2	Food Purchase		172,159		172,159	(16,735)	155,424	(1,755)	153,669		2
3	Housekeeping	131,905	26,428	0	158,333		158,333	0	158,333		3
4	Laundry	20,899	10,706	0	31,605	0	31,605	0	31,605		4
5	Heat and Other Utilities			135,623	135,623		135,623	0	135,623		5
6	Maintenance	92,191	27,183	34,194	153,568		153,568	954	154,522		6
7	Other (specify):*			22,052	22,052		22,052	0	22,052		7
8	<b>TOTAL General Services</b>	431,810	250,435	204,612	886,857	(16,735)	870,122	(801)	869,321		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		21,300	21,300		21,300	0	21,300		9
10	Nursing and Medical Records	1,632,455	136,343	10,975	1,779,773		1,779,773	563	1,780,336		10
10a	Therapy	71,929		0	71,929		71,929	0	71,929		10a
11	Activities	75,765	9,908	840	86,513		86,513	0	86,513		11
12	Social Services	59,758		1,968	61,726		61,726	0	61,726		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			991	991		991	0	991		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	1,839,907	146,251	36,074	2,022,232	0	2,022,232	563	2,022,795		16
	<b>C. General Administration</b>										
17	Administrative	94,725		240,000	334,725		334,725	(56,217)	278,508		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			58,781	58,781	(2,225)	56,556	(1,120)	55,436		19
20	Dues, Fees, Subscriptions & Promotions			26,065	26,065		26,065	(12,299)	13,766		20
21	Clerical & General Office Expenses	126,546	23,080	32,881	182,507		182,507	(11,231)	171,276		21
22	Employee Benefits & Payroll Taxes			363,075	363,075	16,735	379,810	0	379,810		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			3,292	3,292		3,292	286	3,578		24
25	Other Admin. Staff Transportation			8,225	8,225		8,225	1,148	9,373		25
26	Insurance-Prop.Liab.Malpractice			107,718	107,718		107,718	2,828	110,546		26
27	Other (specify):*			68,107	68,107		68,107	(56,002)	12,105		27
28	<b>TOTAL General Administration</b>	221,271	23,080	908,144	1,152,495	14,510	1,167,005	(132,607)	1,034,398		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,492,988	419,766	1,148,830	4,061,584	(2,225)	4,059,359	(132,845)	3,926,514		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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	7,826
	REPAIRS & MAINTENANCE	3,527
	DIRECT CARE DIETICIAN	1,390
		12,743
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	56,653
	ELECTRICITY	35,372
	WATER	41,900
	CABLE TV - LOBBY	1,698
		0
		135,623
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	1,639
	PAINTING & DECORATING	632
	BUILDING REPAIRS	675
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	27,905
	ELEVATOR MAINTENANCE & REPAIR	2,196
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	1,147
		0
		0
		0
		0
		34,194
7	<b>OTHER</b>	
	SCAVENGER	21,455
	SECURITY SERVICE	597
		0
		0
		22,052
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	21,300
		21,300

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	6,005
	LABORATORY & XRAY EXPENSE	225
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	1,920
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	800
	PHARMACY CONSULTANT XVIII B 39-2	980
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	1,045
		0
		10,975
10a	<b>THERAPY</b>	
	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	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	840
		0
		840
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,392
	SOCIAL WORKER XVIII B 45-2	576
		0
		1,968
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	991
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	240,000
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	13,857
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	44,924
		0
		58,781
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	11,351
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	1,033
	DUES & SUBSCRIPTIONS XIX F	9,206
	LICENSES & PERMITS XIX F	2,905
	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	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,570
	PATIENT BACKGROUND CHECKS XIX F	0
		26,065
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	7,730
	EQUIPMENT REPAIR & MAINTENANCE	467
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,120
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	21,461
	MESSENGER SERVICE	103
		0
		32,881

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	186,049
	UNEMPLOYMENT COMPENSATION XIX D	47,594
	WORKERS COMPENSATION INSURANC XIX D	60,294
	HOSPITALIZATION INSURANCE XIX D	61,245
	EMPLOYEE BENEFITS - OTHER XIX D	5,551
	EMPLOYEE PHYSICAL EXAMS XIX D	2,342
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		363,075
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	2,884
	TRAVEL XIX G	408
		3,292
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,225
		8,225
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	107,718
		107,718
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	68,107
		68,107

GRAND TOTAL COLUMN 3 OTHER

1,148,830

ASTA CARE CENTER OF ROCKFORD  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	172,159	PATIENT MEALS	117333
LESS SALES TAX	(1,755)	ADD EMPLOYEE MEALS	12775
	-----		-----
NET FOOD	170,404	TOTAL MEALS/YEAR	130108
TOTAL PATIENT CENSUS	39,111	NET FOOD	170404
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	130108
	-----		
TOTAL PATIENT MEALS	117333	COST PER MEAL	1.31
		TIME EMPLOYEE MEALS	12775
ADD # EMPLOYEE MEALS/DAY	35		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	16735
	-----		=====
TOTAL EMPLOYEE MEALS	12775		

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

#0041772

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			48,881	48,881		48,881	(3,509)	45,372			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			87,237	87,237	2,225	89,462	(7,356)	82,106			32
33	Real Estate Taxes			64,209	64,209		64,209	0	64,209			33
34	Rent-Facility & Grounds			603,619	603,619		603,619	0	603,619			34
35	Rent-Equipment & Vehicles			26,043	26,043		26,043	0	26,043			35
36	Other (specify):*				0		0	0	0			36
37	<b>TOTAL Ownership</b>			829,989	829,989	2,225	832,214	(10,865)	821,349			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		87,120	175,634	262,754		262,754	0	262,754			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			71,175	71,175		71,175	0	71,175			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	87,120	246,809	333,929	0	333,929	0	333,929			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,492,988	506,886	2,225,628	5,225,502	0	5,225,502	(143,710)	5,081,792			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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	(3,509)	30		9
10	Interest and Other Investment Income	(105)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,755)	2		13
14	Non-Care Related Interest	(7,251)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(3,120)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,033)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(2,451)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,107)	27		24
25	Fund Raising, Advertising and Promotional	(11,351)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(24,587)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (123,269)		\$ 0	30

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(20,441)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (20,441)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (143,710)		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ASTA CARE CENTER OF ROCKFORD

ID# 0041772

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	BANK CHARGE	(7,730)	21	2
3	MARKETING SALARY	(13,064)	21	3
4	MARKETING TRAVEL	(3,793)	25	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	<b>Total</b>	(24,587)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD# 0041772

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,755)	0	0	0	0	0	0	0	0	0	0	(1,755)	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	954	0	0	0	0	0	0	0	0	0	954	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,755)</b>	<b>954</b>	<b>0</b>	<b>(801)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	563	0	0	0	0	0	0	0	0	0	563	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>563</b>	<b>0</b>	<b>563</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	(56,217)	0	0	0	0	0	0	0	0	0	(56,217)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,451)	1,331	0	0	0	0	0	0	0	0	0	(1,120)	19
20	Fees, Subscriptions & Promotions	(12,384)	85	0	0	0	0	0	0	0	0	0	(12,299)	20
21	Clerical & General Office Expenses	(23,914)	12,683	0	0	0	0	0	0	0	0	0	(11,231)	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	286	0	0	0	0	0	0	0	0	0	286	24
25	Other Admin. Staff Transportation	(3,793)	4,941	0	0	0	0	0	0	0	0	0	1,148	25
26	Insurance-Prop.Liab.Malpractice	0	2,828	0	0	0	0	0	0	0	0	0	2,828	26
27	Other (specify):*	(68,107)	12,105	0	0	0	0	0	0	0	0	0	(56,002)	27
28	<b>TOTAL General Administration</b>	<b>(110,649)</b>	<b>(21,958)</b>	<b>0</b>	<b>(132,607)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(112,404)</b>	<b>(20,441)</b>	<b>0</b>	<b>(132,845)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD# 0041772

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(3,509)	0	0	0	0	0	0	0	0	0	0	(3,509)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,356)	0	0	0	0	0	0	0	0	0	0	(7,356)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>(10,865)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(10,865)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(123,269)</b>	<b>(20,441)</b>	<b>0</b>	<b>(143,710)</b>	<b>45</b>								

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ASTA		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		HEALTHCARE CO.	ELGIN	MANAGEMENT

**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	\$ 240,000	ASTA HEALTHCARE COMPANY		\$	(240,000)	1
2	V	6 MAINTENANCE				954	954	2
3	V	10 NURSING SUPPLIES				563	563	3
4	V	17 ADMINISTRATIVE				183,783	183,783	4
5	V	19 PROFESSIONAL FEES				1,331	1,331	5
6	V	20 LICENSES & PERMITS				85	85	6
7	V	21 OFFICE EXPENSE				12,683	12,683	7
8	V	24 SEMINARS				286	286	8
9	V	25 STAFF TRANS / TRAVEL				4,941	4,941	9
10	V	26 INSURANCE GEN / WC				2,828	2,828	10
11	V	27 PAYR. TAXES				12,105	12,105	11
12	V							12
13	V							13
14	Total		\$ 240,000			\$ 219,559	\$ * (20,441)	14

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN							SALARY	\$ 38,266	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$175,000										2
3	SETH GILMAN							SALARY	31,703	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986										4
5	SALARY FROM ASTA CARE OF TOLUCA \$23,088 SALARY FROM ASTA CARE OF BLOOMINGTON \$6,926										5
6	CRAIG FRANK							SALARY	31,703	17-7	6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$144,986										7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$30,014										8
9	DAVID MEISELMAN							SALARY	31,015	17-7	9
10	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$141,842										10
11	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,014										11
12	ALIZA FRANK - TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$32,583							SALARY	7,125	21-7	12
13								TOTAL	\$ 139,812		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 ROCKFORD

# 0041772 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PATIENT DAYS	178,865	6	\$ 4,363	\$ 39,111	\$ 954	1
2	10	NURSING SUPPLIES	PATIENT DAYS	178,865	6	2,577	39,111	563	2
3	17	OFFICER'S SALARY - MG	PATIENT DAYS	178,865	6	175,000	39,111	38,266	3
4	17	OFFICER'S SALRY -SETH	PATIENT DAYS	178,865	6	144,986	39,111	31,703	4
5	17	ADMIN. SALARY - CF	PATIENT DAYS	178,865	6	144,986	39,111	31,703	5
6	17	ADMIN. SALARY - DM	PATIENT DAYS	178,865	6	141,842	39,111	31,015	6
7	17	ADMIN. SALARY	PATIENT DAYS	178,865	6	233,674	39,111	51,096	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,865	6	6,085	39,111	1,331	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,865	6	389	39,111	85	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,865	6	58,004	39,111	12,683	10
11	24	SEMINARS	PATIENT DAYS	178,865	6	1,310	39,111	286	11
12	25	STAFF TRANS / TRAVEL	PATIENT DAYS	178,865	6	22,595	39,111	4,941	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,865	6	12,935	39,111	2,828	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,865	6	55,359	39,111	12,105	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,004,105	\$ 639,397	\$ 219,559	25

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

# 0041772

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	LASALLE	X	LINE OF CREDIT	INT ONLY	REVOLV		815,667	REVOLV	PRIME+	77,561										
7																				
8		X	INSURANCE POLICES	INT ONLY						2,425										
9	<b>TOTAL Facility Related</b>					\$ 0	\$ 815,667			\$ 79,986										
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC	X	LATE FEES							7,251										
11		X	LATE FEE																	
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>					\$ 0	\$ 0			\$ 7,251										
15	<b>TOTALS (line 9+line14)</b>					\$ 0	\$ 815,667			\$ 87,237										

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

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	<b>58,763</b>	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.)		\$	<b>61,486</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,723</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>61,486</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>64,209</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	<b>53,333</b>	8	
	2002	<b>54,662</b>	9	
	2003	<b>55,114</b>	10	
	2004	<b>58,763</b>	11	
	2005	<b>61,486</b>	12	
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>				
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.</b>				
	<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME ASTA CARE CENTER OF ROCKFORD COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041772

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 2005 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 2005.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>11-01-304-008</u>	<u>NURSING HOME</u>	\$ <u>61,486.18</u>	\$ <u>61,486.18</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>
		<b>TOTALS</b>	\$ <u>61,486.18</u>	\$ <u>61,486.18</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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				\$	1
2					2
3	TOTALS			\$ 0	3

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD# 0041772

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		NURSES STATION		1997	15,290	392	39	392		3,544	9
10		FIRE PANEL		1997	1,691	43	39	43		389	10
11		ROOF		1997	4,035	104	39	104		940	11
12		TWO BATHROOMS		1998	4,615	118	39	118		1,018	12
13		COOLING TOWER		1998	7,552	194	39	194		1,576	13
14		PLUMBING - GREASE TRAP		1999	1,024	37	27.5	37		279	14
15		PLUMBING - NEW SINKS		1999	1,321	48	27.5	48		362	15
16		HOT WATER HEATER		1999	2,955	107	27.5	107		807	16
17		HEAT EXCHANGE		1999	2,298	84	27.5	84		633	17
18		NEW BATHROOMS		1999	9,975	363	27.5	363		2,737	18
19		NEW CEILING		1999	1,841	67	27.5	67		505	19
20		NURSE CALL SYSTEM		1999	8,437	307	27.5	307		2,315	20
21		NEW COOLING TOWER		1999	4,765	173	27.5	173		1,305	21
22		ROOF		2000	16,000	582	27.5	582		3,807	22
23		COUNTERTOP SINK		2000	2,275	83	27.5	83		543	23
24		TILING		2000	600	22	27.5	22		144	24
25		TOILETS		2000	7,702	280	27.5	280		1,832	25
26		CLOSETS, DRYWALL, TILING		2000	4,600	167	27.5	167		1,093	26
27		SHELVES		2000	1,250	45	27.5	45		295	27
28		DRAPES		2000	1,040	92	7	97	5	992	28
29		DRAPES		2000	10,639	929	7	1,068	139	10,095	29
30		VINYL FLOORING		2000	17,233	1,505	7	1,731	226	16,379	30
31		WALL COVERING		2001	2,696	155	5	141	(14)	2,696	31
32		FLOOR TILE & VINYL		2001	12,481	719	5	739	20	12,481	32
33		CUBICLE CURTAINS		2001	5,873	338	5	332	(6)	5,873	33
34		DOOR LOCKING SYSTEM		2001	2,960	108	27.5	108		598	34
35		DIALYSIS ROOM		2001	19,931	725	27.5	725		4,018	35
36		SEPTIC INJECTOR		2001	3,004	109	27.5	109		604	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 &amp; ID Number ASTA CARE CENTER OF ROCKFORD

# 0041772

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ROOF	2001	\$ 20,600	\$ 749	27.5	\$ 749		\$ 4,151	37
38	SCREEN PORCH	2001	5,500	200	27.5	200		1,108	38
39	ELECTRONIC DOOR SCREEN FOR ELEVATOR	2001	6,887	250	27.5	250		1,386	39
40	BUILD WALLS, PAINTING, WOOD MOLDING	2001	5,700	207	27.5	207		1,147	40
41	FIRE ALARM SYSTEM	2002	12,867	468	27.5	468		2,125	41
42	CHAIR RAIL	2002	546	20	27.5	20		91	42
43	WATER HEATER	2002	2,229	81	27.5	81		368	43
44	GREASE TRAP	2002	1,050	38	27.5	38		173	44
45	SEWAGE EJECTOR PIT	2002	7,657	278	27.5	278		1,263	45
46	CODE ALERT WANDERING SYSTEM	2002	3,173	115	27.5	115		523	46
47	FLOORING, HANDRAILS, CORNER GUARD	2002	59,554	2,166	27.5	2,166		9,837	47
48	COVE BASE	2002	730	27	27.5	27		122	48
49	COVE BASE	2002	630	23	27.5	23		104	49
50	HANDRAILS, CORNER GUARDS	2002	7,947	289	27.5	289		1,313	50
51	WALLCOVERINGS	2002	3,578	288	5	265	(23)	3,578	51
52	PAINTING & WALLCOVERINGS	2002	6,572	530	5	454	(76)	6,572	52
53	WINDOW TREATMENTS	2002	3,722	300	5	338	38	3,722	53
54	WALLCOVERINGS, PAINTING	2002	19,304	1,557	5	1,374	(183)	19,304	54
55	WALLCOVERINGS	2002	2,277	184	5	48	(136)	2,277	55
56	WALLCOVERINGS, PAINTING	2002	12,600	1,016	5	856	(160)	12,600	56
57	WALLCOVERINGS	2002	2,277	184	5	48	(136)	2,277	57
58	GENERATOR	2003	40,000	1,455	27.5	1,455		5,153	58
59	FLOORING	2004	13,068	475	27.5	475		1,207	59
60	FIRE RATED CEILING TILE	2004	5,675	206	27.5	206		524	60
61	GREASE TRAP	2004	1,420	52	27.5	52		132	61
62	EXHAUST FAN	2004	867	32	27.5	32		81	62
63	HEAT EXCHANGER	2005	3,457	126	27.5	126		194	63
64	NEW SINK	2005	621	22	27.5	22		34	64
65	TILING	2005	1,726	63	27.5	63		97	65
66	3 NEW CIRCUITS	2005	1,996	73	27.5	73		112	66
67	SECURITY SYSTEM	2005	3,410	124	27.5	124		191	67
68	SMOKE DETECTING SYSTEM	2005	7,125	259	27.5	259		400	68
69	GENERATOR	2005	15,000	545	27.5	545		841	69
70	TOTAL (lines 4 thru 69)		\$ 453,848	\$ 20,298		\$ 19,992	\$ (306)	\$ 160,867	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 453,848	\$ 20,298		\$ 19,992	\$ (306)	\$ 160,867	1
2	DRAPERIES & VALANCES	2006	14,034	2,807	5	561	(2,246)	561	2
3	SMOKE DETECTORS	2006	6,070	83	27.5	83		83	3
4	GREASE TRAP	2006	1,550	21	27.5	21		21	4
5	FLOORING	2006	23,676	323	27.5	323		323	5
6	WATER SOFTENEN & MIXING VALVE	2006	2,074	28	27.5	28		28	6
7	HALLWAY DOOR ALARM	2006	672	9	27.5	9		9	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)		\$ 501,924	\$ 23,569		\$ 21,017	\$ (2,552)	\$ 161,892	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 213,264	\$ 13,195	\$ 21,326	\$ 8,131	10 YRS	\$ 133,213	71
72	Current Year Purchases	60,586	12,117	3,029	(9,088)	10 YRS	3,029	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 273,850	\$ 25,312	\$ 24,355	\$ (957)		\$ 136,242	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 775,774	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,881	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,372	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,509)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 298,134	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: HOLT HEALTHCARE CENTRE

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:		135	01/01/96	\$ 603,619	30		3
4	Additions					8		4
5								5
6								6
7	TOTAL		135		\$ 603,619			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: \$ 26,043 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		\$	\$ 0	21

10. Effective dates of current rental agreement:

Beginning 06/01/96

Ending 06/01/26

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

Fiscal Year Ending Annual Rent

12. 12/31/2007 \$ 603,619

13. 12/31/2008 \$ 603,619

14. 12/31/2009 \$ 603,619

\* 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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	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	\$		\$ 26,118	\$		\$ 26,118	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			857			857	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			67,150			67,150	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 prescripts				79,224		79,224	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					81,509	7,896		89,405	13
14	<b>TOTAL</b>			\$		\$ 175,634	\$ 87,120		\$ 262,754	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 ROCKFORD

# 0041772

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 7,999	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	940,289		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,417		6
7	Other Prepaid Expenses	5,425		7
8	Accounts Receivable (owners or related parties)	2,803,461		8
9	Other(specify): RE Escrow, Emp. Loan	19,021		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,816,612	\$ 0	10
<b>B. Long-Term Assets</b>				
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	387,598		15
16	Equipment, at Historical Cost	392,611		16
17	Accumulated Depreciation (book methods)	(379,685)		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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 400,524	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,217,136	\$ 0	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,312,855	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	815,667		29
30	Accrued Salaries Payable	101,130		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,964		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,486		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,310,102	\$ 0	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,310,102	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,907,034	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,217,136	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,922,196</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>2</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,922,198</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(15,164)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(15,164)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,907,034</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,077,392	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,077,392	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	116,376	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 116,376	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	105	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 105	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>ADJ. OF PRIOR YEAR INCOME</b>	32,371	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 32,371	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,226,244	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	886,857	31
32	Health Care	2,022,232	32
33	General Administration	1,152,495	33
	<b>B. Capital Expense</b>		
34	Ownership	829,989	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	262,754	35
36	Provider Participation Fee	71,175	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,225,502	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	742	41
42	<b>Income Taxes</b>	(15,906)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (15,164)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **ASTA CARE CENTER OF ROCKFORD**

# **0041772**

Report Period Beginning: **01/01/2006**

Ending:

**12/31/2006**

**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	2,818	3,171	\$ 132,756	\$ 41.87	1
2	Assistant Director of Nursing	94	94	2,983	31.73	2
3	Registered Nurses	11,255	11,770	331,619	28.17	3
4	Licensed Practical Nurses	18,834	20,062	468,168	23.34	4
5	CNAs & Orderlies	57,724	61,704	654,848	10.61	5
6	CNA Trainees					6
7	Licensed Therapist	1,464	1,534	43,347	28.26	7
8	Rehab/Therapy Aides	2,526	2,700	28,582	10.59	8
9	Activity Director	2,005	2,150	24,753	11.51	9
10	Activity Assistants	7,282	7,555	51,012	6.75	10
11	Social Service Workers	5,281	5,645	59,758	10.59	11
12	Dietician					12
13	Food Service Supervisor	3,001	3,306	43,889	13.28	13
14	Head Cook	2,796	3,080	40,884	13.27	14
15	Cook Helpers/Assistants	11,879	13,117	102,042	7.78	15
16	Dishwashers					16
17	Maintenance Workers	8,644	9,282	92,191	9.93	17
18	Housekeepers	15,535	16,605	131,905	7.94	18
19	Laundry	3,168	3,206	20,899	6.52	19
20	Administrator	2,033	2,290	94,725	41.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,828	9,513	126,546	13.30	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	2,737	2,949	39,228	13.30	31
32	Other Health C: <u>WARD CLERK</u>	253	270	2,853	10.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,157	180,003	\$ 2,492,988 *	\$ 13.85	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 7,826	1-3	35
36	Medical Director	O	21,300	9-3	36
37	Medical Records Consultant	N	800	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	980	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	840	11-3	44
45	Social Service Consultant	E	1,968	12-3	45
46	Other(specify) <u>PSYCHO-SOCIAL</u>	S	1,920	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,634		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	200	6,005	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	200	\$ 6,005		53



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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	<b>PAIN/DECORATING</b>	<b>2000</b>	<b>\$ 3,649</b>	<b>3 YRS</b>	<b>\$ 609</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>								
2	<b>PAIN/DECORATING</b>	<b>2001</b>	<b>3,197</b>	<b>3 YRS</b>	<b>1,065</b>	<b>533</b>														
3	<b>PAIN/DECORATING</b>	<b>2002</b>	<b>2,176</b>	<b>3 YRS</b>	<b>725</b>	<b>725</b>	<b>363</b>													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		<b>\$ 9,022</b>		<b>\$ 2,399</b>	<b>\$ 1,258</b>	<b>\$ 363</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>								

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD# 0041772Report Period Beginning: 01/01/2006Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (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. \$8398
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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. \$ \_\_\_\_\_ 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 \_\_\_\_\_ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO \_\_\_\_\_ 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. \$ 71,175  
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. \$ 16,735 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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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 \$2500, 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