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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0041772

Facility Name: ASTA CARE CENTER OF ROCKFORD, LLC

Address: 707 W. 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 01/01/2011 to 12/31/2011 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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	697	209	3,303	4,209	8
9	SNF/PED					9
10	ICF	30,900	98	31	31,029	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,597	307	3,334	35,238	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.26%

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 3,123

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LI # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	260,144	21,768	12,782	294,694		294,694		294,694			1
2	Food Purchase		204,664		204,664	(21,973)	182,691	(840)	181,851			2
3	Housekeeping	241,685	33,787		275,472		275,472		275,472			3
4	Laundry	31,095	14,332	7,941	53,368		53,368		53,368			4
5	Heat and Other Utilities			116,044	116,044		116,044		116,044			5
6	Maintenance	26,979	40,376	53,660	121,015		121,015		121,015			6
7	Other (specify):*			25,564	25,564		25,564		25,564			7
8	TOTAL General Services	559,903	314,927	215,991	1,090,821	(21,973)	1,068,848	(840)	1,068,008			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	1,716,156	154,370	31,242	1,901,768		1,901,768	11,190	1,912,958			10
10a	Therapy	133,137			133,137		133,137		133,137			10a
11	Activities	105,601	9,267	1,935	116,803		116,803		116,803			11
12	Social Services	100,925			100,925		100,925		100,925			12
13	CNA Training											13
14	Program Transportation			1,543	1,543		1,543		1,543			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,055,819	163,637	73,720	2,293,176		2,293,176	11,190	2,304,366			16
	C. General Administration											
17	Administrative					123,057	123,057	74,557	197,614			17
18	Directors Fees											18
19	Professional Services			212,693	212,693	(123,057)	89,636	(25,649)	63,987			19
20	Dues, Fees, Subscriptions & Promotions			29,246	29,246		29,246	(16,209)	13,037			20
21	Clerical & General Office Expenses	182,166	24,211	61,152	267,529		267,529	5,525	273,054			21
22	Employee Benefits & Payroll Taxes			374,406	374,406	21,973	396,379		396,379			22
23	Inservice Training & Education			240	240		240		240			23
24	Travel and Seminar			680	680		680		680			24
25	Other Admin. Staff Transportation			5,175	5,175		5,175	5,642	10,817			25
26	Insurance-Prop.Liab.Malpractice			153,570	153,570		153,570		153,570			26
27	Other (specify):*			91,250	91,250		91,250	(82,803)	8,447			27
28	TOTAL General Administration	182,166	24,211	928,412	1,134,789	21,973	1,156,762	(38,937)	1,117,825			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,797,888	502,775	1,218,123	4,518,786		4,518,786	(28,587)	4,490,199			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, LLC #0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,158	
	REPAIRS & MAINTENANCE		2,599	
	DIRECT CARE DIETICIAN		2,025	12,782
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		7,941	
			0	7,941
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		30,473	
	ELECTRICITY		44,111	
	WATER		36,033	
	CABLE TV - LOBBY		5,427	
			0	116,044
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,245	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		2,782	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		29,845	
	ELEVATOR MAINTENANCE & REPAIR		9,667	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		5,121	
			0	
			0	
			0	
			0	53,660
7	**OTHER**			
	SCAVENGER		25,564	
	SECURITY SERVICE		0	
			0	
			0	25,564
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	39,000	39,000

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	390	
	PHARMACY CONSULTANT	XVIII B 39-2	5,852	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	LAWSUIT SETTLEMENT		25,000	
			0	31,242
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		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,935	
			0	1,935
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC **#0041772** **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,543	1,543
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	20,374	
	ADMINISTRATIVE CONSULTANTS	XIX C	123,057	
	PROFESSIONAL FEES	XIX C	69,262	
				212,693
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	13,208	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	1,300	
	DUES & SUBSCRIPTIONS	XIX F	6,935	
	LICENSES & PERMITS	XIX F	2,945	
	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	2,153	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,465	
	PATIENT BACKGROUND CHECKS	XIX F	1,240	
				29,246
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		9,286	
	EQUIPMENT REPAIR & MAINTENANCE		981	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	18,010	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		31,501	
	MESSENGER SERVICE		1,374	
			0	61,152

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	212,828	
	UNEMPLOYMENT COMPENSATION	XIX D	62,825	
	WORKERS COMPENSATION INSURANC	XIX D	63,474	
	HOSPITALIZATION INSURANCE	XIX D	30,760	
	EMPLOYEE BENEFITS - OTHER	XIX D	812	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,707	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	374,406
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		240	
				240
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	680	
				680
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,175	
				5,175
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		153,570	
				153,570
27	**OTHER**			
	BAD DEBTS	VI 24	91,250	
				91,250

GRAND TOTAL COLUMN 3 OTHER **1,218,123**

ASTA CARE CENTER OF ROCKFORD, LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	204,664
LESS SALES TAX	(840)
NET FOOD	203,824
TOTAL PATIENT CENSUS	35,238
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	105,714
ADD # EMPLOYEE MEALS/DAY	35
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	12,775
PATIENT MEALS	105,714
ADD EMPLOYEE MEALS	12,775
TOTAL MEALS/YEAR	118,489
NET FOOD	203,824
DIVIDE TOTAL MEALS/YEAR	118,489
COST PER MEAL	1.72
TIME EMPLOYEE MEALS	12,775
EMPLOYEE MEAL RECLASSIFICATION	**21,973**
	========

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC #0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			59,347	59,347		59,347	149,975	209,322			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,390	56,390		56,390	239,159	295,549			32
33	Real Estate Taxes			80,225	80,225		80,225		80,225			33
34	Rent-Facility & Grounds			541,500	541,500		541,500	(541,500)				34
35	Rent-Equipment & Vehicles			121,892	121,892		121,892		121,892			35
36	Other (specify):*											36
37	**TOTAL Ownership**			859,354	859,354		859,354	(152,366)	706,988			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,990	436,384	560,374		560,374	29,028	589,402			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,160	171,160		171,160		171,160			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		123,990	607,544	731,534		731,534	29,028	760,562			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,797,888	626,765	2,685,021	6,109,674		6,109,674	(151,925)	5,957,749			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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(39,878)	30		9
10	Interest and Other Investment Income	(6,888)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(840)	2		13
14	Non-Care Related Interest	(3,550)	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	(18,010)	21		18
19	Entertainment		20		19
20	Contributions	(3,453)	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	(91,250)	27		24
25	Fund Raising, Advertising and Promotional	(13,208)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(20,609)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (197,686)		$	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)	45,761		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 45,761		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (151,925)		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.		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

STATE OF ILLINOIS

ASTA CARE CENTER OF ROCKFORD, LLC

ID# 0041772

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	LAWSUIT SETTLEMENT	(25,000)	19	2
3	RELATED PARTY THERAPY ADJUSTMENT	29,028	39	3
4	NONALLOWABLE PROFESSIONAL FEES	(6,835)	19	4
5	NON ALLOWABLE MARKETING SALARY	(17,802)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(20,609)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(840)	0	0	0	0	0	0	0	0	0	0	(840)	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**	(840)	0	0	0	0	0	0	0	0	0	0	(840)	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	11,190	0	0	0	0	0	0	0	0	0	11,190	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	11,190	0	0	0	0	0	0	0	0	0	11,190	16
	C. General Administration													
17	Administrative	0	74,557	0	0	0	0	0	0	0	0	0	74,557	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(31,835)	6,186	0	0	0	0	0	0	0	0	0	(25,649)	19
20	Fees, Subscriptions & Promotions	(16,661)	452	0	0	0	0	0	0	0	0	0	(16,209)	20
21	Clerical & General Office Expenses	(35,812)	41,337	0	0	0	0	0	0	0	0	0	5,525	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	5,642	0	0	0	0	0	0	0	0	0	5,642	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(91,250)	8,447	0	0	0	0	0	0	0	0	0	(82,803)	27
28	**TOTAL General Administration**	(175,558)	136,621	0	0	0	0	0	0	0	0	0	(38,937)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(176,398)	147,811	0	0	0	0	0	0	0	0	0	(28,587)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(39,878)	0	189,853	0	0	0	0	0	0	0	0	149,975	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,438)	0	249,597	0	0	0	0	0	0	0	0	239,159	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(541,500)	0	0	0	0	0	0	0	0	(541,500)	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**	(50,316)	0	(102,050)	0	0	0	0	0	0	0	0	(152,366)	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	29,028	0	0	0	0	0	0	0	0	0	0	29,028	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**	29,028	0	0	0	0	0	0	0	0	0	0	29,028	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(197,686)	147,811	(102,050)	0	0	0	0	0	0	0	0	(151,925)	45

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ASTA		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		HEALTHCARE CO.	ELGIN	MANAGEMENT
				ASTA THERAPY		
				ASTA ROCKFORD	ELGIN	THERAPY
				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		ASTA HEALTHCARE COMPANY		11,190	11,190	2
3	V	17	ADMINISTRATIVE		ASTA HEALTHCARE COMPANY		74,557	74,557	3
4	V	19	PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY		6,186	6,186	4
5	V	20	LICENSES & PERMITS		ASTA HEALTHCARE COMPANY		452	452	5
6	V	21	OFFICE EXPENSE		ASTA HEALTHCARE COMPANY		41,337	41,337	6
7	V	25	STAFF TRANS/ TRAVEL		ASTA HEALTHCARE COMPANY		5,642	5,642	7
8	V	27	PAYR TAXES & W/C INS		ASTA HEALTHCARE COMPANY		8,447	8,447	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 147,811	$ * 147,811	14

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 541,500	ASTA ROCKFORD PROPERTIES, LLC		$	$ (541,500)	15
16	V	30	DEPRECIATION				189,853	189,853	16
17	V	32	INTEREST				249,597	249,597	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			$ 541,500			$ 439,450	$ * (102,050)	39

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, L # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	ADMINISTRATOR	administrative/	32.00				SALARY	$ 37,139	17-7	1
2			management								2
3					SEE	SEE					3
4	CRAIG FRANK	CFO	finance manage.		ATTACHED	ATTACHED		SALARY	31,104	17-7	4
5					SCHEDULE	SCHEDULE					5
6											6
7											7
8											8
9	DAVID MEISELMAN	THERAPY MGMNT	management					SALARY	39,286	39-7	9
10											10
11	ALIZA FRANK	PAYROLL CLERK	PAYROLL	9.50				SALARY	6,314	17-7	11
12											12
13								TOTAL	$ 113,843		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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	189,761	7	$ 60,259	$ 57,558	35,238	$ 11,190	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	189,761	7	200,000	200,000	35,238	37,139	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	189,761	7	167,500	167,500	35,238	31,104	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	189,761	7	34,000	34,000	35,238	6,314	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	189,761	7	33,313		35,238	6,186	5
6	20	LICENSES & PERMITS	PATIENT DAYS	189,761	7	2,436		35,238	452	6
7	21	OFFICE EXPENSE	PATIENT DAYS	189,761	7	222,607	160,308	35,238	41,337	7
8	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	189,761	7	30,383		35,238	5,642	8
9	27	PAYR. TAXES & W/C	PATIENT DAYS	189,761	7	45,486		35,238	8,447	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					$ 795,984	$ 619,366		$ 147,811	25

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 ROCKFORD PROPERTY
Street Address: 707 W RIVERSIDE BOULEVARD
City / State / Zip Code: ROCKFORD ILL 61103
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	30	DEPRECIATION	DIRECT	1	1	$ 189,853	$	1	$ 189,853	1
2	32	INTEREST	DIRECT	1	1	249,597		1	249,597	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					$ 439,450	$		$ 439,450	25

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LL # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 3,241,077	10/29/14	0.0350	$ 233,265	1
2	rel party- loan costs		X	LOAN COSTS			72,002	40,802			14,400	2
3	rel party- american leasing		X	GENERATOR PURCHASE	$1,248.24	8/23/11	46,275	44,462			1,932	3
4	HARRIS BANK		X	MCDANIEL FIRE SYSTEM	$2,529.52	3/01/07	116,225	7,451	3/1/12	0.1104	6,694	4
5				INSURANCE POLICIES							3,409	5
	Working Capital											
6	COLEY TAYLOR BANK		X	WORKING CAPITAL				981,323		PRIME+	39,754	6
7	NAVISTAR		X	VAN PURCHASE	$995.75	4/1/07	48,307	2,945	3/21/12	0.0870	817	7
8	MICHAEL GILLMAN	X									2,166	8
9	TOTAL Facility Related				$38,773.51		$ 3,882,809	$ 4,318,060			$ 302,437	9
	B. Non-Facility Related*											
10												10
11				BED TAX							3,550	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,550	14
15	TOTALS (line 9+line14)						$ 3,882,809	$ 4,318,060			$ 305,987	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, LLC # 0041772 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 73,093	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.)		$ 76,709	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,616	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,609	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.		$ 80,225	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	62,578	8
	2007	65,649	9
	2008	69,913	10
	2009	73,093	11
	2010	76,709	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF ROCKFORD, LLC 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-01-304-008	NURSING HOME	$ 76,709.00	$ 76,709.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,709.00	$ 76,709.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [x] (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? [x] (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 [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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 283,415	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NURSES STATION			1997	15,290	392	39	392		5,504	9
10	FIRE PANEL			1997	1,691	43	39	43		604	10
11	ROOF			1997	4,035	104	39	104		1,460	11
12	TWO BATHROOMS			1998	4,615	118	39	118		1,608	12
13	COOLING TOWER			1998	7,552	194	39	194		2,546	13
14	PLUMBING - GREASE TRAP			1999	1,024	37	27.5	37		464	14
15	PLUMBING - NEW SINKS			1999	1,321	48	27.5	48		602	15
16	HOT WATER HEATER			1999	2,955	107	27.5	107		1,342	16
17	HEAT EXCHANGE			1999	2,298	84	27.5	84		1,053	17
18	NEW BATHROOMS			1999	9,975	363	27.5	363		4,552	18
19	NEW CEILING			1999	1,841	67	27.5	67		840	19
20	NURSE CALL SYSTEM			1999	8,437	307	27.5	307		3,850	20
21	NEW COOLING TOWER			1999	4,765	173	27.5	173		2,170	21
22	ROOF			2000	16,000	582	27.5	582		6,717	22
23	COUNTERYOP SINK			2000	2,275	83	27.5	83		958	23
24	TILING			2000	600	22	27.5	22		254	24
25	TOILETS			2000	7,702	280	27.5	280		3,232	25
26	CLOSETS, DRYWALL, TILING			2000	4,600	167	27.5	167		1,928	26
27	SHELVES			2000	1,250	45	27.5	45		520	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		1,138	34
35	DIALYSIS ROOM			2001	19,931	725	27.5	725		7,643	35
36	SEPTIC INJECTOR			2001	3,004	109	27.5	109		1,149	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 7,896	37
38	SCREEN PORCH	2001	5,500	200	27.5	200		2,108	38
39	ELECTRONIC DOOR SCREEN FOR ELEVATOR	2001	6,887	250	27.5	250		2,636	39
40	BUILD WALLS, PAINTING, WOOD MOLDING	2001	5,700	207	27.5	207		2,182	40
41	FIRE ALARM SYSTEM	2002	12,867	468	27.5	468		4,465	41
42	CHAIR RAIL	2002	546	20	27.5	20		191	42
43	WATER HEATER	2002	2,229	81	27.5	81		773	43
44	GREASE TRAP	2002	1,050	38	27.5	38		363	44
45	SEWAGE EJECTOR PIT	2002	7,657	278	27.5	278		2,653	45
46	CODE ALERT WANDERING SYSTEM	2002	3,173	115	27.5	115		1,098	46
47	FLOORING, HANDRAILS, CORNER GUARD	2002	59,554	2,166	27.5	2,166		20,667	47
48	COVE BASE	2002	730	27	27.5	27		257	48
49	COVE BASE	2002	630	23	27.5	23		219	49
50	HANDRAILS, CORNER GUARDS	2002	7,947	289	27.5	289		2,758	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		12,428	58
59	FLOORING	2004	13,068	475	27.5	475		3,582	59
60	FIRE RATED CEILING TILE	2004	5,675	206	27.5	206		1,554	60
61	GREASE TRAP	2004	1,420	52	27.5	52		392	61
62	EXHAUST FAN	2004	867	32	27.5	32		241	62
63	HEAT EXCHANGER	2005	3,457	126	27.5	126		824	63
64	NEW SINK	2005	621	22	27.5	22		144	64
65	TILING	2005	1,726	63	27.5	63		412	65
66	3 NEW CIRCUITS	2005	1,996	73	27.5	73		477	66
67	SECURITY SYSTEM	2005	3,410	124	27.5	124		811	67
68	SMOKE DETECTING SYSTEM	2005	7,125	259	27.5	259		1,695	68
69	GENERATOR	2005	15,000	545	27.5	545		3,566	69
70	TOTAL (lines 4 thru 69)		$ 3,983,173	$ 140,840		$ 140,840	$	$ 508,233	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 508,233	1
2	DRAPERIES & VALANCES	2006	14,034	807	5	2,807	2,000	14,596	2
3	SMOKE DETECTORS	2006	6,070	221	27.5	221		1,188	3
4	GREASE TRAP	2006	1,550	56	27.5	56		301	4
5	FLOORING	2006	23,676	861	27.5	861		4,628	5
6	WATER SOFTENEN & MIXING VALVE	2006	2,074	76	27.5	76		408	6
7	HALLWAY DOOR ALARM	2006	672	24	27.5	24		129	7
8	WINDSHIELD SHELTER	2007	6,229	415	15	415		1,920	8
9	WOOD FENCE	2007	2,700	180	15	180		832	9
10	OUTDOOR DECK	2007	4,947	330	15	330		1,526	10
11	FLOORING	2007	9,758	355	27.5	355		1,553	11
12	ROOF	2007	3,000	109	27.5	109		477	12
13	INSTALL MIXING VALVE	2007	8,300	302	27.5	302		1,321	13
14	GENERATOR REPAIR	2007	3,489	127	27.5	127		556	14
15	WET FIRE PROTECTION SYSTEMS	2007	116,225	4,226	27.5	4,226		19,545	15
16	SIGN	2008	5,000	333	15	333		1,166	16
17	WALK IN COOLER	2008	26,405	960	27.5	960		3,480	17
18	MODIFICATION OF FIRE ALARM SYSTEM	2008	9,218	335	27.5	335		1,214	18
19	DOORS	2008	4,125	150	27.5	150		544	19
20	WINDOWS	2008	2,595	95	27.5	95		344	20
21	SEWAGE PUMP	2008	4,564	166	27.5	166		602	21
22	GENERATOR REPAIR	2009	11,275	410	27.5	410		974	22
23	WATER PURIFICATION SYSTEM	2009	6,582	239	27.5	239		568	23
24	ROOF	2009	4,800	175	27.5	175		415	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	$ 151,792		$ 153,792	$ 2,000	$ 566,520	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 151,792		$ 153,792	$ 2,000	$ 566,520	1
2	ASTA ROCKFORD PROPERTY, LLC								2
3	PANEL ANNUNCIATORS	2010	3,827	139	27.5	139		157	3
4	WANDER GUARD SYSTEM	2010	7,085	258	27.5	258		290	4
5	PANEL EXPANSION FOR ADD'L CIRCUITS	2010	2,580	94	27.5	94		106	5
6	WATER SERVICE	2010	3,275	119	27.5	119		134	6
7	GENERATOR REPAIR	2010	4,458	162	27.5	162		182	7
8	INSTALLATION OF NEW PHONE SYSTEM	2011	9,385	270	27.5	270		270	8
9	GENERATOR (1ST POST CAP COST REPORT IMPROVE)	2011	57,240	260	27.5	260		260	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)		$ 4,348,311	$ 153,094		$ 155,094	$ 2,000	$ 567,919	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 199,617	$ 8,131	$ 17,457	$ 9,326	10 YRS	$ 132,585	71
72	Current Year Purchases	22,198	22,198	1,110	(21,088)	10 YRS	1,110	72
73	Fully Depreciated Assets	117,980					117,980	73
74	RELATED PARTY		60,212	26,000	(34,212)			74
75	TOTALS	$ 339,795	$ 90,541	$ 44,567	$ (45,974)		$ 251,675	75

D. Vehicle Costs. (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	$ 43,475	76
77										77
78										78
79										79
80	TOTALS			$ 48,307	$ 5,565	$ 9,661	$ 4,096		$ 43,475	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)	$ 5,403,913	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 249,200	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 209,322	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (39,878)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 863,069	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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:				$ 541,500			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 541,500 **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 119,219 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		2010 TOYOTA CORLOA		2,673	18
19					19
20					20
21	TOTAL		$	$ 2,673	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 81,227	$		$ 81,227	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			52,617			52,617	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			215,188			215,188	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				115,912		115,912	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Inhalation,Radiology,Lab, I.V. Therapy Other (specify): Med Supplies	39-2 39-2				87,352	 8,078		87,352 8,078	13
14	TOTAL			$		$ 436,384	$ 123,990		$ 560,374	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 10,377	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (51,000))	2,280,780		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,857		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,562,081		8
9	Other(specify): Employee Loans, Exchange	7,012		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,901,107	$	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	502,428		16
17	Accumulated Depreciation (book methods)	(663,249)		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 Deposit	19,059		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 475,048	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,376,155	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,092,279	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	991,719		29
30	Accrued Salaries Payable	155,013		30
31	Accrued Taxes Payable (excluding real estate taxes)	336,199		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,609		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)**	$ 4,651,819	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,651,819	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 724,336	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,376,155	$	48

*(See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 592,134	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	(39,002)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 553,132	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	171,204	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)**	$ 171,204	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)**	$ 724,336	24 *

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

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 6,065,194	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,065,194	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	169,202	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 169,202	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***	6,888	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,888	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)**	$ 6,241,284	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,090,821	31
32	Health Care	2,293,176	32
33	General Administration	1,134,789	33
	B. Capital Expense		
34	Ownership	859,354	34
	C. Ancillary Expense		
35	Special Cost Centers	560,374	35
36	Provider Participation Fee	171,160	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38		(39,594)	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,070,080	40
41	**Income before Income Taxes (line 30 minus line 40)****	171,204	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 171,204	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2,201	2,417	$ 117,221	$ 48.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,168	7,815	223,219	28.56	3
4	Licensed Practical Nurses	22,561	24,777	614,541	24.80	4
5	CNAs & Orderlies	53,237	59,318	719,746	12.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,620	6,183	133,137	21.53	8
9	Activity Director					9
10	Activity Assistants	8,446	9,338	105,601	11.31	10
11	Social Service Workers	7,067	8,084	100,925	12.48	11
12	Dietician					12
13	Food Service Supervisor	2,371	2,656	34,769	13.09	13
14	Head Cook	5,114	5,730	75,004	13.09	14
15	Cook Helpers/Assistants	13,725	15,366	150,371	9.79	15
16	Dishwashers					16
17	Maintenance Workers	1,862	2,056	26,979	13.12	17
18	Housekeepers	20,534	22,859	241,685	10.57	18
19	Laundry	2,705	2,907	31,095	10.70	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,870	12,175	182,166	14.96	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	2,472	2,769	41,429	14.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,953	184,450	$ 2,797,888 *	$ 15.17	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	$ 8,158	1-3	35
36	Medical Director	O	39,000	9-3	36
37	Medical Records Consultant	N	390	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,852	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,935	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)		$ 55,335		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
	$
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		212,693
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 212,693

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,474
Unemployment Compensation Insurance	62,825
FICA Taxes	212,828
Employee Health Insurance	30,760
Employee Meals	21,973
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	812
EMPLOYEE PHYSICAL EXAMS	3,707
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)	$ 396,379

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	0
Health Care Worker Background Check	1,465
(Indicate # of checks performed 42)	
Patient Background Checks 126	1,240
TRUST/FRANCHISE/CONTRIB/ETC	3,453
MARKETING/ADV/PROMO	13,208
LICENSES/DUES/SUBSCRIPTIONS	7,890
MGMT CO ALLOC	452
TRUST/FRANCHISE/CONTRIB/ETC	(3,453)
Less: Public Relations Expense	(0)
Non-allowable advertising	(13,208)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,037

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	680
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 680

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ROCKFORD, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	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, LLC # 0041772 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. $5,647**

(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. $ **21,524** 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. $ **171,160**
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. $ **21,973** 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 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.