

		FOR OFF USE					

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**2000  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2000)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0020438</u></p> <p><b>Facility Name:</b> <u>Aspire on Eastern</u></p> <p><b>Address:</b> <u>105 Eastern Ave.</u> <u>Bellwood</u> <u>60104</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>708-547-3550</u> <b>Fax #</b> <u>708-547-4067</u></p> <p><b>IDPA ID Number:</b> <u>362654558-001</u></p> <p><b>Date of Initial License for Current Owners:</b> _____</p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> <u>501 (c) 3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Jim O'Brien</u> <b>Telephone Number:</b> <u>##</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/99</u> to <u>6/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td style="border: none;">           (Signed) _____            (Type or Print Name) <u>James B. O'Brien</u>            (Title) <u>VP of Business Administration</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="border: none;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) ( ) _____ Fax # ( ) _____         </td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>James B. O'Brien</u> (Title) <u>VP of Business Administration</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>James B. O'Brien</u> (Title) <u>VP of Business Administration</u>							
<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							



Facility Name & ID Number Aspire on Eastern

# 0020438 Report Period Beginning: 7/1/99 Ending: 6/30/00

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	82	Intermediate/DD	82	29,930	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	29,304			29,304	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,304			29,304	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.91%

D. How many bed-hold days during this year were paid by Public Aid? 389 (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)  
\_\_\_\_\_

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 03/01/75

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

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**IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES**

STATE OF ILLINOIS

Facility Name & ID Number      Aspire on Eastern      #      0020438      Report Period Beginning:      7/1/99      Ending:      6/30/00

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	170,132	11,853	6,730	188,715	90	188,805	0	188,805		1
2	Food Purchase		141,195		141,195	219	141,414	0	141,414		2
3	Housekeeping	131,948	33,875		165,823	2,744	168,567	0	168,567		3
4	Laundry	56,929	10,504		67,433		67,433	0	67,433		4
5	Heat and Other Utilities			86,161	86,161	3,827	89,988	0	89,988		5
6	Maintenance	61,156	71,856	21,770	154,782	22,622	177,404	0	177,404		6
7	Other (specify):*							0			7
8	<b>TOTAL General Services</b>	420,165	269,283	114,661	804,109	29,502	833,611		833,611		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,300	9,300		9,300	0	9,300		9
10	Nursing and Medical Records	282,808	64,889	9,007	356,704		356,704	0	356,704		10
10a	Therapy			1,950	1,950		1,950	0	1,950		10a
11	Activities	1,341,245	71,561		1,412,806		1,412,806	0	1,412,806		11
12	Social Services	147,248		26,636	173,884		173,884	0	173,884		12
13	Nurse Aide Training	7,956			7,956		7,956	0	7,956		13
14	Program Transportation	9,775	33,076		42,851		42,851	0	42,851		14
15	Other (specify):*							0			15
16	<b>TOTAL Health Care and Programs</b>	1,789,032	169,526	46,893	2,005,451		2,005,451		2,005,451		16
	<b>C. General Administration</b>										
17	Administrative	41,204		116,041	157,245	(116,041)	41,204	0	41,204		17
18	Directors Fees							0			18
19	Professional Services			5,784	5,784	26,654	32,438	(20,830)	11,608		19
20	Dues, Fees, Subscriptions & Promotions			17,902	17,902	13,033	30,935	(5,484)	25,451		20
21	Clerical & General Office Expenses	360,624	27,184	8,456	396,264	22,061	418,325	(6,109)	412,216		21
22	Employee Benefits & Payroll Taxes			461,102	461,102		461,102	0	461,102		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			1,943	1,943	5,291	7,234	(5,291)	1,943		24
25	Other Admin. Staff Transportation					1,049	1,049	0	1,049		25
26	Insurance-Prop.Liab.Malpractice			69	69	300	369	0	369		26
27	Other (specify):*							0			27
28	<b>TOTAL General Administration</b>	401,828	27,184	611,297	1,040,309	(47,653)	992,656	(37,714)	954,942		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,611,025	465,995	772,851	3,849,869	(18,151)	3,831,718	(37,714)	3,794,004		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.

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**IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES**

STATE OF ILLINOIS

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			92,777	92,777	7,295	100,072	(7,295)	92,777			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			41,624	41,624	7,544	49,168	0	49,168			32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds					3,312	3,312	0	3,312			34
35	Rent-Equipment & Vehicles			2,028	2,028		2,028	0	2,028			35
36	Other (specify):* <b>amortization</b>			3,366	3,366		3,366	0	3,366			36
37	<b>TOTAL Ownership</b>			139,795	139,795	18,151	157,946	(7,295)	150,651			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			232,532	232,532		232,532	0	232,532			42
43	Other (specify):*							0				43
44	<b>TOTAL Special Cost Centers</b>			232,532	232,532		232,532		232,532			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,611,025	465,993	1,145,178	4,222,196	0	4,222,196	(45,009)	4,177,187			45

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

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**FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/99 Ending: 6/30/00

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,109)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38,900)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (45,009)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (45,009)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY						
48		49	50	51	52	

Print Previe



**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **Aspire on Eastern**

# **0020438** Report Period Beginning:

**7/1/99**

Ending:

**6/30/00**

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

Print Summary		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)
		<b>A. General Services</b>												
1		Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2		Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 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		<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 8</b>
		<b>B. Health Care and Programs</b>												
9		Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10		Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 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		Nurse Aide 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		<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 16</b>
		<b>C. General Administration</b>												
17		Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18		Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19		Professional Services	0	0	0	0	0	0	0	0	0	0	0	0 19
20		Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0 20
21		Clerical & General Office Expenses	(6,109)	0	0	0	0	0	0	0	0	0	0	(6,109) 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	0	0	0	0	0	0	0	0	0	0	0 25
26		Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28		<b>TOTAL General Administration</b>	<b>(6,109)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,109) 28</b>
29		<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(6,109)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,109) 29</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/99

Ending:

6/30/00

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

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(6,109)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,109)</b>	<b>45</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY

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
NA						

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

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

Schedule V	Line	Item	Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
	1	V					1
	2	V					2
	3	V					3
	4	V					4
	5	V					5
	6	V					6
	7	V					7
	8	V					8
	9	V					9
	10	V					10
	11	V					11
	12	V					12
	13	V					13
	14	Total					14

Sum\_6

\* Total must agree with the amount recorded on line 24 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS

- Enter the information on pages 5 and 5A.
- For pages 6 thru 61, the information you enter does not need to be sorted by line reference.
- For pages 6 thru 61, a line can be referenced as many times as needed per page.
- For pages 6 thru 61, related organization costs for therapy must be referenced as line number 10a.
- The adjustments entered on this page will automatically transfer to the summary pages.

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Line 1 2 3 4 5 6 7 9 10 10a 11 12 13 14 15 17 18 19 20 21 22 23 24 25 26 27 30 31 32 33 34 35 36 38 39 40 41 42 43

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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.

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Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning: 7/1/99

Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Aspire of Illinois  
 Street Address 9901 Derby lane  
 City / State / Zip Code Westchester, IL 60154  
 Phone Number ( 708-547-3550  
 Fax Number ( 708-547-4067

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Kitchen Supplies	Direct Cost	13,591,579	30	\$ 286	\$ 4,254,164	\$ 90	1
2	2	Food/Beverage	Direct Cost	13,591,579	30	700	4,254,164	219	2
3	3	Houskeeping Supplies	Direct Cost	13,591,579	30	1,909	4,254,164	598	3
4	3	Hskp. Other	Direct Cost	13,591,579	30	6,855	4,254,164	2,146	4
5	5	Utilities	Direct Cost	13,591,579	30	12,226	4,254,164	3,827	5
6	6	Maint. Supplies	Direct Cost	13,591,579	30	34,316	4,254,164	10,741	6
7	6	Maint. Other	Direct Cost	13,591,579	30	37,958	4,254,164	11,881	7
8	19	Prof. Services	Direct Cost	13,591,579	30	85,157	4,254,164	26,654	8
9	20	Dues, Fees, Other	Direct Cost	13,591,579	30	41,638	4,254,164	13,033	9
10	21	Clerical Supplies	Direct Cost	13,591,579	30	46,814	4,254,164	14,653	10
11	21	Telephone	Direct Cost	13,591,579	30	23,668	4,254,164	7,408	11
12	24	Travel and Seminar	Direct Cost	13,591,579	30	16,904	4,254,164	5,291	12
13	25	Staff Travel	Direct Cost	13,591,579	30	3,351	4,254,164	1,049	13
14	26	Insurance	Direct Cost	13,591,579	30	957	4,254,164	300	14
15	30	Depreciation	Direct Cost	13,591,579	30	23,307	4,254,164	7,295	15
16	32	Interest	Direct Cost	13,591,579	30	24,101	4,254,164	7,544	16
17	34	Building Rental	Direct Cost	13,591,579	30	10,580	4,254,164	3,312	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 370,727	\$	\$ 116,041	25

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**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	IHFA		xx	Aspire on Eastern	\$28,351.00	08/01/88	\$ 2,276,000	\$	08/01/03	7.57	\$ 24,488	1								
2	Illinois Facilities Fund		xx	9901 Derby Lane	\$4,631.00	10/13/99	495,000		10/13/15	7.65	7,544	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Banco Popular		xx	Line of Credit							17,136	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$32,982.00		\$ 2,771,000	\$			\$ 49,168	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,771,000	\$			\$ 49,168	15								

\* 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.)

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Facility Name & ID Number **Aspire on Eastern**# **0020438** Report Period Beginning:**7/1/99**

Ending:

**6/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	0	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.)	\$	0	2
3. Under or (over) accrual (line 2 minus line 1).	\$	0	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	0	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. 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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	0	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	8	
	1996	9	
	1997	10	
	1998	11	
	1999	12	
	<b>FOR OFF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 1999	\$ 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.**

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Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/99

Ending:

6/30/00

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 28,330 B. General Construction Type: Exterior Brick Frame Metal Number of Stories One

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>	<u>195,000</u>	<u>1975</u>	<u>\$ 175,000</u>	1
2					2
3	<b>TOTALS</b>	<b>195,000</b>		<b>\$ 175,000</b>	<b>3</b>

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**IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.**

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/99

Ending:

6/30/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82		1975	1975	\$ 835,850	\$ 20,896	40	\$ 20,896	\$	\$ 501,286	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Remodeling		1976		4,485					4,485	9
10	Bldg Improvements		1980		27,900					27,900	10
11	Blacktopping		1980		11,625		15			11,625	11
12	Remodeling		1982		16,244		20	812	812	13,249	12
13	Patio		1983		4,095		10			4,095	13
14	Nurses Station		1983		2,065		10			2,065	14
15	Fan Shut Down		1983		2,136		10			2,136	15
16	Intercom		1984		1,412		10			1,412	16
17	Fence		1985		4,658		10			4,658	17
18	Fire Alarm		1985		1,358		10			1,358	18
19	Booster Water Temp		1985		1,415		10			1,415	19
20	Laundry Room		1986		7,775	0	30	260	260	3,770	20
21	Tiling		1986		1,125	0	20	56	56	812	21
22	Garbage Disposal		1986		1,159		10			1,159	22
23	A/C		1986		3,075		10			3,075	23
24	HVAC		1987		1,906		8			1,906	24
25	Insulation		1987		6,639	0	20	332	332	4,482	25
26	Electrical		1987		28,350	0	20	1,418	1,418	19,143	26
27	Water Heater		1987		1,422	0	15	94	94	1,269	27
28	HVAC		1987		6,534		8			6,534	28
29	Electrical		1988		11,456	0	20	572	572	7,150	29
30	Water Cond.		1988		1,900	0	15	126	126	1,575	30
31	Paving		1989		18,732		15	1,248	1,248	14,352	31
32	Water Softener		1989		2,000		12	166	166	1,909	32
33	HVAC		1989		9,774		8			9,774	33
34	Walk-In Cooler		1989		23,330		25	934	934	10,741	34
35	Front Enclosure		1989		3,595		20	180	180	2,070	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 20,896		\$ 27,094	\$ 6,198	\$ 665,405	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.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/99

Ending:

6/30/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Bldg. Addition		1992		464,250	15,474	30	15,474		139,266	9
10	Bldg. Addition		1993		13,070	436	30	436		3,488	10
11	Doors		1990		5,072		10	507	507	5,072	11
12	HVAC		1990		7,878		8			7,878	12
13	sink		1991		3,150		20	158	158	1,657	13
14	HVAC		1991		6,872		8			6,872	14
15	Roof		1992		30,828		20	1,541	1,541	14,641	15
16	Sealcoating		1993		2,650		8	331	331	2,650	16
17	Hot Water Heater		1993		3,075		15	205	205	1,743	17
18	HVAC		1993		6,230		8	779	779	5,921	18
19	Security System		1993		1,365		10	137	137	1,163	19
20	Dishwater		1994		6,032		10	603	603	3,893	20
21	HVAC		1995		3,250		8	406	406	2,436	21
22	Water Heater		1995		2,500		10	250	250	1,500	22
23	Ventilators		1995		3,145		8	392	392	2,352	23
24	Bathroom Tile		1995		4,278		20	214	214	1,284	24
25	Bathtub		1995		12,353		15	824	824	4,944	25
26	HVAC		1995		6,906		8	864	864	5,184	26
27	Paving Bus Area		1995		3,990		15	266	266	1,596	27
28	Front End		1984		13,115		30	438	438	7,226	28
29	Security Camera		1995		1,499		5	300	300	1,499	29
30	Carpeting		1995		16,348		8	2,044	2,044	10,220	30
31	Roof Cooler		1995		1,300	163	8	163		815	31
32	Hot Water Heater		1996		2,500		8	313	313	1,565	32
33	Remodeling		1996		7,221	362	20	362		1,448	33
34	Canopy		1996		12,300	1,230	10	1,230		4,920	34
35	HVAC		1997		2,246	280	8	280		1,120	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 17,945		\$ 28,517	\$ 10,572	\$ 242,353	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.

Print Previe

**IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.**

Print Page 12

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/99 Ending: 6/30/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Soffit & Facia		1997		12,782	1,278	10	1,278		5,112	9
10	Sealcoating		1997		11,000	1,376	8	1,376		5,504	10
11	Fence		1997		5,091	254	20	254		1,016	11
12	Remodel-cafeteria		1988		28,076	1,404	20	1,404		4,212	12
13	Plumbing Waver Heater		1998		8,300	1,038	8	1,038		3,114	13
14	Nurses Station		1998		3,880	194	20	194		582	14
15	HVAC		1998		5,635	704	8	704		2,112	15
16	Sealcoating		1998		11,000	1,375	8	1,375		4,125	16
17	Electrical		1998		6,368	318	20	318		954	17
18	A/C		1999		6,800	680	10	680		1,360	18
19	Security System		1999		1,200	120	10	120		240	19
20	Patio Cover		1999		11,205	560	20	560		1,120	20
21	HVAC		2000		2,450	153	8	306	153	306	21
22	Roof		2000		1,250	42	15	83	41	156	22
23	Later in Life Renovation		2000		162,432	675	30	5,414	4,739	5,414	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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 10,171		\$ 15,104	\$ 4,933	\$ 35,327	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.

Print Previe

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/99 Ending: 6/30/00

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	
37	Purchased in Prior Years	\$ 136,515	\$ 12,593	\$ 12,593	\$	8	\$ 92,510	37
38	Current Year Purchases	35,202	2,200	4,400	2,200	8	4,400	38
39	Fully Depreciated Assets	228,194					228,194	39
40								40
41	TOTALS	\$ 399,911	\$ 14,793	\$ 16,993	\$ 2,200		\$ 325,104	41

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	
42	Facility Business	1997 Dodge Van	1998	\$ 22,800	\$ 5,278	\$ 5,068	\$ (210)	4	\$ 10,136	42
43										43
44										44
45										45
46	TOTALS			\$ 22,800	\$ 5,278	\$ 5,068	\$ (210)		\$ 10,136	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 69,083	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 92,777	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 23,694	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,278,325	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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.

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**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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 Date of Lease	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	<b>TOTAL</b>				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 2,028

Description: Various one-time rentals

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2001 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2002 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2003 \$ \_\_\_\_\_

\* 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.

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

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>COMMUNITY COLLEGE      <input type="checkbox"/></p> <p>HOURS PER AIDE      <u>40</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>HOURS PER AIDE      <u>40</u></p>
--	---	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies				
3 Classroom Wages (a)		3,978		3,978
4 Clinical Wages (b)		3,978		3,978
5 In-House Trainer Wages (c)		8,800		8,800
6 Transportation				
7 Contractual Payments				
8 Nurse Aide Competency Tests				
9 TOTALS	\$	\$ 16,756	\$	\$ 16,756
10 SUM OF line 9, col. 1 and 2 (e)	\$	16,756		

- (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 aide 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 aides.

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>14</b>

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
					Units	Cost						
1	Licensed Occupational Therapist	N/A	hrs	\$		\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL			\$		\$		\$		\$		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 nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number **Aspire on Eastern**

# **0020438**

Report Period Beginning: **7/1/99**

Ending:

**6/30/00**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **6/30/00**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 81,571	1
2	Cash-Patient Deposits		63,563	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )		1,265,733	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		38,301	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 1,449,168	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,391,282	13
14	Buildings, at Historical Cost		7,680,433	14
15	Leasehold Improvements, at Historical Cost		373,337	15
16	Equipment, at Historical Cost		2,219,767	16
17	Accumulated Depreciation (book methods)		(4,061,893)	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): <b>Deposit and Loan Costs</b>		33,773	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 7,636,699	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 9,085,867	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$ 601,639	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		63,563	28
29	Short-Term Notes Payable		1,064,144	29
30	Accrued Salaries Payable		554,615	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ 2,283,961	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,515,461	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,515,461	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ 5,799,422	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 822,965	\$ 3,286,445	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 822,965	\$ 9,085,867	48

\*(See instructions.)

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**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 747,591	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 747,591	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	75,374	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 75,374	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 822,965	24 *

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

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Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/99

Ending:

6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,001,752	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,001,752	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	222,689	10
11	Nurses Aide Training Reimbursements	11,176	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 233,865	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	61,884	24
25	Interest and Other Investment Income***	69	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 61,953	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,297,570	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	\$ 804,109	31
32	Health Care	2,005,451	32
33	General Administration	1,040,309	33
<b>B. Capital Expense</b>			
34	Ownership	139,795	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	232,532	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)**</b>	\$ 4,222,196	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	75,374	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 75,374	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* 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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,726	2,080	\$ 45,519	\$ 21.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	12,550	14,425	237,289	16.45	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	3,515	4,040	62,093	15.37	11
12	Dietician					12
13	Food Service Supervisor	1,768	2,080	22,592	10.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,845	19,362	147,540	7.62	15
16	Dishwashers					16
17	Maintenance Workers	4,721	5,426	61,156	11.27	17
18	Housekeepers	14,512	16,681	131,948	7.91	18
19	Laundry	6,822	7,841	56,929	7.26	19
20	Administrator	1,726	2,080	41,204	19.81	20
21	Assistant Administrator	2,669	3,140	64,092	20.41	21
22	Other Administrative	8,315	9,899	229,846	23.22	22
23	Office Manager					23
24	Clerical	7,007	8,054	66,686	8.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,977	6,840	85,155	12.45	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	133,868	150,413	1,349,201	8.97	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Program Transp	923	1,061	9,775	9.21	33
34	TOTAL (lines 1 - 33)	222,944	253,422	\$ 2,611,025 *	\$ 10.30	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	160	\$ 6,730	1	35
36	Medical Director	60	7,500	9	36
37	Medical Records Consultant	33	1,172	10	37
38	Nurse Consultant	261	7,835	10	38
39	Pharmacist Consultant		1,950	10	39
40	Physical Therapy Consultant	34	2,012	12	40
41	Occupational Therapy Consultant	63	3,775	12	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	92	5,499	12	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	100	14,970	12	46
47	<u>Neurologist</u>	12	1,800	9	47
48	<u>Psychologist</u>	5	380	12	48
49	TOTAL (lines 35 - 48)	820	\$ 53,623		49

C. CONTRACT NURSES

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

Print Preview



Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/99

Ending:

6/30/00

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY1997	6 FY1998	7 FY1999	8 FY2000	9 FY2001	10 FY2002	11 FY2003	12 FY2004	13 FY2005
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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Facility Name & ID Number Aspire on Eastern# 0020438

Report Period Beginning:

7/1/99

Ending:

6/30/00**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? no  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,752 Line 10
- (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 xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO xx 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 of Public Aid during this cost report period. \$ 232,532  
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 of Public Aid, 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. \$ 0 Has any meal income been offset against related costs? 0 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? 100  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: BDO Seidman The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, 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.