

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	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	3,888	366	3,152	7,406	8
9	SNF/PED					9
10	ICF	26,924	1,012	1,140	29,076	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,812	1,378	4,292	36,482	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.89%

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 69 and days of care provided 3,152

Medicare Intermediary NATIONAL GORVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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	252,559	19,860	14,229	286,648		286,648	286,648		1	
2	Food Purchase		199,467		199,467	(18,068)	181,399	(1,376)	180,023	2	
3	Housekeeping	162,816	34,729		197,545		197,545		197,545	3	
4	Laundry	38,087	10,260	2,015	50,362		50,362		50,362	4	
5	Heat and Other Utilities			106,848	106,848		106,848		106,848	5	
6	Maintenance	85,729	23,025	30,545	139,299		139,299	1,044	140,343	6	
7	Other (specify):*			25,758	25,758		25,758		25,758	7	
8	TOTAL General Services	539,191	287,341	179,395	1,005,927	(18,068)	987,859	(332)	987,527	8	
	B. Health Care and Programs										
9	Medical Director			38,250	38,250		38,250		38,250	9	
10	Nursing and Medical Records	1,854,365	162,690	2,495	2,019,550		2,019,550	2,658	2,022,208	10	
10a	Therapy	158,542			158,542		158,542		158,542	10a	
11	Activities	171,225	8,388	2,080	181,693		181,693		181,693	11	
12	Social Services	112,540			112,540		112,540		112,540	12	
13	CNA Training									13	
14	Program Transportation			1,651	1,651		1,651		1,651	14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	2,296,672	171,078	44,476	2,512,226		2,512,226	2,658	2,514,884	16	
	C. General Administration										
17	Administrative	118,217	31,870	250,000	400,087		400,087	(144,882)	255,205	17	
18	Directors Fees									18	
19	Professional Services			99,426	99,426		99,426	(3,994)	95,432	19	
20	Dues, Fees, Subscriptions & Promotions			21,538	21,538		21,538	(8,001)	13,537	20	
21	Clerical & General Office Expenses	208,111		103,795	311,906		311,906	(60,485)	251,421	21	
22	Employee Benefits & Payroll Taxes			389,032	389,032	18,068	407,100		407,100	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			1,540	1,540		1,540	56	1,596	24	
25	Other Admin. Staff Transportation			7,622	7,622		7,622	4,694	12,316	25	
26	Insurance-Prop.Liab.Malpractice			119,505	119,505		119,505	1,885	121,390	26	
27	Other (specify):*			36,888	36,888		36,888	(27,655)	9,233	27	
28	TOTAL General Administration	326,328	31,870	1,029,346	1,387,544	18,068	1,405,612	(238,382)	1,167,230	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,162,191	490,289	1,253,217	4,905,697		4,905,697	(236,056)	4,669,641	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	10,237
	REPAIRS & MAINTENANCE	3,992
		0
		14,229
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,015
		0
		2,015
5	HEAT & OTHER UTILITIES	
	GAS HEAT	40,303
	ELECTRICITY	25,572
	WATER	35,190
	CABLE TV - LOBBY	5,783
		0
		106,848
6	MAINTENANCE	
	GROUNDS MAINTENANCE	9,793
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	13,673
	ELEVATOR MAINTENANCE & REPAIR	3,316
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	3,763
		0
		0
		0
		0
		30,545
7	OTHER	
	SCAVENGER	25,045
	SECURITY SERVICE	713
		0
		0
		25,758
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	38,250
		38,250

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	200
	PHARMACY CONSULTANT XVIII B 39-2	1,210
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	1,085
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		2,495
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 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	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,080
		0
		2,080
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,651
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	250,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	17,903
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	81,523
		0
		99,426
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,805
	EMPLOYEE WANT ADS XIX F	551
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	4,955
	LICENSES & PERMITS XIX F	3,499
	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	2,545
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,183
	PATIENT BACKGROUND CHECKS XIX F	2,000
		21,538
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	7,405
	EQUIPMENT REPAIR & MAINTENANCE	103
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	72,759
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	108
	TELEPHONE	23,420
	MESSENGER SERVICE	0
		0
		103,795

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	238,492
	UNEMPLOYMENT COMPENSATION XIX D	29,496
	WORKERS COMPENSATION INSURANC XIX D	58,506
	HOSPITALIZATION INSURANCE XIX D	56,390
	EMPLOYEE BENEFITS - OTHER XIX D	2,144
	EMPLOYEE PHYSICAL EXAMS XIX D	4,004
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		389,032
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,540
	TRAVEL XIX G	0
		1,540
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,622
		7,622
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	119,505
		119,505
27	OTHER	
	BAD DEBTS VI 24	36,888
		36,888

GRAND TOTAL COLUMN 3 OTHER **1,253,217**

ASTA CARE CENTER OF ROCKFORD
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	199,467
LESS SALES TAX	<u>(1,376)</u>
NET FOOD	198,091

TOTAL PATIENT CENSUS	36,482
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	109,446

ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	10,950

PATIENT MEALS	109,446
ADD EMPLOYEE MEALS	<u>10,950</u>
TOTAL MEALS/YEAR	120,396

NET FOOD	198,091
DIVIDE TOTAL MEALS/YEAR	<u>120,396</u>

COST PER MEAL	1.65
TIME EMPLOYEE MEALS	<u>10,950</u>
EMPLOYEE MEAL RECLASSIFICATION	18,068

=====

Facility Name & ID Number

ASTA CARE CENTER OF ROCKFORD

#0041772

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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			47,449	47,449		47,449	49,630	97,079			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			160,673	160,673		160,673	(1,774)	158,899			32
33	Real Estate Taxes			74,177	74,177		74,177		74,177			33
34	Rent-Facility & Grounds			597,797	597,797		597,797	(90,000)	507,797			34
35	Rent-Equipment & Vehicles			23,165	23,165		23,165		23,165			35
36	Other (specify):*											36
37	TOTAL Ownership			903,261	903,261		903,261	(42,144)	861,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		174,004	350,000	524,004		524,004		524,004			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		174,004	421,175	595,179		595,179		595,179			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,162,191	664,293	2,577,653	6,404,137		6,404,137	(278,200)	6,125,937			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	9,893	30		9
10	Interest and Other Investment Income	(13,518)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,376)	2		13
14	Non-Care Related Interest	(11,026)	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	(72,759)	21		18
19	Entertainment		20		19
20	Contributions	(2,545)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,888)	27		24
25	Fund Raising, Advertising and Promotional	(6,805)	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	(40,865)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (175,889)		\$	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)	(102,311)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (102,311)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (278,200)		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: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	MARKETING TRAVEL	(4,141)	25	2
3	COLLECTION FEE	(1,804)	19	3
4	MARKETING SALARY	(32,420)	21	4
5	WOUND CARE BILLING	(2,500)	19	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		(40,865)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,376)	0	0	0	0	0	0	0	0	0	0	(1,376)	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	1,044	0	0	0	0	0	0	0	0	0	1,044	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,376)	1,044	0	(332)	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	2,658	0	0	0	0	0	0	0	0	0	2,658	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	2,658	0	2,658	16								
	C. General Administration													
17	Administrative	0	(144,882)	0	0	0	0	0	0	0	0	0	(144,882)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,304)	310	0	0	0	0	0	0	0	0	0	(3,994)	19
20	Fees, Subscriptions & Promotions	(9,350)	1,349	0	0	0	0	0	0	0	0	0	(8,001)	20
21	Clerical & General Office Expenses	(105,179)	44,694	0	0	0	0	0	0	0	0	0	(60,485)	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	56	0	0	0	0	0	0	0	0	0	56	24
25	Other Admin. Staff Transportation	(4,141)	8,835	0	0	0	0	0	0	0	0	0	4,694	25
26	Insurance-Prop.Liab.Malpractice	0	1,885	0	0	0	0	0	0	0	0	0	1,885	26
27	Other (specify):*	(36,888)	9,233	0	0	0	0	0	0	0	0	0	(27,655)	27
28	TOTAL General Administration	(159,862)	(78,520)	0	(238,382)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(161,238)	(74,818)	0	(236,056)	29								

STATE OF ILLINOIS

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

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	9,893	0	39,737	0	0	0	0	0	0	0	0	49,630	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,544)	0	22,770	0	0	0	0	0	0	0	0	(1,774)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(90,000)	0	0	0	0	0	0	0	0	(90,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,651)	0	(27,493)	0	(42,144)	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)	(175,889)	(74,818)	(27,493)	0	(278,200)	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	\$ 250,000	ASTA HEALTHCARE COMPANY		\$ (250,000)	1
2	V	6	MAINTENANCE			1,044	1,044	2
3	V	10	NURSING			2,658	2,658	3
4	V	17	ADMINISTRATIVE			105,118	105,118	4
5	V	19	PROFESSIONAL FEES			310	310	5
6	V	20	LICENSES & PERMITS			1,349	1,349	6
7	V	21	OFFICE EXPENSE			44,694	44,694	7
8	V	24	SEMINARS			56	56	8
9	V	25	STAFF TRANS/ TRAVEL			8,835	8,835	9
10	V	26	INSURANCE GEN / WC			1,885	1,885	10
11	V	27	PAYR. TAXES & GRP INS			9,233	9,233	11
12	V							12
13	V							13
14	Total		\$ 250,000			\$ 175,182	\$ * (74,818)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 90,000	ASTA ROCKFORD PROPERTIES		\$	\$ (90,000)
16	V	30 DEPRECIATION				39,737	39,737
17	V	32 INTEREST				22,770	22,770
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 90,000			\$ 62,507	\$ * (27,493)

* 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: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN							SALARY	\$ 39,869	17-7	1
2											2
3	SETH GILLMAN							SALARY	1,381	17-7	3
4											4
5											5
6					SEE	SEE					6
7	CRAIG FRANK				ATTACHED	ATTACHED		SALARY	33,608	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,333				SCHEDULE	SCHEDULE					8
9											9
10											10
11											11
12	ALIZA FRANK							SALARY	6,952	17-7	12
13								TOTAL	\$ 81,810		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: 01/01/2009

Ending: 2/31/2009

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	6	MAINTENANCE	PATIENT DAYS	178,434	6	\$ 5,107	\$ 36,482	\$ 1,044	1	
2	10	NURSING	PATIENT DAYS	178,434	6	13,000	13,000	36,482	2,658	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	178,434	6	195,000	195,000	36,482	39,869	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	178,434	6	6,755	6,755	36,482	1,381	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	178,434	6	164,375	164,375	36,482	33,608	5
6	17	ADMIN. SALARY -AF	PATIENT DAYS	178,434	6	34,000	34,000	36,482	6,952	6
7	17	ADMIN. SALARY- JS	PATIENT DAYS	178,434	6	114,000	114,000	36,482	23,308	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,434	6	1,518		36,482	310	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,434	6	6,596		36,482	1,349	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,434	6	218,597	139,019	36,482	44,694	10
11	24	SEMINARS	PATIENT DAYS	178,434	6	275		36,482	56	11
12	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	178,434	6	43,211		36,482	8,835	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,434	6	9,222		36,482	1,885	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,434	6	45,157		36,482	9,233	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 856,813	\$ 666,149	\$ 175,182		25

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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 ROCKFORD PROPERTIES
 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	30	DEPRECIATION	DIRECT COST	1	1	\$ 39,737	1	\$ 39,737	1
2	32	INTEREST	DIRECT COST	1	1	22,770	1	22,770	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 62,507	\$	\$ 62,507	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	related party- Cole Taylor		X	MORTGAGE	\$34,000.00	10/29/09	\$ 3,600,000	\$ 3,585,643	10/29/14	0.0350	\$ 22,770	1						
2	COLE TAYLOR		X	WORKING CAPITAL	INT ONLY	10/29/09	612,000	612,000		0.0600	6,528	2						
3	INSURANCE POLICIES										3,971	3						
4	HARRIS BANK		X	MCDANIEL FIRE SYSTEM	\$2,529.52	3/01/07	116,225	60,230	3/01/12	0.1104	14,714	4						
5	NAVISTAR		X	VAN PUTCHASE	\$995.75	4/01/07	48,307	24,338	3/21/12	0.0870	2,942	5						
Working Capital																		
6	FIRST BANK		X	WORKING CAPITAL	INT	REVOLV			REVOLV	PRIME +	83,451	6						
7	HOLT HEALTHCARE										35,827	7						
8	MICHAEL GILLMAN	X									2,214	8						
9	TOTAL Facility Related				\$37,525.27		\$ 4,376,532	\$ 4,282,211			\$ 172,417	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11	BED TAX		X								11,026	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 11,026	14						
15	TOTALS (line 9+line14)						\$ 4,376,532	\$ 4,282,211			\$ 183,443	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

1. Real Estate Tax accrual used on 2008 report.		\$	65,649	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.)		\$	69,913	2
3. Under or (over) accrual (line 2 minus line 1).		\$	4,264	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	69,913	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.		\$	74,177	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	58,763	8	
	2005	61,486	9	
	2006	62,578	10	
	2007	65,649	11	
	2008	69,913	12	

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL				

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$		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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>69,912.96</u>	\$ <u>69,912.96</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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	NURSING HOME		2009	\$ 667,500	1
2					2
3	TOTALS			\$ 667,500	3

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**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	130		2010		\$ 3,529,325	\$ 26,737	27.5	\$ 26,737	\$	\$ 26,737	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		NURSES STATION	1997		15,290	392	39	392		4,720	9
10		FIRE PANEL	1997		1,691	43	39	43		518	10
11		ROOF	1997		4,035	104	39	104		1,252	11
12		TWO BATHROOMS	1998		4,615	118	39	118		1,372	12
13		COOLING TOWER	1998		7,552	194	39	194		2,158	13
14		PLUMBING - GREASE TRAP	1999		1,024	37	27.5	37		390	14
15		PLUMBING - NEW SINKS	1999		1,321	48	27.5	48		506	15
16		HOT WATER HEATER	1999		2,955	107	27.5	107		1,128	16
17		HEAT EXCHANGE	1999		2,298	84	27.5	84		885	17
18		NEW BATHROOMS	1999		9,975	363	27.5	363		3,826	18
19		NEW CEILING	1999		1,841	67	27.5	67		706	19
20		NURSE CALL SYSTEM	1999		8,437	307	27.5	307		3,236	20
21		NEW COOLING TOWER	1999		4,765	173	27.5	173		1,824	21
22		ROOF	2000		16,000	582	27.5	582		5,553	22
23		COUNTRYOP SINK	2000		2,275	83	27.5	83		792	23
24		TILING	2000		600	22	27.5	22		210	24
25		TOILETS	2000		7,702	280	27.5	280		2,672	25
26		CLOSETS, DRYWALL, TILING	2000		4,600	167	27.5	167		1,594	26
27		SHELVES	2000		1,250	45	27.5	45		430	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		922	34
35		DIALYSIS ROOM	2001		19,931	725	27.5	725		6,193	35
36		SEPTIC INJECTOR	2001		3,004	109	27.5	109		931	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:

01/01/2009 Ending: 12/31/2009

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	\$	\$ 6,398	37
38	SCREEN PORCH	2001	5,500	200	27.5	200		1,708	38
39	ELECTRONIC DOOR SCREEN FOR ELEVATOR	2001	6,887	250	27.5	250		2,136	39
40	BUILD WALLS, PAINTING, WOOD MOLDING	2001	5,700	207	27.5	207		1,768	40
41	FIRE ALARM SYSTEM	2002	12,867	468	27.5	468		3,529	41
42	CHAIR RAIL	2002	546	20	27.5	20		151	42
43	WATER HEATER	2002	2,229	81	27.5	81		611	43
44	GREASE TRAP	2002	1,050	38	27.5	38		287	44
45	SEWAGE EJECTOR PIT	2002	7,657	278	27.5	278		2,097	45
46	CODE ALERT WANDERING SYSTEM	2002	3,173	115	27.5	115		868	46
47	FLOORING, HANDRAILS, CORNER GUARD	2002	59,554	2,166	27.5	2,166		16,335	47
48	COVE BASE	2002	730	27	27.5	27		203	48
49	COVE BASE	2002	630	23	27.5	23		173	49
50	HANDRAILS, CORNER GUARDS	2002	7,947	289	27.5	289		2,180	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		9,518	58
59	FLOORING	2004	13,068	475	27.5	475		2,632	59
60	FIRE RATED CEILING TILE	2004	5,675	206	27.5	206		1,142	60
61	GREASE TRAP	2004	1,420	52	27.5	52		288	61
62	EXHAUST FAN	2004	867	32	27.5	32		177	62
63	HEAT EXCHANGER	2005	3,457	126	27.5	126		572	63
64	NEW SINK	2005	621	22	27.5	22		100	64
65	TILING	2005	1,726	63	27.5	63		286	65
66	3 NEW CIRCUITS	2005	1,996	73	27.5	73		331	66
67	SECURITY SYSTEM	2005	3,410	124	27.5	124		563	67
68	SMOKE DETECTING SYSTEM	2005	7,125	259	27.5	259		1,177	68
69	GENERATOR	2005	15,000	545	27.5	545		2,476	69
70	TOTAL (lines 4 thru 69)		\$ 3,983,173	\$ 39,238		\$ 39,238	\$	\$ 226,553	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:

01/01/2009

Ending:

12/31/2009

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,983,173	\$ 39,238		\$ 39,238	\$	\$ 226,553	1
2	DRAPERIES & VALANCES	2006	14,034	1,617	5	2,807	1,190	8,982	2
3	SMOKE DETECTORS	2006	6,070	221	27.5	221		746	3
4	GREASE TRAP	2006	1,550	56	27.5	56		189	4
5	FLOORING	2006	23,676	861	27.5	861		2,906	5
6	WATER SOFTENEN & MIXING VALVE	2006	2,074	76	27.5	76		256	6
7	HALLWAY DOOR ALARM	2006	672	24	27.5	24		81	7
8	WINDSHIELD SHELTER	2007	6,229	415	15	415		1,090	8
9	WOOD FENCE	2007	2,700	180	15	180		472	9
10	OUTDOOR DECK	2007	4,947	330	15	330		866	10
11	FLOORING	2007	9,758	355	27.5	355		843	11
12	ROOF	2007	3,000	109	27.5	109		259	12
13	INSTALL MIXING VALVE	2007	8,300	302	27.5	302		717	13
14	GENERATOR REPAIR	2007	3,489	127	27.5	127		302	14
15	WET FIRE PROTECTION SYSTEMS	2007	116,225	4,226	27.5	4,226		11,093	15
16	SIGN	2008	5,000	333	15	333		500	16
17	WALK IN COOLER	2008	26,405	960	27.5	960		1,560	17
18	MODIFICATION OF FIRE ALARM SYSTEM	2008	9,218	335	27.5	335		544	18
19	DOORS	2008	4,125	150	27.5	150		244	19
20	WINDOWS	2008	2,595	95	27.5	95		154	20
21	SEWAGE PUMP	2008	4,564	166	27.5	166		270	21
22	GENERATOR REPAIR	2009	11,275	154	27.5	154		154	22
23	WATER PURIFICATION SYSTEM	2009	6,582	90	27.5	90		90	23
24	ROOF	2009	4,800	65	27.5	65		65	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)		\$ 4,260,461	\$ 50,485		\$ 51,675	\$ 1,190	\$ 258,936	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	\$ 130,836	\$ 14,426	\$ 22,743	\$ 8,317	10 YRS	\$ 130,836	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	80,920				10 YRS	80,920	73
74	REL PARTY	260,000	13,000	13,000		10 YRS	13,000	74
75	TOTALS	\$ 471,756	\$ 27,426	\$ 35,743	\$ 8,317		\$ 224,756	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	\$ 9,275	\$ 9,661	\$ 386	5 YRS	\$ 24,153	76
77										77
78										78
79										79
80	TOTALS			\$ 48,307	\$ 9,275	\$ 9,661	\$ 386		\$ 24,153	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)	\$ 5,448,024	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,186	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,079	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,893	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 507,845	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>597,797</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>597,797</u>			7

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 23,165 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	50,033	\$		\$	50,033	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				29,829				29,829	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				199,020				199,020	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescrpts					153,658			153,658	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Radiology, IV therapy</u>	39-3					71,118				71,118	12
13	Other (specify): <u>Supplies, Lab</u>	39-2						20,346			20,346	13
14	TOTAL			\$		\$	350,000	\$	174,004	\$	524,004	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# 0041772Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 48,366	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	959,569		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	47,028		7
8	Accounts Receivable (owners or related parties)	1,813,752		8
9	Other(specify): <u>EMPLOYEE LOANS</u>	5,174		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,873,889	\$	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	731,136		15
16	Equipment, at Historical Cost	356,656		16
17	Accumulated Depreciation (book methods)	(557,302)		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): <u>SECURITY DEPOSITS</u>	5,249		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 535,739	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,409,628	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,613,422	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	640,685		29
30	Accrued Salaries Payable	144,745		30
31	Accrued Taxes Payable (excluding real estate taxes)	85,921		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,913		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)	\$ 2,554,686	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	55,883		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)	\$ 55,883	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,610,569	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 799,059	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,409,628	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,044,266	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	(400,644)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,643,622	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(844,563)	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)	\$ (844,563)	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)	\$ 799,059	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,328,747	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,328,747	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	168,501	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 168,501	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***	13,518	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,518	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other expense adj - out of period	48,808	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 48,808	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,559,574	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,005,927	31
32	Health Care	2,512,226	32
33	General Administration	1,387,544	33
B. Capital Expense			
34	Ownership	903,261	34
C. Ancillary Expense			
35	Special Cost Centers	524,004	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)*	\$ 6,404,137	40
41	Income before Income Taxes (line 30 minus line 40)**	(844,563)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (844,563)	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: 01/01/2009

Ending: 12/31/2009

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	2,457	2,760	\$ 129,021	\$ 46.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,897	8,354	274,697	32.88	3
4	Licensed Practical Nurses	21,595	24,127	605,228	25.09	4
5	CNAs & Orderlies	63,511	70,039	812,552	11.60	5
6	CNA Trainees					6
7	Licensed Therapist	4,545	5,155	126,269	24.49	7
8	Rehab/Therapy Aides	2,441	2,692	32,273	11.99	8
9	Activity Director	1,711	1,966	25,621	13.03	9
10	Activity Assistants	12,445	13,827	145,604	10.53	10
11	Social Service Workers	6,662	8,764	112,540	12.84	11
12	Dietician					12
13	Food Service Supervisor	1,988	3,150	49,243	15.63	13
14	Head Cook	5,386	5,831	64,823	11.12	14
15	Cook Helpers/Assistants	13,424	15,460	138,493	8.96	15
16	Dishwashers					16
17	Maintenance Workers	5,524	5,875	85,729	14.59	17
18	Housekeepers	15,924	17,983	162,816	9.05	18
19	Laundry	3,966	4,426	38,087	8.61	19
20	Administrator	1,950	2,649	118,217	44.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,001	13,689	208,111	15.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,931	2,179	32,867	15.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,358	208,926	\$ 3,162,191 *	\$ 15.14	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	\$ 10,237	1-3	35
36	Medical Director	O	38,250	9-3	36
37	Medical Records Consultant	N	200	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,210	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	2,080	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 51,977		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

0041772

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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. \$4,605
- (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? _____
- (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. \$ 17,543 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 X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ 18,068 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.