FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0041772

Facility Name: ASTA CARE CENTER OF ROCKFORD

Address: 707 WEST RIVERSIDE BOULEVARD (Number) ROCKFORD (City) 61103 (Zip Code)

County: WINNEBAGO

Telephone Number: (847) 742-8822 **Fax #** (847) 742-9013

HFS ID Number:

Date of Initial License for Current Owners: 06/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MICHAEL GILLMAN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,917	431	3,057	6,405	8
9	SNF/PED					9
10	ICF	28,865	118	113	29,096	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,782	549	3,170	35,501	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.82%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 69 and days of care provided 2,948

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	242,196	20,110	12,609	274,915		274,915		274,915			1
2	Food Purchase		198,924		198,924	(9,691)	189,233	(904)	188,329			2
3	Housekeeping	207,460	35,455		242,915		242,915		242,915			3
4	Laundry	31,125	16,477	4,896	52,498		52,498		52,498			4
5	Heat and Other Utilities			115,273	115,273		115,273		115,273			5
6	Maintenance	35,093	39,957	51,745	126,795		126,795		126,795			6
7	Other (specify):*			24,590	24,590		24,590		24,590			7
8	**TOTAL General Services**	515,874	310,923	209,113	1,035,910	(9,691)	1,026,219	(904)	1,025,315			8
	B. Health Care and Programs											
9	Medical Director			38,000	38,000		38,000		38,000			9
10	Nursing and Medical Records	1,691,556	173,602	7,471	1,872,629	5,085	1,877,714	9,771	1,887,485			10
10a	Therapy	152,133			152,133		152,133		152,133			10a
11	Activities	119,427	8,406	2,694	130,527		130,527		130,527			11
12	Social Services	96,643			96,643		96,643		96,643			12
13	CNA Training											13
14	Program Transportation			7,633	7,633		7,633		7,633			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,059,759	182,008	55,798	2,297,565	5,085	2,302,650	9,771	2,312,421			16
	C. General Administration											
17	Administrative	1,032			1,032	121,060	122,092	100,859	222,951			17
18	Directors Fees											18
19	Professional Services			248,153	248,153	(126,145)	122,008	(320)	121,688			19
20	Dues, Fees, Subscriptions & Promotions			27,553	27,553		27,553	(15,972)	11,581			20
21	Clerical & General Office Expenses	189,547	29,208	101,655	320,410		320,410	(46,345)	274,065			21
22	Employee Benefits & Payroll Taxes			365,172	365,172	9,691	374,863		374,863			22
23	Inservice Training & Education			3,337	3,337		3,337		3,337			23
24	Travel and Seminar			5,876	5,876		5,876	(5,393)	483			24
25	Other Admin. Staff Transportation			8,419	8,419		8,419	2,665	11,084			25
26	Insurance-Prop.Liab.Malpractice			119,239	119,239		119,239	1,471	120,710			26
27	Other (specify):*			34,199	34,199		34,199	(24,523)	9,676			27
28	**TOTAL General Administration**	190,579	29,208	913,603	1,133,390	4,606	1,137,996	12,442	1,150,438			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,766,212	522,139	1,178,514	4,466,865		4,466,865	21,309	4,488,174			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.

Facility Name & ID#: ASTA CARE CENTER OF ROCKFORD #0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,551	
	REPAIRS & MAINTENANCE		1,975	
	OUTSIDE SERVICES		1,083	12,609
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,490	
	CONTRACTED LAUNDRY SERVICES		406	4,896
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		30,873	
	ELECTRICITY		43,800	
	WATER		35,015	
	CABLE TV - LOBBY		5,585	
			0	115,273
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,179	
	PAINTING & DECORATING		660	
	BUILDING REPAIRS		3,762	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		32,380	
	ELEVATOR MAINTENANCE & REPAIR		3,589	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		2,175	
			0	
			0	
			0	
			0	51,745
7	**OTHER**			
	SCAVENGER		23,983	
	SECURITY SERVICE		607	
			0	
			0	24,590
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	38,000	38,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,994	
	PHARMACY CONSULTANT	XVIII B 39-2	5,477	
	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	7,471
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	2,694	
			0	2,694
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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD **#0041772** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		7,633	7,633
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	18,478	
	ADMINISTRATIVE CONSULTANTS	XIX C	121,060	
	PROFESSIONAL FEES	XIX C	108,615	
			0	248,153
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	14,936	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,309	
	LICENSES & PERMITS	XIX F	3,028	
	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	2,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	980	
	PATIENT BACKGROUND CHECKS	XIX F	1,300	
				27,553
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,310	
	EQUIPMENT REPAIR & MAINTENANCE		505	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	67,141	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		80	
	TELEPHONE		26,184	
	MESSENGER SERVICE		435	
				101,655

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	206,534	
	UNEMPLOYMENT COMPENSATION	XIX D	37,573	
	WORKERS COMPENSATION INSURANC	XIX D	77,922	
	HOSPITALIZATION INSURANCE	XIX D	41,331	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,812	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	365,172
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,337	
				3,337
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	5,876	
				5,876
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,419	
				8,419
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		119,239	
				119,239
27	**OTHER**			
	BAD DEBTS	VI 24	34,199	
				34,199

GRAND TOTAL COLUMN 3 OTHER **1,178,514**

ASTA CARE CENTER OF ROCKFORD
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	198,924
LESS SALES TAX	(904)
NET FOOD	198,020
TOTAL PATIENT CENSUS	35,501
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	106,503
ADD # EMPLOYEE MEALS/DAY	15
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	5,475
PATIENT MEALS	106,503
ADD EMPLOYEE MEALS	5,475
TOTAL MEALS/YEAR	111,978
NET FOOD	198,020
DIVIDE TOTAL MEALS/YEAR	111,978
COST PER MEAL	1.77
TIME EMPLOYEE MEALS	5,475
EMPLOYEE MEAL RECLASSIFICATION	**9,691**
	========

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD #0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			46,600	46,600		46,600	238,655	285,255			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,620	62,620		62,620	252,052	314,672			32
33	Real Estate Taxes			76,273	76,273		76,273		76,273			33
34	Rent-Facility & Grounds			523,300	523,300		523,300	(523,300)				34
35	Rent-Equipment & Vehicles			62,402	62,402		62,402		62,402			35
36	Other (specify):*											36
37	**TOTAL Ownership**			771,195	771,195		771,195	(32,593)	738,602			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,327	411,496	548,823		548,823		548,823			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**		137,327	482,671	619,998		619,998		619,998			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,766,212	659,466	2,432,380	5,858,058		5,858,058	(11,284)	5,846,774			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,866	30		9
10	Interest and Other Investment Income	(528)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(904)	2		13
14	Non-Care Related Interest	(7,136)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5,876)	24		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(67,141)	21		18
19	Entertainment		20		19
20	Contributions	(2,000)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,466)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,199)	27		24
25	Fund Raising, Advertising and Promotional	(14,936)	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	(25,087)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (149,407)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	138,123		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 138,123		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (11,284)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	MARKETING SALARY	(20,001)	21	2
3	MARKETING TRAVEL	(5,086)	25	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**	(25,087)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD **#** 0041772 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(904)	0	0	0	0	0	0	0	0	0	0	(904)	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(904)	0	0	0	0	0	0	0	0	0	0	(904)	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	9,771	0	0	0	0	0	0	0	0	0	9,771	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	9,771	0	0	0	0	0	0	0	0	0	9,771	16
	C. General Administration													
17	Administrative	0	100,859	0	0	0	0	0	0	0	0	0	100,859	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,466)	1,146	0	0	0	0	0	0	0	0	0	(320)	19
20	Fees, Subscriptions & Promotions	(16,936)	964	0	0	0	0	0	0	0	0	0	(15,972)	20
21	Clerical & General Office Expenses	(87,142)	40,797	0	0	0	0	0	0	0	0	0	(46,345)	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	(5,876)	483	0	0	0	0	0	0	0	0	0	(5,393)	24
25	Other Admin. Staff Transportation	(5,086)	7,751	0	0	0	0	0	0	0	0	0	2,665	25
26	Insurance-Prop.Liab.Malpractice	0	1,471	0	0	0	0	0	0	0	0	0	1,471	26
27	Other (specify):*	(34,199)	9,676	0	0	0	0	0	0	0	0	0	(24,523)	27
28	**TOTAL General Administration**	(150,705)	163,147	0	0	0	0	0	0	0	0	0	12,442	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(151,609)	172,918	0	0	0	0	0	0	0	0	0	21,309	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	9,866	0	228,789	0	0	0	0	0	0	0	0	238,655	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,664)	0	259,716	0	0	0	0	0	0	0	0	252,052	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(523,300)	0	0	0	0	0	0	0	0	(523,300)	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**	2,202	0	(34,795)	0	0	0	0	0	0	0	0	(32,593)	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)**	(149,407)	172,918	(34,795)	0	0	0	0	0	0	0	0	(11,284)	45

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		HEALTHCARE CO.		
				ASTA THERAPY	ELGIN	THERAPY
				ASTA ROCKFORD		
				PROPERTY,LLC	ELGIN	REAL ESTATE

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$	ASTA HEALTHCARE COMPANY		$	$	1
2	V	10	NURSING				9,771	9,771	2
3	V	17	ADMINISTRATIVE				100,859	100,859	3
4	V	19	PROFESSIONAL FEES				1,146	1,146	4
5	V	20	LICENSES & PERMITS				964	964	5
6	V	21	OFFICE EXPENSE				40,797	40,797	6
7	V	24	SEMINARS				483	483	7
8	V	25	STAFF TRANS/ TRAVEL				7,751	7,751	8
9	V	26	INSURANCE GEN / WC				1,471	1,471	9
10	V	27	PAYR. TAXES & GRP INS				9,676	9,676	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 172,918	$ * 172,918	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: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 523,300	ASTA ROCKFORD PROPERTIES, LLC		$	$ (523,300)	15
16	V	30	DEPRECIATION				228,789	228,789	16
17	V	32	INTEREST				259,716	259,716	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 523,300			$ 488,505	$ * (34,795)	39

* 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: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN							SALARY	$ 38,398	17-7	1
2											2
3					SEE	SEE				17-7	3
4					ATTACHED	ATTACHED					4
5	CRAIG FRANK				SCHEDULE	SCHEDULE		SALARY	39,259	17-7	5
6	SALARY FROM ASTA CARE OF FORD COUNTY $43,541										6
7	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $25,000										7
8										17-7	8
9	ALIZA FRANK		PAYROLL					SALARY	6,974		9
10											10
11											11
12											12
13								TOTAL	$ 84,631		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: 01/01/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	180,290	7	$ 49,619	$ 49,619	35,501	$ 9,771	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	180,290	7	195,000	195,000	35,501	38,398	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	180,290	7	199,375	199,375	35,501	39,259	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	180,290	7	35,417	35,417	35,501	6,974	4
5	17	ADMIN. SALARY- JS	PATIENT DAYS	180,290	7	82,414	82,414	35,501	16,228	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	180,290	7	5,819		35,501	1,146	6
7	20	LICENSES & PERMITS	PATIENT DAYS	180,290	7	4,897		35,501	964	7
8	21	OFFICE EXPENSE	PATIENT DAYS	180,290	7	207,187	169,766	35,501	40,797	8
9	24	SEMINARS	PATIENT DAYS	180,290	7	2,453		35,501	483	9
10	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	180,290	7	39,363		35,501	7,751	10
11	26	INSURANCE GEN / WC	PATIENT DAYS	180,290	7	7,472		35,501	1,471	11
12	27	PAYR. TAXES & GRP INS	PATIENT DAYS	180,290	7	49,140		35,501	9,676	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					$ 878,156	$ 731,591		$ 172,918	25

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	REL PARTY COLE TAYLOR		X	MORTGAGE	$34,000.00	10/29/09	$ 3,600,000	$ 3,413,360	10/29/14	0.0350	$ 245,316	1
2	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		72,002	55,202			14,400	2
3												3
4	HARRIS BANK		X	MCDANIEL FIRE SYSTEM	$2,529.52	3/01/07	116,225		3/01/12	0.1104	5,157	4
5			X	INSURANCE FINANCE							4,659	5
	Working Capital											
6	COLE TAYLOR BANK		X	WORKING CAPITAL				687,000		PRIME+	40,788	6
7	NAVISTAR		X	VAN PURCHASE	$995.75	4/01/07	48,307		3/21/12	0.0870	2,237	7
8	MICHAEL GILLMAN	X									2,643	8
9	TOTAL Facility Related				$37,525.27		$ 3,836,534	$ 4,155,562			$ 315,200	9
	B. Non-Facility Related*											
10	BED TAX		X								7,118	10
11	IRS		X	LATE FEES							18	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,136	14
15	TOTALS (line 9+line14)						$ 3,836,534	$ 4,155,562			$ 322,336	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **N/A** **Line #** **36**

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

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 69,913	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.)		$ 73,093	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,180	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,093	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.		$ 76,273	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	61,486	8
	2006	62,578	9
	2007	65,649	10
	2008	69,913	11
	2009	73,093	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-01-304-008	NURSING HOME	$ 73,093.28	$ 73,093.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,093.28	$ 73,093.28

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/2010 Ending: 12/31/2010

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. [X] (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. [X] (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		2009		$ 3,529,325	$ 128,339	27.5	$ 128,339	$	$ 155,076	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NURSES STATION			1997	15,290	392	39	392		5,112	9
10	FIRE PANEL			1997	1,691	43	39	43		561	10
11	ROOF			1997	4,035	104	39	104		1,356	11
12	TWO BATHROOMS			1998	4,615	118	39	118		1,490	12
13	COOLING TOWER			1998	7,552	194	39	194		2,352	13
14	PLUMBING - GREASE TRAP			1999	1,024	37	27.5	37		427	14
15	PLUMBING - NEW SINKS			1999	1,321	48	27.5	48		554	15
16	HOT WATER HEATER			1999	2,955	107	27.5	107		1,235	16
17	HEAT EXCHANGE			1999	2,298	84	27.5	84		969	17
18	NEW BATHROOMS			1999	9,975	363	27.5	363		4,189	18
19	NEW CEILING			1999	1,841	67	27.5	67		773	19
20	NURSE CALL SYSTEM			1999	8,437	307	27.5	307		3,543	20
21	NEW COOLING TOWER			1999	4,765	173	27.5	173		1,997	21
22	ROOF			2000	16,000	582	27.5	582		6,135	22
23	COUNTERYOP SINK			2000	2,275	83	27.5	83		875	23
24	TILING			2000	600	22	27.5	22		232	24
25	TOILETS			2000	7,702	280	27.5	280		2,952	25
26	CLOSETS, DRYWALL, TILING			2000	4,600	167	27.5	167		1,761	26
27	SHELVES			2000	1,250	45	27.5	45		475	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		1,030	34
35	DIALYSIS ROOM			2001	19,931	725	27.5	725		6,918	35
36	SEPTIC INJECTOR			2001	3,004	109	27.5	109		1,040	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ROOF	2001	$ 20,600	$ 749	27.5	$ 749	$	$ 7,147	37
38	SCREEN PORCH	2001	5,500	200	27.5	200		1,908	38
39	ELECTRONIC DOOR SCREEN FOR ELEVATOR	2001	6,887	250	27.5	250		2,386	39
40	BUILD WALLS, PAINTING, WOOD MOLDING	2001	5,700	207	27.5	207		1,975	40
41	FIRE ALARM SYSTEM	2002	12,867	468	27.5	468		3,997	41
42	CHAIR RAIL	2002	546	20	27.5	20		171	42
43	WATER HEATER	2002	2,229	81	27.5	81		692	43
44	GREASE TRAP	2002	1,050	38	27.5	38		325	44
45	SEWAGE EJECTOR PIT	2002	7,657	278	27.5	278		2,375	45
46	CODE ALERT WANDERING SYSTEM	2002	3,173	115	27.5	115		983	46
47	FLOORING, HANDRAILS, CORNER GUARD	2002	59,554	2,166	27.5	2,166		18,501	47
48	COVE BASE	2002	730	27	27.5	27		230	48
49	COVE BASE	2002	630	23	27.5	23		196	49
50	HANDRAILS, CORNER GUARDS	2002	7,947	289	27.5	289		2,469	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		10,973	58
59	FLOORING	2004	13,068	475	27.5	475		3,107	59
60	FIRE RATED CEILING TILE	2004	5,675	206	27.5	206		1,348	60
61	GREASE TRAP	2004	1,420	52	27.5	52		340	61
62	EXHAUST FAN	2004	867	32	27.5	32		209	62
63	HEAT EXCHANGER	2005	3,457	126	27.5	126		698	63
64	NEW SINK	2005	621	22	27.5	22		122	64
65	TILING	2005	1,726	63	27.5	63		349	65
66	3 NEW CIRCUITS	2005	1,996	73	27.5	73		404	66
67	SECURITY SYSTEM	2005	3,410	124	27.5	124		687	67
68	SMOKE DETECTING SYSTEM	2005	7,125	259	27.5	259		1,436	68
69	GENERATOR	2005	15,000	545	27.5	545		3,021	69
70	TOTAL (lines 4 thru 69)		$ 3,983,173	$ 140,840		$ 140,840	$	$ 367,393	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,983,173	$ 140,840		$ 140,840	$	$ 367,393	1
2	DRAPERIES & VALANCES	2006	14,034	1,617	5	2,807	1,190	11,789	2
3	SMOKE DETECTORS	2006	6,070	221	27.5	221		967	3
4	GREASE TRAP	2006	1,550	56	27.5	56		245	4
5	FLOORING	2006	23,676	861	27.5	861		3,767	5
6	WATER SOFTENEN & MIXING VALVE	2006	2,074	76	27.5	76		332	6
7	HALLWAY DOOR ALARM	2006	672	24	27.5	24		105	7
8	WINDSHIELD SHELTER	2007	6,229	415	15	415		1,505	8
9	WOOD FENCE	2007	2,700	180	15	180		652	9
10	OUTDOOR DECK	2007	4,947	330	15	330		1,196	10
11	FLOORING	2007	9,758	355	27.5	355		1,198	11
12	ROOF	2007	3,000	109	27.5	109		368	12
13	INSTALL MIXING VALVE	2007	8,300	302	27.5	302		1,019	13
14	GENERATOR REPAIR	2007	3,489	127	27.5	127		429	14
15	WET FIRE PROTECTION SYSTEMS	2007	116,225	4,226	27.5	4,226		15,319	15
16	SIGN	2008	5,000	333	15	333		833	16
17	WALK IN COOLER	2008	26,405	960	27.5	960		2,520	17
18	MODIFICATION OF FIRE ALARM SYSTEM	2008	9,218	335	27.5	335		879	18
19	DOORS	2008	4,125	150	27.5	150		394	19
20	WINDOWS	2008	2,595	95	27.5	95		249	20
21	SEWAGE PUMP	2008	4,564	166	27.5	166		436	21
22	GENERATOR REPAIR	2009	11,275	410	27.5	410		564	22
23	WATER PURIFICATION SYSTEM	2009	6,582	239	27.5	239		329	23
24	ROOF	2009	4,800	175	27.5	175		240	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	$ 152,602		$ 153,792	$ 1,190	$ 412,728	34

**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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,260,461	$ 152,602		$ 153,792	$ 1,190	$ 412,728	1
2	ASTA ROCKFORD PROPERTY, LLC								2
3	PANEL ANNUNCIATORS	2010	3,827	18	27.5	18		18	3
4	WANDER GUARD SYSTEM	2010	7,085	32	27.5	32		32	4
5	PANEL EXPANSION FOR ADD'L CIRCUITS	2010	2,580	12	27.5	12		12	5
6	WATER SERVICE	2010	3,275	15	27.5	15		15	6
7	GENERATOR REPAIR	2010	4,458	20	27.5	20		20	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,281,686	$ 152,699		$ 153,889	$ 1,190	$ 412,825	34

**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: 01/01/2010 Ending: 12/31/2010

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	$ 308,349	$ 11,223	$ 20,890	$ 9,667	10 YRS	$ 151,726	71
72	Current Year Purchases	9,248	5,549	462	(5,087)	10 YRS	462	72
73	Fully Depreciated Assets	80,920					80,920	73
74	RELATED PARTY		100,353	100,353				74
75	TOTALS	$ 398,517	$ 117,125	$ 121,705	$ 4,580		$ 233,108	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	2007	$ 48,307	$ 5,565	$ 9,661	$ 4,096	5 YRS	$ 33,814	76
77										77
78										78
79										79
80	TOTALS			$ 48,307	$ 5,565	$ 9,661	$ 4,096		$ 33,814	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)	$ 5,396,010	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 275,389	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 285,255	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,866	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 679,747	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.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

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:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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: *

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.		$
13.		$
14.		$

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: $ 60,476 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		2010 Toyota Corloa	$	$ 1,926	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,926	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: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD

STATE OF ILLINOIS
0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 76,611	$		$ 76,611	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			63,350			63,350	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			197,664			197,664	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				127,516		127,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Dialysis	39-3				73,871			73,871	12
13	Radiology, Laboratory Other (specify): Medical Supplies	39-2 39-2					9,119 692		9,119 692	13
14	TOTAL			$		$ 411,496	$ 137,327		$ 548,823	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.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 9,115	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	621,315		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,817		6
7	Other Prepaid Expenses	47,000		7
8	Accounts Receivable (owners or related parties)	1,504,637		8
9	Other(specify):	4,666		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,237,550	$	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	616,810		15
16	Equipment, at Historical Cost	480,230		16
17	Accumulated Depreciation (book methods)	(603,902)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	19,059		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 512,197	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,749,747	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,194,130	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	725,998		29
30	Accrued Salaries Payable	134,796		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,200		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,093		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)**	$ 2,147,217	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,396		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)**	$ 10,396	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,157,613	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 592,134	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,749,747	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 799,059	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 799,059	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(206,925)	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)**	$ (206,925)	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)**	$ 592,134	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,411,034	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,411,034	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	201,045	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 201,045	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***	528	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 528	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,612,607	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,035,910	31
32	Health Care	2,297,565	32
33	General Administration	1,133,390	33
	B. Capital Expense		
34	Ownership	771,195	34
	C. Ancillary Expense		
35	Special Cost Centers	548,823	35
36	Provider Participation Fee	71,175	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(38,526)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,819,532	40
41	**Income before Income Taxes (line 30 minus line 40)****	(206,925)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (206,925)	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: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,950	2,353	$ 104,902	$ 44.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,982	8,217	261,388	31.81	3
4	Licensed Practical Nurses	21,444	23,812	575,012	24.15	4
5	CNAs & Orderlies	54,890	62,087	713,837	11.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,236	7,266	152,133	20.94	8
9	Activity Director	463	463	6,827	14.75	9
10	Activity Assistants	8,388	10,144	112,600	11.10	10
11	Social Service Workers	5,660	6,422	96,643	15.05	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,113	29,662	14.04	13
14	Head Cook	5,332	6,158	72,371	11.75	14
15	Cook Helpers/Assistants	13,418	15,073	140,163	9.30	15
16	Dishwashers					16
17	Maintenance Workers	2,426	2,638	35,093	13.30	17
18	Housekeepers	18,418	20,727	207,460	10.01	18
19	Laundry	3,039	3,252	31,125	9.57	19
20	Administrator		26	1,032	39.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,481	11,800	189,547	16.06	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	2,120	2,448	36,417	14.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,175	184,999	$ 2,766,212 *	$ 14.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,551	1-3	35
36	Medical Director	O	38,000	9-3	36
37	Medical Records Consultant	N	1,994	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,477	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	2,694	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)		$ 57,716		49

C. CONTRACT NURSES

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PATRICIA BOOMGARDEN	ADMINISTRATOR	0	$ 1,032
		.	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 1,032

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		248,153
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 248,153

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,922
Unemployment Compensation Insurance	37,573
FICA Taxes	206,534
Employee Health Insurance	41,331
Employee Meals	9,691
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	1,812
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 374,863

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	980
(Indicate # of checks performed 98)	
Patient Background Checks 130	1,300
TRUST/FRANCHISE/CONTRIB/ETC	2,000
MARKETING/ADV/PROMO	14,936
LICENSES/DUES/SUBSCRIPTIONS	6,347
MGMT CO ALLOC	964
TRUST/FRANCHISE/CONTRIB/ETC	(2,000)
Less: Public Relations Expense	(0)
Non-allowable advertising	(14,936)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,581

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	5,876
NON ALLOW TRAVEL	(5,876)
Seminar Expense	
	0
MGMT CO ALLOC	483
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 483

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD # 0041772 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8							N/A						
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: 01/01/2010 Ending: 12/31/2010

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 HEALTH CARE ASSOC $6,344**

(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. $ **21,066** 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. $ **9,691** 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.