

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

<p>I. IDPH License ID Number: <u>0041772</u></p> <p>Facility Name: <u>ASTA CARE CENTER OF ROCKFORD</u></p> <p>Address: <u>707 WEST RIVERSIDE BOULEVARD</u> <u>ROCKFORD</u> <u>61103</u> <small>Number City Zip Code</small></p> <p>County: <u>WINNEBAGO</u></p> <p>Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 942-9012</u></p> <p>HFS ID Number: <u>36-4080354</u></p> <p>Date of Initial License for Current Owners: <u>06/01/96</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%;">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 rowspan="5">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <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> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MICHAEL GILLMAN</u>	(Title) <u>MEMBER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <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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Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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>1,004</u>	<u>173</u>	<u>4,525</u>	<u>5,702</u>	8
9	SNF/PED					9
10	ICF	<u>32,478</u>	<u>690</u>	<u>1,380</u>	<u>34,548</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>33,482</u>	<u>863</u>	<u>5,905</u>	<u>40,250</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.83%

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 4,525

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	212,234	19,538	11,459	243,231		243,231		243,231		1
2	Food Purchase		199,334		199,334	(23,652)	175,682	(1,456)	174,226		2
3	Housekeeping	134,380	33,846		168,226		168,226		168,226		3
4	Laundry	26,969	16,860		43,829		43,829		43,829		4
5	Heat and Other Utilities			120,351	120,351		120,351	167	120,518		5
6	Maintenance	129,360	36,855	40,780	206,995		206,995	482	207,477		6
7	Other (specify):*			22,515	22,515		22,515		22,515		7
8	TOTAL General Services	502,943	306,433	195,105	1,004,481	(23,652)	980,829	(807)	980,022		8
	B. Health Care and Programs										
9	Medical Director			19,000	19,000		19,000		19,000		9
10	Nursing and Medical Records	1,759,208	145,685	47,820	1,952,713		1,952,713	727	1,953,440		10
10a	Therapy	98,299	1,039		99,338		99,338		99,338		10a
11	Activities	114,562	9,682	1,880	126,124		126,124		126,124		11
12	Social Services	70,441		3,132	73,573		73,573		73,573		12
13	CNA Training										13
14	Program Transportation			3,358	3,358		3,358		3,358		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,042,510	156,406	75,190	2,274,106		2,274,106	727	2,274,833		16
	C. General Administration										
17	Administrative	96,079		249,144	345,223		345,223	(49,657)	295,566		17
18	Directors Fees										18
19	Professional Services			92,379	92,379		92,379	1,215	93,594		19
20	Dues, Fees, Subscriptions & Promotions			34,535	34,535		34,535	(12,808)	21,727		20
21	Clerical & General Office Expenses	179,396	25,960	27,990	233,346		233,346	(13,517)	219,829		21
22	Employee Benefits & Payroll Taxes			378,715	378,715	23,652	402,367		402,367		22
23	Inservice Training & Education										23
24	Travel and Seminar			910	910		910	718	1,628		24
25	Other Admin. Staff Transportation			10,033	10,033		10,033	1,101	11,134		25
26	Insurance-Prop.Liab.Malpractice			91,135	91,135		91,135	2,514	93,649		26
27	Other (specify):*			21,561	21,561		21,561	(8,726)	12,835		27
28	TOTAL General Administration	275,475	25,960	906,402	1,207,837	23,652	1,231,489	(79,160)	1,152,329		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,820,928	488,799	1,176,697	4,486,424		4,486,424	(79,240)	4,407,184		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	7,649
	REPAIRS & MAINTENANCE	3,810
		0
		11,459
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	45,966
	ELECTRICITY	45,502
	WATER	28,883
	CABLE TV - LOBBY	0
		0
		120,351
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,988
	PAINTING & DECORATING	333
	BUILDING REPAIRS	1,396
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	30,004
	ELEVATOR MAINTENANCE & REPAIR	2,527
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	532
		0
		0
		0
		0
		40,780
7	OTHER	
	SCAVENGER	20,929
	SECURITY SERVICE	1,586
		0
		0
		22,515
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	19,000
		19,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	42,919
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	883
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	600
	PHARMACY CONSULTANT XVIII B 39-2	723
	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	2,695
		0
		47,820
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,880
		0
		1,880
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	480
	SOCIAL WORKER XVIII B 45-2	2,652
		0
		3,132
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	3,358
		3,358
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	249,144
		249,144
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	14,908
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	77,471
		0
		92,379
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	10,605
	EMPLOYEE WANT ADS XIX F	2,307
	CONTRIBUTIONS VI 20 XIX F	3,400
	DUES & SUBSCRIPTIONS XIX F	8,885
	LICENSES & PERMITS XIX F	6,764
	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	1,574
	PATIENT BACKGROUND CHECKS XIX F	1,000
		34,535
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,971
	EQUIPMENT REPAIR & MAINTENANCE	1,292
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,972
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,755
	MESSENGER SERVICE	0
		0
		27,990

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	211,236
	UNEMPLOYMENT COMPENSATION XIX D	41,129
	WORKERS COMPENSATION INSURANC XIX D	76,244
	HOSPITALIZATION INSURANCE XIX D	41,273
	EMPLOYEE BENEFITS - OTHER XIX D	3,383
	EMPLOYEE PHYSICAL EXAMS XIX D	5,450
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		378,715
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	910
	TRAVEL XIX G	0
		910
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,033
		10,033
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	91,135
		91,135
27	OTHER	
	BAD DEBTS VI 24	21,561
		21,561

GRAND TOTAL COLUMN 3 OTHER

1,176,697

**ASTA CARE CENTER OF ROCKFORD
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	199,334
LESS SALES TAX	<u>(1,456)</u>
NET FOOD	197,878

TOTAL PATIENT CENSUS	40,250
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	120,750

ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	16,425

PATIENT MEALS	120,750
ADD EMPLOYEE MEALS	<u>16,425</u>
TOTAL MEALS/YEAR	137,175

NET FOOD	197,878
DIVIDE TOTAL MEALS/YEAR	<u>137,175</u>

COST PER MEAL	1.44
TIME EMPLOYEE MEALS	<u>16,425</u>
EMPLOYEE MEAL RECLASSIFICATION	23,652

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Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

#0041772

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			65,964	65,964		65,964	(11,179)	54,785			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,463	128,463		128,463	(8,956)	119,507			32
33	Real Estate Taxes			63,671	63,671		63,671		63,671			33
34	Rent-Facility & Grounds			603,619	603,619		603,619		603,619			34
35	Rent-Equipment & Vehicles			28,747	28,747		28,747	693	29,440			35
36	Other (specify):*											36
37	TOTAL Ownership			890,464	890,464		890,464	(19,442)	871,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		174,104	339,402	513,506		513,506		513,506			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,175	71,175		71,175		71,175			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		174,104	410,577	584,681		584,681		584,681			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,820,928	662,903	2,477,738	5,961,569		5,961,569	(98,682)	5,862,887			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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(11,179)	30		9
10	Interest and Other Investment Income	(44)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,456)	2		13
14	Non-Care Related Interest	(8,912)	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	(2,972)	21		18
19	Entertainment		20		19
20	Contributions	(3,400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(878)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,561)	27		24
25	Fund Raising, Advertising and Promotional	(10,605)	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	(33,033)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (94,040)		\$	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	2	
		Amount	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)	(4,642)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,642)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (98,682)		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
		Yes	No	Amount	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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

ASTA CARE CENTER OF ROCKFORD

ID# 0041772

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3	STAFF TRANSPORTATION - MARKETING	(6,385)	25	3
4	MARKETING SALARIES	(26,648)	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	(33,033)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(1,456)	0	0	0	0	0	0	0	0	0	0	(1,456)	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	167	0	0	0	0	0	0	0	0	0	167	5
6	Maintenance	0	482	0	0	0	0	0	0	0	0	0	482	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,456)	649	0	(807)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	727	0	0	0	0	0	0	0	0	0	727	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	727	0	727	16								
	C. General Administration													
17	Administrative	0	(49,657)	0	0	0	0	0	0	0	0	0	(49,657)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(878)	2,093	0	0	0	0	0	0	0	0	0	1,215	19
20	Fees, Subscriptions & Promotions	(14,005)	1,197	0	0	0	0	0	0	0	0	0	(12,808)	20
21	Clerical & General Office Expenses	(29,620)	16,103	0	0	0	0	0	0	0	0	0	(13,517)	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	718	0	0	0	0	0	0	0	0	0	718	24
25	Other Admin. Staff Transportation	(6,385)	7,486	0	0	0	0	0	0	0	0	0	1,101	25
26	Insurance-Prop.Liab.Malpractice	0	2,514	0	0	0	0	0	0	0	0	0	2,514	26
27	Other (specify):*	(21,561)	12,835	0	0	0	0	0	0	0	0	0	(8,726)	27
28	TOTAL General Administration	(72,449)	(6,711)	0	(79,160)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,905)	(5,335)	0	(79,240)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(11,179)	0	0	0	0	0	0	0	0	0	0	(11,179)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,956)	0	0	0	0	0	0	0	0	0	0	(8,956)	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	693	0	0	0	0	0	0	0	0	0	693	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,135)	693	0	(19,442)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(94,040)	(4,642)	0	(98,682)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ASTA		
				HEALTHCARE CO.	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				ASTA 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	\$ 249,144	ASTA HEALTHCARE COMPANY		\$	(249,144)	1	
2	V	5 UTILITIES				167	167	2	
3	V	6 MAINTENANCE				482	482	3	
4	V	10 NURSING				727	727	4	
5	V	17 ADMINISTRATIVE				199,487	199,487	5	
6	V	19 PROFESSIONAL FEES				2,093	2,093	6	
7	V	20 LICENSES & PERMITS				1,197	1,197	7	
8	V	21 OFFICE EXPENSE				16,103	16,103	8	
9	V	24 SEMINARS				718	718	9	
10	V	25 STAFF TRANS/ TRAVEL				7,486	7,486	10	
11	V	26 INSURANCE GEN / WC				2,514	2,514	11	
12	V	27 PAYR. TAXES & GRP INS				12,835	12,835	12	
13	V	35 EQUIPMENT RENTAL				693	693	13	
14	Total		\$ 249,144			\$ 244,502	\$ *	(4,642)	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: 01/01/2007 Ending: 12/31/2007

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			40.00		LIST	ATTACHED	SALARY	\$ 35,685	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										2
3	SETH GILLMAN			7.50		LIST	ATTACHED	SALARY	35,685	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										4
5	SALARY FROM ASTA CARE OF TOLUCA \$30,097										5
6	CRAIG FRANK					LIST	ATTACHED	SALARY	35,685	17-7	6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$38,397										8
9	DAVID MEISELMAN-TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE \$153,958					LIST	ATTACHED	SALARY	33,297	17-7	9
10	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,159										10
11	ALIZA FRANK - TOTAL SALARY RECEIVED FROM			7.50		LIST	ATTACHED	SALARY	7,444	21-7	11
12	ASTA HEALTHCARE \$34,417										12
13	TOTAL								\$ 147,796		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: 01/01/2007

Ending: 2/31/2007

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 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	5	UTILITIES	PATIENT DAYS	186,106	6	\$ 773	40,250	\$ 167	1
2	6	MAINTENANCE	PATIENT DAYS	186,106	6	2,228	40,250	482	2
3	10	NURSING	PATIENT DAYS	186,106	6	3,360	40,250	727	3
4	17	OFFICER'S SALARY -MG	PATIENT DAYS	186,106	6	165,000	40,250	35,685	4
5	17	OFFICER'S SALARY - SETH	PATIENT DAYS	186,106	6	165,000	40,250	35,685	5
6	17	ADMIN. SALARY -CF	PATIENT DAYS	186,106	6	165,000	40,250	35,685	6
7	17	ADMIN. SALARY - DM	PATIENT DAYS	186,106	6	153,958	40,250	33,297	7
8	17	ADMIN. SALARY	PATIENT DAYS	186,106	6	273,426	40,250	59,135	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	186,106	6	9,677	40,250	2,093	9
10	20	LICENSES & PERMITS	PATIENT DAYS	186,106	6	5,535	40,250	1,197	10
11	21	OFFICE EXPENSE	PATIENT DAYS	186,106	6	74,457	40,250	16,103	11
12	24	SEMINARS	PATIENT DAYS	186,106	6	3,319	40,250	718	12
13	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	186,106	6	34,613	40,250	7,486	13
14	26	INSURANCE GEN / WC	PATIENT DAYS	186,106	6	11,622	40,250	2,514	14
15	27	PAYR. TAXES & GRP INS	PATIENT DAYS	186,106	6	59,344	40,250	12,835	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	186,106	6	3,205	40,250	693	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,130,517	\$ 960,161	\$ 244,502	25

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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																				
2																				
3																				
4	HOLT HEALTHCARE		X							20,791										
5	INSURANCE POLICIES		X	INSURANCE						1,814										
Working Capital																				
6	FIRST BANK		X	WORKING CAPITAL	INTEREST	REVOLV		801,541	REVOLV	PRIME+	84,757									
7	HARRIS BANK		X	MCDANIEL FIRE SYSTEM	\$2,529.52	030107	116,225	102,591	03/01/12	11.0430	8,879									
8	NAVISTAR		X	VAN	\$995.75	04/01/07	48,307	41,637	03/21/12	8.7000	3,310									
9	TOTAL Facility Related				\$3,525.27		\$ 164,532	\$ 945,769			\$ 119,551									
B. Non-Facility Related*																				
10																				
11																				
12			X	BED TAX							8,912									
13																				
14	TOTAL Non-Facility Related						\$	\$			\$ 8,912									
15	TOTALS (line 9+line14)						\$ 164,532	\$ 945,769			\$ 128,463									

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 2006 report.		\$	61,486	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	62,578	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,092	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	62,579	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.		\$	63,671	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	54,662	8
	2003	55,114	9
	2004	58,763	10
	2005	61,486	11
	2006	62,578	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2006 TAX BILL.

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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

	(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>62,578.60</u>	\$ <u>62,578.60</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>62,578.60</u>	\$ <u>62,578.60</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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			\$	3

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

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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
	Improvement Type**										
9		NURSES STATION		1997	15,290	392	39	392		3,936	9
10		FIRE PANEL		1997	1,691	43	39	43		432	10
11		ROOF		1997	4,035	104	39	104		1,044	11
12		TWO BATHROOMS		1998	4,615	118	39	118		1,136	12
13		COOLING TOWER		1998	7,552	194	39	194		1,770	13
14		PLUMBING - GREASE TRAP		1999	1,024	37	27.5	37		316	14
15		PLUMBING - NEW SINKS		1999	1,321	48	27.5	48		410	15
16		HOT WATER HEATER		1999	2,955	107	27.5	107		914	16
17		HEAT EXCHANGE		1999	2,298	84	27.5	84		717	17
18		NEW BATHROOMS		1999	9,975	363	27.5	363		3,100	18
19		NEW CEILING		1999	1,841	67	27.5	67		572	19
20		NURSE CALL SYSTEM		1999	8,437	307	27.5	307		2,622	20
21		NEW COOLING TOWER		1999	4,765	173	27.5	173		1,478	21
22		ROOF		2000	16,000	582	27.5	582		4,389	22
23		COUNTERTOP SINK		2000	2,275	83	27.5	83		626	23
24		TILING		2000	600	22	27.5	22		166	24
25		TOILETS		2000	7,702	280	27.5	280		2,112	25
26		CLOSETS, DRYWALL, TILING		2000	4,600	167	27.5	167		1,260	26
27		SHELVES		2000	1,250	45	27.5	45		340	27
28		DRAPES		2000	1,040	58	7	48	(10)	1,040	28
29		DRAPES		2000	10,639	813	7	544	(269)	10,639	29
30		VINYL FLOORING		2000	17,233	1,316	7	854	(462)	17,233	30
31		WALL COVERING		2001	2,696		5			2,696	31
32		FLOOR TILE & VINYL		2001	12,481		5			12,481	32
33		CUBICLE CURTAINS		2001	5,873		5			5,873	33
34		DOOR LOCKING SYSTEM		2001	2,960	108	27.5	108		706	34
35		DIALYSIS ROOM		2001	19,931	725	27.5	725		4,743	35
36		SEPTIC INJECTOR		2001	3,004	109	27.5	109		713	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 4,900	37
38	SCREEN PORCH	2001	5,500	200	27.5	200		1,308	38
39	ELECTRONIC DOOR SCREEN FOR ELEVATOR	2001	6,887	250	27.5	250		1,636	39
40	BUILD WALLS, PAINTING, WOOD MOLDING	2001	5,700	207	27.5	207		1,354	40
41	FIRE ALARM SYSTEM	2002	12,867	468	27.5	468		2,593	41
42	CHAIR RAIL	2002	546	20	27.5	20		111	42
43	WATER HEATER	2002	2,229	81	27.5	81		449	43
44	GREASE TRAP	2002	1,050	38	27.5	38		211	44
45	SEWAGE EJECTOR PIT	2002	7,657	278	27.5	278		1,541	45
46	CODE ALERT WANDERING SYSTEM	2002	3,173	115	27.5	115		638	46
47	FLOORING, HANDRAILS, CORNER GUARD	2002	59,554	2,166	27.5	2,166		12,003	47
48	COVE BASE	2002	730	27	27.5	27		149	48
49	COVE BASE	2002	630	23	27.5	23		127	49
50	HANDRAILS, CORNER GUARDS	2002	7,947	289	27.5	289		1,602	50
51	WALLCOVERINGS	2002	3,578	144	5		(144)	3,578	51
52	PAINTING & WALLCOVERINGS	2002	6,572	265	5		(265)	6,572	52
53	WINDOW TREATMENTS	2002	3,722	150	5		(150)	3,722	53
54	WALLCOVERINGS, PAINTING	2002	19,304	778	5		(778)	19,304	54
55	WALLCOVERINGS	2002	2,277	92	5		(92)	2,277	55
56	WALLCOVERINGS, PAINTING	2002	12,600	508	5		(508)	12,600	56
57	WALLCOVERINGS	2002	2,277	92	5		(92)	2,277	57
58	GENERATOR	2003	40,000	1,455	27.5	1,455		6,608	58
59	FLOORING	2004	13,068	475	27.5	475		1,682	59
60	FIRE RATED CEILING TILE	2004	5,675	206	27.5	206		730	60
61	GREASE TRAP	2004	1,420	52	27.5	52		184	61
62	EXHAUST FAN	2004	867	32	27.5	32		113	62
63	HEAT EXCHANGER	2005	3,457	126	27.5	126		320	63
64	NEW SINK	2005	621	22	27.5	22		56	64
65	TILING	2005	1,726	63	27.5	63		160	65
66	3 NEW CIRCUITS	2005	1,996	73	27.5	73		185	66
67	SECURITY SYSTEM	2005	3,410	124	27.5	124		315	67
68	SMOKE DETECTING SYSTEM	2005	7,125	259	27.5	259		659	68
69	GENERATOR	2005	15,000	545	27.5	545		1,386	69
70	TOTAL (lines 4 thru 69)		\$ 453,848	\$ 16,717		\$ 13,947	\$ (2,770)	\$ 174,814	70

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	
1	Totals from Page 12A, Carried Forward		\$ 453,848	\$ 16,717		\$ 13,947	\$ (2,770)	\$ 174,814	1
2	DRAPERIES & VALANCES	2006	14,034	4,491	5	2,807	(1,684)	3,368	2
3	SMOKE DETECTORS	2006	6,070	221	27.5	221		304	3
4	GREASE TRAP	2006	1,550	56	27.5	56		77	4
5	FLOORING	2006	23,676	861	27.5	861		1,184	5
6	WATER SOFTENEN & MIXING VALVE	2006	2,074	76	27.5	76		104	6
7	HALLWAY DOOR ALARM	2006	672	24	27.5	24		33	7
8	WINDSHIELD SHELTER	2007	6,229	260	15	260		260	8
9	WOOD FENCE	2007	2,700	112	15	112		112	9
10	OUTDOOR DECK	2007	4,947	206	15	206		206	10
11	FLOORING	2007	9,758	133	27.5	133		133	11
12	ROOF	2007	3,000	41	27.5	41		41	12
13	INSTALL MIXING VALVE	2007	8,300	113	27.5	113		113	13
14	GENERATOR REPAIR	2007	3,489	48	27.5	48		48	14
15	WET FIRE PROTECTION SYSTEMS	2007	116,225	2,641	27.5	2,641		2,641	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)		\$ 656,572	\$ 26,000		\$ 21,546	\$ (4,454)	\$ 183,438	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	\$ 273,850	\$ 26,217	\$ 27,387	\$ 1,170	10 YRS	\$ 163,629	71
72	Current Year Purchases	20,428	4,086	1,021	(3,065)	10 YRS	1,021	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 294,278	\$ 30,303	\$ 28,408	\$ (1,895)		\$ 164,650	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2007 FORD ELDORADO VAN	2007	\$ 48,307	\$ 9,661	\$ 4,831	\$ (4,830)	5 YRS	\$ 4,831	76
77										77
78										78
79										79
80	TOTALS			\$ 48,307	\$ 9,661	\$ 4,831	\$ (4,830)		\$ 4,831	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)	\$ 999,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,964	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,785	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,179)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 352,919	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:	<u>135</u>	<u>01/01/96</u>	\$ <u>603,619</u>	<u>30</u>		3
4	Additions						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: \$ 28,747 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 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. /2008 \$ 603,619

13. /2009 \$ 603,619

14. /2010 \$ 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$		\$ 60,724	\$		\$ 60,724	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,295			25,295	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			170,861			170,861	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				162,797		162,797	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	inhalation therapy, radiology, lab Other (specify): <u>supplies, other svcs</u>	39-8 39-8				14,885 67,637	11,307		14,885 78,944	13
14	TOTAL			\$		\$ 339,402	\$ 174,104		\$ 513,506	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,925	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,279,402		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	127,900		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,482,038		8
9	Other(specify): RE Escrow, Emp Loan	5,269		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,897,534	\$	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	542,246		15
16	Equipment, at Historical Cost	456,911		16
17	Accumulated Depreciation (book methods)	(441,215)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 557,942	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,455,476	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,198,196	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	830,863		29
30	Accrued Salaries Payable	120,375		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,951		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,579		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)	\$ 2,230,964	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	115,543		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)	\$ 115,543	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,346,507	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,108,969	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,455,476	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,907,034	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,907,033	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,936	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	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 201,936	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)	\$ 2,108,969	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	\$ 5,745,867	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,745,867	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	282,004	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 282,004	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***	44	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ OF PRIOR YEAR INCOME	138,863	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 138,863	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,166,778	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,004,481	31
32	Health Care	2,274,106	32
33	General Administration	1,207,837	33
	B. Capital Expense		
34	Ownership	890,464	34
	C. Ancillary Expense		
35	Special Cost Centers	513,506	35
36	Provider Participation Fee	71,175	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,961,569	40
41	Income before Income Taxes (line 30 minus line 40)**	205,209	41
42	Income Taxes	(3,273)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 201,936	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: **01/01/2007**

Ending:

12/31/2007

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	2,784	3,090	\$ 135,331	\$ 43.80	1
2	Assistant Director of Nursing	403	403	10,999	27.29	2
3	Registered Nurses	11,470	12,027	312,851	26.01	3
4	Licensed Practical Nurses	20,201	21,879	552,032	25.23	4
5	CNAs & Orderlies	59,978	63,888	705,822	11.05	5
6	CNA Trainees					6
7	Licensed Therapist	2,508	2,665	69,297	26.00	7
8	Rehab/Therapy Aides	2,790	2,972	29,002	9.76	8
9	Activity Director	1,997	2,200	26,988	12.27	9
10	Activity Assistants	10,112	10,540	87,574	8.31	10
11	Social Service Workers	4,882	5,200	70,441	13.55	11
12	Dietician	3,684	4,180	53,054	12.69	12
13	Food Service Supervisor					13
14	Head Cook	2,457	2,787	44,017	15.79	14
15	Cook Helpers/Assistants	12,866	13,983	115,163	8.24	15
16	Dishwashers					16
17	Maintenance Workers	11,425	12,665	129,360	10.21	17
18	Housekeepers	14,524	16,016	134,380	8.39	18
19	Laundry	3,502	3,657	26,969	7.37	19
20	Administrator	1,961	2,194	96,079	43.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,887	12,900	179,396	13.91	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	2,788	3,021	42,173	13.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,219	196,267	\$ 2,820,928 *	\$ 14.37	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	\$ 7,649	1-3	35
36	Medical Director	O	19,000	9-3	36
37	Medical Records Consultant	N	600	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	723	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	1,880	11-3	44
45	Social Service Consultant	E	3,132	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,984		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		42,919	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$ 42,919		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JUDY Z BINDEN	ADMINISTRATOR	100	\$ 96,079	Workers' Compensation Insurance	\$ 76,244	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	41,129	Advertising: Employee Recruitment	2,307	
	OTHER ADMIN		0	FICA Taxes	211,236	Health Care Worker Background Check	1,574	
				Employee Health Insurance	41,273	(Indicate # of checks performed <u>90</u>)		
				Employee Meals	23,652	Patient Background Checks	100	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,400	
				EMPLOYEE BENEFITS - OTHER	3,383	MARKETING/ADV/PROMO	10,605	
				EMPLOYEE PHYSICAL EXAMS	5,450	LICENSES/DUES/SUBSCRIPTIONS	15,649	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,197	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,400)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(10,605)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,079	TOTAL (agree to Schedule V, line 22, col.8)	\$ 402,367	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,727	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
ASTA HEALTH CARE CO. MANAGEMENT FEES			\$ 249,144			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 249,144				Seminar Expense	910
							MANGEMENT COMP ALLOCATION	718
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 92,379	TOTAL		\$	TOTAL	\$ 1,628

* Attach copy of IMRF notifications

**See instructions.

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. ILLINOIS HEALTHCARE ASSOC \$8,554
- (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. \$ 35,000 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. \$ 23,652 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 \$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