

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>26,352</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,228</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>47,580</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>2,560</u>	<u>606</u>	<u>4,208</u>	<u>7,374</u>	8
9	SNF/PED					9
10	ICF	<u>28,717</u>	<u>1,439</u>	<u>595</u>	<u>30,751</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>31,277</u>	<u>2,045</u>	<u>4,803</u>	<u>38,125</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.13%

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 4,208

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	243,356	24,856	12,609	280,821		280,821		280,821		1
2	Food Purchase		219,539		219,539	(27,505)	192,034	(1,477)	190,557		2
3	Housekeeping	148,651	35,007		183,658		183,658		183,658		3
4	Laundry	46,840	8,839	3,399	59,078		59,078		59,078		4
5	Heat and Other Utilities			132,852	132,852		132,852		132,852		5
6	Maintenance	90,599	33,932	57,483	182,014		182,014	936	182,950		6
7	Other (specify):*			21,339	21,339		21,339		21,339		7
8	TOTAL General Services	529,446	322,173	227,682	1,079,301	(27,505)	1,051,796	(541)	1,051,255		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,841,988	160,979	5,126	2,008,093		2,008,093	8,778	2,016,871		10
10a	Therapy	81,003	109	2,121	83,233		83,233		83,233		10a
11	Activities	176,332	11,291	200	187,823		187,823		187,823		11
12	Social Services	98,762		4,762	103,524		103,524		103,524		12
13	CNA Training										13
14	Program Transportation			1,372	1,372		1,372		1,372		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,198,085	172,379	37,581	2,408,045		2,408,045	8,778	2,416,823		16
	C. General Administration										
17	Administrative	112,162		40,000	152,162		152,162	108,162	260,324		17
18	Directors Fees										18
19	Professional Services			68,050	68,050		68,050	1,954	70,004		19
20	Dues, Fees, Subscriptions & Promotions			28,875	28,875		28,875	(9,356)	19,519		20
21	Clerical & General Office Expenses	214,426	22,562	80,527	317,515		317,515	(46,948)	270,567		21
22	Employee Benefits & Payroll Taxes			402,189	402,189	27,505	429,694		429,694		22
23	Inservice Training & Education			904	904		904		904		23
24	Travel and Seminar							721	721		24
25	Other Admin. Staff Transportation			10,877	10,877		10,877	4,394	15,271		25
26	Insurance-Prop.Liab.Malpractice			111,264	111,264		111,264	2,256	113,520		26
27	Other (specify):*			44,173	44,173		44,173	(33,526)	10,647		27
28	TOTAL General Administration	326,588	22,562	786,859	1,136,009	27,505	1,163,514	27,657	1,191,171		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,054,119	517,114	1,052,122	4,623,355		4,623,355	35,894	4,659,249		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	8,824
	REPAIRS & MAINTENANCE	3,785
		0
		12,609
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,399
		0
		3,399
5	HEAT & OTHER UTILITIES	
	GAS HEAT	61,655
	ELECTRICITY	36,642
	WATER	32,218
	CABLE TV - LOBBY	2,337
		0
		132,852
6	MAINTENANCE	
	GROUNDS MAINTENANCE	9,295
	PAINTING & DECORATING	0
	BUILDING REPAIRS	10,066
	MAINTENANCE TRAVEL	49
	EQUIPMENT MAINTENANCE & REPAIR	33,438
	ELEVATOR MAINTENANCE & REPAIR	2,949
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	100
	FIRE SERVICE	1,586
		0
		0
		0
		0
		57,483
7	OTHER	
	SCAVENGER	21,339
	SECURITY SERVICE	0
		0
		0
		21,339
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	24,000
		24,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	2,347
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	927
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	600
	PHARMACY CONSULTANT XVIII B 39-2	1,252
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		5,126
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	2,121
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,121
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	200
		0
		200
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,762
		0
		4,762
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	1,372
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	40,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,419
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	56,631
		0
		68,050
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,401
	EMPLOYEE WANT ADS XIX F	3,077
	CONTRIBUTIONS VI 20 XIX F	3,600
	DUES & SUBSCRIPTIONS XIX F	7,466
	LICENSES & PERMITS XIX F	6,337
	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	624
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,370
	PATIENT BACKGROUND CHECKS XIX F	0
		28,875
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	7,756
	EQUIPMENT REPAIR & MAINTENANCE	150
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	47,667
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	24,212
	MESSENGER SERVICE	742
		0
		80,527

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	229,230
	UNEMPLOYMENT COMPENSATION XIX D	29,840
	WORKERS COMPENSATION INSURANC XIX D	101,432
	HOSPITALIZATION INSURANCE XIX D	33,460
	EMPLOYEE BENEFITS - OTHER XIX D	2,521
	EMPLOYEE PHYSICAL EXAMS XIX D	5,706
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		402,189
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	904
		904
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,877
		10,877
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	111,264
		111,264
27	OTHER	
	BAD DEBTS VI 24	44,173
		44,173

GRAND TOTAL COLUMN 3 OTHER

1,052,122

**ASTA CARE CENTER OF ROCKFORD
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	219,539
LESS SALES TAX	<u>(1,477)</u>
NET FOOD	218,062

TOTAL PATIENT CENSUS	38,125
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	114,375

ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	16,470

PATIENT MEALS	114,375
ADD EMPLOYEE MEALS	<u>16,470</u>
TOTAL MEALS/YEAR	130,845

NET FOOD	218,062
DIVIDE TOTAL MEALS/YEAR	<u>130,845</u>

COST PER MEAL	1.67
TIME EMPLOYEE MEALS	<u>16,470</u>
EMPLOYEE MEAL RECLASSIFICATION	27,505

=====

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

#0041772

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			68,638	68,638		68,638	(10,789)	57,849			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,144	102,144		102,144	(2,325)	99,819			32
33	Real Estate Taxes			68,719	68,719		68,719		68,719			33
34	Rent-Facility & Grounds			603,619	603,619		603,619		603,619			34
35	Rent-Equipment & Vehicles			13,171	13,171		13,171	625	13,796			35
36	Other (specify):*											36
37	TOTAL Ownership			856,291	856,291		856,291	(12,489)	843,802			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		235,746	342,538	578,284		578,284		578,284			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,370	71,370		71,370		71,370			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		235,746	413,908	649,654		649,654		649,654			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,054,119	752,860	2,322,321	6,129,300		6,129,300	23,405	6,152,705			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	(10,789)	30		9
10	Interest and Other Investment Income	(116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,477)	2		13
14	Non-Care Related Interest	(2,209)	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	(47,667)	21		18
19	Entertainment		20		19
20	Contributions	(4,224)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(198)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,173)	27		24
25	Fund Raising, Advertising and Promotional	(6,401)	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	(20,072)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (137,326)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	160,731		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 160,731		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 23,405		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						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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	MARKETING TRAVEL	(3,987)	25	2
3	MARKETING SALARY	(16,085)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(20,072)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(1,477)	0	0	0	0	0	0	0	0	0	0	(1,477)	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	936	0	0	0	0	0	0	0	0	0	936	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,477)	936	0	(541)	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	8,778	0	0	0	0	0	0	0	0	0	8,778	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	8,778	0	8,778	16								
	C. General Administration													
17	Administrative	0	108,162	0	0	0	0	0	0	0	0	0	108,162	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(198)	2,152	0	0	0	0	0	0	0	0	0	1,954	19
20	Fees, Subscriptions & Promotions	(10,625)	1,269	0	0	0	0	0	0	0	0	0	(9,356)	20
21	Clerical & General Office Expenses	(63,752)	16,804	0	0	0	0	0	0	0	0	0	(46,948)	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	721	0	0	0	0	0	0	0	0	0	721	24
25	Other Admin. Staff Transportation	(3,987)	8,381	0	0	0	0	0	0	0	0	0	4,394	25
26	Insurance-Prop.Liab.Malpractice	0	2,256	0	0	0	0	0	0	0	0	0	2,256	26
27	Other (specify):*	(44,173)	10,647	0	0	0	0	0	0	0	0	0	(33,526)	27
28	TOTAL General Administration	(122,735)	150,392	0	27,657	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(124,212)	160,106	0	35,894	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(10,789)	0	0	0	0	0	0	0	0	0	0	(10,789)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,325)	0	0	0	0	0	0	0	0	0	0	(2,325)	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	625	0	0	0	0	0	0	0	0	0	625	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(13,114)	625	0	(12,489)	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)	(137,326)	160,731	0	23,405	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	\$ 40,000	ASTA HEALTHCARE COMPANY		\$ (40,000)	1
2	V	6	MAINTENANCE			936	936	2
3	V	10	NURSING			8,778	8,778	3
4	V	17	ADMINISTRATIVE			148,162	148,162	4
5	V	19	PROFESSIONAL FEES			2,152	2,152	5
6	V	20	LICENSES & PERMITS			1,269	1,269	6
7	V	21	OFFICE EXPENSE			16,804	16,804	7
8	V	24	SEMINARS			721	721	8
9	V	25	STAFF TRANS/ TRAVEL			8,381	8,381	9
10	V	26	INSURANCE GEN / WC			2,256	2,256	10
11	V	27	PAYR. TAXES & GRP INS			10,647	10,647	11
12	V	35	EQUIPMENT RENTAL			625	625	12
13	V							13
14	Total		\$ 40,000			\$ 200,731	\$ * 160,731	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: 01/01/2008 Ending: 12/31/2008

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	LIST	ATTACHED	SALARY	\$ 40,220	17-7	1
2											2
3	SETH GILLMAN			7.50	LIST ATTACHED	LIST	ATTACHED	SALARY	25,322	17-7	3
4	PROFESSIONAL FEE FOR WOUND BILLING (BLOOMINGTON) \$3,964										4
5	SALARY FROM ASTA CARE OF TOLUCA \$31,317										5
6											6
7	CRAIG FRANK				LIST ATTACHED	LIST	ATTACHED	SALARY	31,197	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,572										8
9											9
10	DAVID MEISELMAN				LIST ATTACHED	LIST	ATTACHED	SALARY	2,499	17-7	10
11	SALARY FROM ASTA CARE OF ELGIN \$233,408										11
12	ALIZA FRANK			7.50	LIST ATTACHED	LIST	ATTACHED	SALARY	6,721	21-7	12
13								TOTAL	\$ 105,959		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:

01/01/2008

Ending: 2/31/2008

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	184,841	6	\$ 4,539	\$ 38,125	\$ 936	1
2	10	NURSING	PATIENT DAYS	184,841	6	42,560	42,560	8,778	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	184,841	6	195,000	195,000	40,220	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	184,841	6	122,770	122,770	25,322	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	184,841	6	151,251	151,251	31,197	5
6	17	ADMIN. SALARY - DM	PATIENT DAYS	184,841	6	12,117	12,117	2,499	6
7	17	ADMIN. SALARY	PATIENT DAYS	184,841	6	184,098	184,098	37,972	7
8	17	OUTSIDE CLERICAL	PATIENT DAYS	184,841	6	53,100	38,125	10,952	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	184,841	6	10,435	38,125	2,152	9
10	20	LICENSES & PERMITS	PATIENT DAYS	184,841	6	6,154	38,125	1,269	10
11	21	OFFICE EXPENSE	PATIENT DAYS	184,841	6	48,883	5,629	10,083	11
12	21	CLERICAL SALARY-AF	PATIENT DAYS	184,841	6	32,584	32,584	6,721	12
13	24	SEMINARS	PATIENT DAYS	184,841	6	3,497	38,125	721	13
14	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	184,841	6	40,634	38,125	8,381	14
15	26	INSURANCE GEN / WC	PATIENT DAYS	184,841	6	10,938	38,125	2,256	15
16	27	PAYR. TAXES & GRP INS	PATIENT DAYS	184,841	6	51,620	38,125	10,647	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	184,841	6	3,029	38,125	625	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 973,209	\$ 746,009	\$ 200,731	25

Facility Name & ID Number

ASTA CARE CENTER OF ROCKFORD

0041772

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	Name of Lender	2		3	4	5	6		7	8	9	10
		Related**					Purpose of Loan	Monthly Payment Required				
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3	INSURANCE POLICIES										3,786	3
4	HARRIS BANK - MEMBER			MCDANIEL FIRE SYSTEM	\$2,529.52	3/01/07	116,225	82,574	3/01/12	0.1104	12,624	4
5	NAVISTAR		X	VAN PURCHASE	\$995.75	4/01/07	48,307	32,722	3/21/12	0.0870	3,116	5
	Working Capital											
6	FIRST BANK		X	WORKING CAPITAL	INT	REVOLV		869,724	REVOLV	PRIME +	51,136	6
7	HARRIS BANK - MEMBER										4,523	7
8	HOLT HEALTHCARE CTR										24,750	8
9	TOTAL Facility Related				\$3,525.27		\$ 164,532	\$ 985,020			\$ 99,935	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12	PART FEE			LATE FEE							1,774	12
13	MISC			LATE FEES							435	13
14	TOTAL Non-Facility Related						\$	\$			\$ 2,209	14
15	TOTALS (line 9+line14)						\$ 164,532	\$ 985,020			\$ 102,144	15

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 2007 report.

\$ **62,579** 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.)

\$ **65,649** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **3,070** 3

4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **65,649** 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.

\$ **68,719** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	55,114	8
	2004	58,763	9
	2005	61,486	10
	2006	62,578	11
	2007	65,649	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

	(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>65,648.58</u>	\$ <u>65,648.58</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>65,648.58</u>	\$ <u>65,648.58</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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:

01/01/2008 Ending: 12/31/2008

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		4,328	9
10		FIRE PANEL		1997	1,691	43	39	43		475	10
11		ROOF		1997	4,035	104	39	104		1,148	11
12		TWO BATHROOMS		1998	4,615	118	39	118		1,254	12
13		COOLING TOWER		1998	7,552	194	39	194		1,964	13
14		PLUMBING - GREASE TRAP		1999	1,024	37	27.5	37		353	14
15		PLUMBING - NEW SINKS		1999	1,321	48	27.5	48		458	15
16		HOT WATER HEATER		1999	2,955	107	27.5	107		1,021	16
17		HEAT EXCHANGE		1999	2,298	84	27.5	84		801	17
18		NEW BATHROOMS		1999	9,975	363	27.5	363		3,463	18
19		NEW CEILING		1999	1,841	67	27.5	67		639	19
20		NURSE CALL SYSTEM		1999	8,437	307	27.5	307		2,929	20
21		NEW COOLING TOWER		1999	4,765	173	27.5	173		1,651	21
22		ROOF		2000	16,000	582	27.5	582		4,971	22
23		COUNTERTOP SINK		2000	2,275	83	27.5	83		709	23
24		TILING		2000	600	22	27.5	22		188	24
25		TOILETS		2000	7,702	280	27.5	280		2,392	25
26		CLOSETS, DRYWALL, TILING		2000	4,600	167	27.5	167		1,427	26
27		SHELVES		2000	1,250	45	27.5	45		385	27
28		DRAPES		2000	1,040		7			1,040	28
29		DRAPES		2000	10,639		7			10,639	29
30		VINYL FLOORING		2000	17,233		7			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		814	34
35		DIALYSIS ROOM		2001	19,931	725	27.5	725		5,468	35
36		SEPTIC INJECTOR		2001	3,004	109	27.5	109		822	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$	\$ 5,649	37
38	SCREEN PORCH	2001	5,500	200	27.5	200		1,508	38
39	ELECTRONIC DOOR SCREEN FOR ELEVATOR	2001	6,887	250	27.5	250		1,886	39
40	BUILD WALLS, PAINTING, WOOD MOLDING	2001	5,700	207	27.5	207		1,561	40
41	FIRE ALARM SYSTEM	2002	12,867	468	27.5	468		3,061	41
42	CHAIR RAIL	2002	546	20	27.5	20		131	42
43	WATER HEATER	2002	2,229	81	27.5	81		530	43
44	GREASE TRAP	2002	1,050	38	27.5	38		249	44
45	SEWAGE EJECTOR PIT	2002	7,657	278	27.5	278		1,819	45
46	CODE ALERT WANDERING SYSTEM	2002	3,173	115	27.5	115		753	46
47	FLOORING, HANDRAILS, CORNER GUARD	2002	59,554	2,166	27.5	2,166		14,169	47
48	COVE BASE	2002	730	27	27.5	27		176	48
49	COVE BASE	2002	630	23	27.5	23		150	49
50	HANDRAILS, CORNER GUARDS	2002	7,947	289	27.5	289		1,891	50
51	WALLCOVERINGS	2002	3,578		5			3,578	51
52	PAINTING & WALLCOVERINGS	2002	6,572		5			6,572	52
53	WINDOW TREATMENTS	2002	3,722		5			3,722	53
54	WALLCOVERINGS, PAINTING	2002	19,304		5			19,304	54
55	WALLCOVERINGS	2002	2,277		5			2,277	55
56	WALLCOVERINGS, PAINTING	2002	12,600		5			12,600	56
57	WALLCOVERINGS	2002	2,277		5			2,277	57
58	GENERATOR	2003	40,000	1,455	27.5	1,455		8,063	58
59	FLOORING	2004	13,068	475	27.5	475		2,157	59
60	FIRE RATED CEILING TILE	2004	5,675	206	27.5	206		936	60
61	GREASE TRAP	2004	1,420	52	27.5	52		236	61
62	EXHAUST FAN	2004	867	32	27.5	32		145	62
63	HEAT EXCHANGER	2005	3,457	126	27.5	126		446	63
64	NEW SINK	2005	621	22	27.5	22		78	64
65	TILING	2005	1,726	63	27.5	63		223	65
66	3 NEW CIRCUITS	2005	1,996	73	27.5	73		258	66
67	SECURITY SYSTEM	2005	3,410	124	27.5	124		439	67
68	SMOKE DETECTING SYSTEM	2005	7,125	259	27.5	259		918	68
69	GENERATOR	2005	15,000	545	27.5	545		1,931	69
70	TOTAL (lines 4 thru 69)		\$ 453,848	\$ 12,501		\$ 12,501	\$	\$ 187,315	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:

01/01/2008 Ending: 12/31/2008

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	\$ 12,501		\$ 12,501	\$	\$ 187,315	1
2	DRAPERIES & VALANCES	2006	14,034	2,695	5	2,807	112	6,175	2
3	SMOKE DETECTORS	2006	6,070	221	27.5	221		525	3
4	GREASE TRAP	2006	1,550	56	27.5	56		133	4
5	FLOORING	2006	23,676	861	27.5	861		2,045	5
6	WATER SOFTENEN & MIXING VALVE	2006	2,074	76	27.5	76		180	6
7	HALLWAY DOOR ALARM	2006	672	24	27.5	24		57	7
8	WINDSHIELD SHELTER	2007	6,229	415	15	415		675	8
9	WOOD FENCE	2007	2,700	180	15	180		292	9
10	OUTDOOR DECK	2007	4,947	330	15	330		536	10
11	FLOORING	2007	9,758	355	27.5	355		488	11
12	ROOF	2007	3,000	109	27.5	109		150	12
13	INSTALL MIXING VALVE	2007	8,300	302	27.5	302		415	13
14	GENERATOR REPAIR	2007	3,489	127	27.5	127		175	14
15	WET FIRE PROTECTION SYSTEMS	2007	116,225	4,226	27.5	4,226		6,867	15
16	SIGN	2008	5,000	167	15	167		167	16
17	WALK IN COOLER	2008	26,405	600	27.5	600		600	17
18	MODIFICATION OF FIRE ALARM SYSTEM	2008	9,218	209	27.5	209		209	18
19	DOORS	2008	4,125	94	27.5	94		94	19
20	WINDOWS	2008	2,595	59	27.5	59		59	20
21	SEWAGE PUMP	2008	4,564	104	27.5	104		104	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)		\$ 708,479	\$ 23,711		\$ 23,823	\$ 112	\$ 207,261	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	\$ 259,858	\$ 21,026	\$ 23,661	\$ 2,635	10 YRS	\$ 153,889	71
72	Current Year Purchases	14,071	8,443	704	(7,739)	10 YRS	704	72
73	Fully Depreciated Assets	34,420					34,420	73
74								74
75	TOTALS	\$ 308,349	\$ 29,469	\$ 24,365	\$ (5,104)		\$ 189,013	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	\$ 15,458	\$ 9,661	\$ (5,797)	5 YRS	\$ 14,492	76
77										77
78										78
79										79
80	TOTALS			\$ 48,307	\$ 15,458	\$ 9,661	\$ (5,797)		\$ 14,492	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)	\$ 1,065,135	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,638	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,849	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,789)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 410,766	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>603,619</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>603,619</u>			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: \$ 13,171 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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	\$		\$ 64,121	\$		\$ 64,121	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			40,779			40,779	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			226,683			226,683	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				219,774		219,774	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Radiology</u>					10,955			10,955	12
13	Other (specify): <u>Supplies</u>						15,972		15,972	13
14	TOTAL			\$		\$ 342,538	\$ 235,746		\$ 578,284	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: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 360,399	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,794,253		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,482		6
7	Other Prepaid Expenses	18,754		7
8	Accounts Receivable (owners or related parties)	2,767,137		8
9	Other(specify): EMPL LOANS	5,068		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,987,093	\$	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	708,479		15
16	Equipment, at Historical Cost	356,656		16
17	Accumulated Depreciation (book methods)	(509,853)		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)	\$ 555,282	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,542,375	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,287,617	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	898,409		29
30	Accrued Salaries Payable	141,559		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,264		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,649		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)	\$ 3,410,498	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	87,611		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)	\$ 87,611	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,498,109	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,044,266	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,542,375	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,108,969	1
2	Restatements (describe):		2
3			3
4	ROUNDING	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,108,968	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(64,702)	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)	\$ (64,702)	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)	\$ 2,044,266	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	\$ 5,684,634	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,684,634	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	227,214	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 227,214	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***	116	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 116	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other expense adj - out of period</u>	153,607	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 153,607	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,065,571	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,079,301	31
32	Health Care	2,408,045	32
33	General Administration	1,136,009	33
	B. Capital Expense		
34	Ownership	856,291	34
	C. Ancillary Expense		
35	Special Cost Centers	578,284	35
36	Provider Participation Fee	71,370	36
	D. Other Expenses (specify):		
37	<u>OUT-OF-PERIOD EXPENSES</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,129,300	40
41	Income before Income Taxes (line 30 minus line 40)**	(63,729)	41
42	Income Taxes	(973)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (64,702)	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: 01/01/2008

Ending: 12/31/2008

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	2,631	2,956	\$ 136,700	\$ 46.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,712	8,108	233,526	28.80	3
4	Licensed Practical Nurses	23,251	25,184	663,253	26.34	4
5	CNAs & Orderlies	62,113	66,920	769,583	11.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,078	4,350	81,003	18.62	8
9	Activity Director	1,994	2,185	28,418	13.01	9
10	Activity Assistants	12,418	13,778	147,914	10.74	10
11	Social Service Workers	7,972	8,588	98,762	11.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,014	23,358	243,356	10.42	15
16	Dishwashers					16
17	Maintenance Workers	7,735	8,158	90,599	11.11	17
18	Housekeepers	15,403	16,958	148,651	8.77	18
19	Laundry	5,375	5,785	46,840	8.10	19
20	Administrator	1,978	2,311	112,162	48.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,310	14,617	214,426	14.67	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	2,416	2,653	38,926	14.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,400	205,909	\$ 3,054,119 *	\$ 14.83	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	\$ 8,824	1-3	35
36	Medical Director	O	24,000	9-3	36
37	Medical Records Consultant	N	600	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,252	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		2,121	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	200	11-3	44
45	Social Service Consultant	E	4,762	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,759		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		2,347	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$ 2,347		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 ZBINDEN	ADMINISTRATOR	0	\$ 112,162	Workers' Compensation Insurance	\$ 101,432	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	29,840	Advertising: Employee Recruitment	3,077	
	OTHER ADMIN		0	FICA Taxes	229,230	Health Care Worker Background Check	1,370	
				Employee Health Insurance	33,460	(Indicate # of checks performed _____)		
				Employee Meals	27,505	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,224	
				EMPLOYEE BENEFITS - OTHER	2,521	MARKETING/ADV/PROMO	6,401	
				EMPLOYEE PHYSICAL EXAMS	5,706	LICENSES/DUES/SUBSCRIPTIONS	13,803	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,269	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,224)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(6,401)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 112,162	TOTAL (agree to Schedule V, line 22, col.8)	\$ 429,694	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,519	
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			\$ 40,000			\$	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)			\$ 40,000				Seminar Expense	0
							MGMT CO ALLOC	721
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 721
SEE SCHEDULE ATTACHED			68,050					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 68,050	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD# 0041772Report Period Beginning: 01/01/2008Ending: 12/31/2008**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. \$7,176
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,187 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. \$ 71,370
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. \$ 27,505 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