

		FOR OHF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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>I. IDPH Facility ID Number: <u>0020438</u></p> <p>Facility Name: <u>Aspire on Eastern</u></p> <p>Address: <u>105 Eastern Avenue</u> <u>Bellwood</u> <u>60104</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>708-547-3550</u> Fax # <u>708-547-4067</u></p> <p>IDPA ID Number: <u>362654558-001</u></p> <p>Date of Initial License for Current Owners: <u>3/1/75</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 c 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jim O'Brien</u> Telephone Number: <u>708-547-3550</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 c 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/04</u> to <u>6/30/05</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 border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>James O'Brien</u></td> </tr> <tr> <td></td> <td>(Title) <u>VP of Business Admin</u></td> </tr> <tr> <td></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="center"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>James O'Brien</u>		(Title) <u>VP of Business Admin</u>		(Signed) _____ (Date) _____	Paid Preparer	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (____) _____ Fax # (____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Signed) _____ (Date) _____																																						
Paid Preparer	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) (____) _____ Fax # (____) _____																																						

Facility Name & ID Number Aspire on Eastern

0020438 Report Period Beginning: 7/1/04 Ending: 6/30/05

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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	29,312	365		29,677	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,312	365		29,677	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.15%

D. How many bed-hold days during this year were paid by the Department? 196 (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 3/1/75

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.

STATE OF ILLINOIS

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/04 Ending: 6/30/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	194,695	23,743	12,171	230,609	33	230,642	230,642			1
2	Food Purchase		157,198		157,198	1,458	158,656	158,656			2
3	Housekeeping	191,180	57,636		248,816	4,899	253,715	253,715			3
4	Laundry	67,872	5,540		73,412		73,412	73,412			4
5	Heat and Other Utilities			87,914	87,914	3,075	90,989	90,989			5
6	Maintenance	81,674	29,627	73,278	184,579	12,862	197,441	197,441			6
7	Other (specify):*										7
8	TOTAL General Services	535,421	273,744	173,363	982,528	22,327	1,004,855	1,004,855			8
B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500	10,500			9
10	Nursing and Medical Records	347,966	69,223	4,215	421,404		421,404	421,404			10
10a	Therapy										10a
11	Activities	1,653,211	58,629		1,711,840		1,711,840	1,711,840			11
12	Social Services	183,205		55,802	239,007		239,007	239,007			12
13	CNA Training	23,050			23,050		23,050	23,050			13
14	Program Transportation	4,117	61,266		65,383		65,383	65,383			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,211,549	189,118	70,517	2,471,184		2,471,184	2,471,184			16
C. General Administration											
17	Administrative	49,922		123,802	173,724	(123,802)	49,922	49,922			17
18	Directors Fees										18
19	Professional Services			5,784	5,784	34,560	40,344	(26,731)	13,613		19
20	Dues, Fees, Subscriptions & Promotions			15,611	15,611	7,022	22,633	(5,251)	17,382		20
21	Clerical & General Office Expenses	379,970	5,675	33,899	419,544	21,607	441,151	441,151			21
22	Employee Benefits & Payroll Taxes			594,506	594,506		594,506	594,506			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,516	1,516	840	2,356	(840)	1,516		24
25	Other Admin. Staff Transportation			5,038	5,038	1,961	6,999	6,999			25
26	Insurance-Prop.Liab.Malpractice			18,324	18,324	413	18,737	18,737			26
27	Other (specify):*										27
28	TOTAL General Administration	429,892	5,675	798,480	1,234,047	(57,399)	1,176,648	(32,822)	1,143,826		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,176,862	468,537	1,042,360	4,687,759	(35,072)	4,652,687	(32,822)	4,619,865		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 Number Aspire on Eastern

#0020438

Report Period Beginning:

7/1/04

Ending:

6/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 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	
	D. Ownership											
30	Depreciation			102,935	102,935	10,180	113,115	(15,133)	97,982			30
31	Amortization of Pre-Op. & Org.			1,821	1,821		1,821		1,821			31
32	Interest			38,325	38,325	24,892	63,217		63,217			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,345	6,345		6,345		6,345			35
36	Other (specify):*											36
37	TOTAL Ownership			149,426	149,426	35,072	184,498	(15,133)	169,365			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				237,251		237,251		237,251			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers				237,251		237,251		237,251			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,176,862	468,537	1,191,786	5,074,436		5,074,436	(47,955)	5,026,481			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 Aspire on Eastern

0020438

Report Period Beginning: 7/1/04

Ending: 6/30/05

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	(15,133)	30		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	(26,731)	19		17
18	Fines and Penalties				18
19	Entertainment	(840)	24		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	(5,251)	24		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,955)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (47,955)		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	TOTAL (C): (sum of lines 38-46)			\$		47

Aspire on Eastern

ID# 0020438

Report Period Beginning: 7/1/04

Ending: 6/30/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aspire on Eastern# 0020438 Report Period Beginning:7/1/04

Ending:

6/30/05

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	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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	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	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	(26,731)	0	0	0	0	0	0	0	0	0	0	(26,731)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(6,091)	0	0	0	0	0	0	0	0	0	0	(6,091)	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	TOTAL General Administration	(32,822)	0	0	0	0	0	0	0	0	0	0	(32,822)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,822)	0	0	0	0	0	0	0	0	0	0	(32,822)	29

Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning: 7/1/04

Ending: 6/30/05

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
N/A						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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

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

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/04 Ending: 6/30/05

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

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/04 Ending: 6/30/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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)

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

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	1	Kitchen Supplies	Direct Cost	16,011,168	30	\$ 104	\$ 5,113,948	\$ 33	1
2	2	Food/Beverage	Direct Cost	16,011,168	30	4,566	5,113,948	1,458	2
3	3	Housekeeping Supplies	Direct Cost	16,011,168	30	3,241	5,113,948	1,035	3
4	3	Hskp. Other	Direct Cost	16,011,168	30	12,097	5,113,948	3,864	4
5	5	Utilities	Direct Cost	16,011,168	30	9,626	5,113,948	3,075	5
6	6	Maint. Supplies	Direct Cost	16,011,168	30	4,390	5,113,948	1,402	6
7	6	Maint. Other	Direct Cost	16,011,168	30	35,880	5,113,948	11,460	7
8	19	Prof. Services	Direct Cost	16,011,168	30	108,204	5,113,948	34,560	8
9	20	Dues, Fees, Other	Direct Cost	16,011,168	30	21,986	5,113,948	7,022	9
10	21	Clerical Supplies	Direct Cost	16,011,168	30	54,139	5,113,948	17,292	10
11	21	Telephone	Direct Cost	16,011,168	30	13,509	5,113,948	4,315	11
12	24	Travel Seminar	Direct Cost	16,011,168	30	2,629	5,113,948	840	12
13	25	Staff Travel	Direct Cost	16,011,168	30	6,139	5,113,948	1,961	13
14	26	Insurance	Direct Cost	16,011,168	30	1,293	5,113,948	413	14
15	30	Depreciation	Direct Cost	16,011,168	30	31,871	5,113,948	10,180	15
16	32	Interest	Direct Cost	16,011,168	30	77,933	5,113,948	24,892	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 387,607	\$	\$ 123,802	25

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/04 Ending: 6/30/05

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			
A. Directly Facility Related																				
Long-Term																				
1	Banco Popular		x	Aspire on Eastern	\$23,273.00	8/22/03	\$ 3,000,000	\$ 45,139		5.0000	\$ 38,325	1								
2	Illinois Facilities		x	9901 Derby	\$4,631.00	10/13/99	495,000	42,290		7.6500	8,446	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Banco Popular		x	Line of Credit							16,446	6								
7												7								
8												8								
9	TOTAL Facility Related				\$27,904.00		\$ 3,495,000	\$ 87,429			\$ 63,217	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 3,495,000	\$ 87,429			\$ 63,217	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

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

Facility Name & ID Number Aspire on Eastern# 0020438 Report Period Beginning: 7/1/04 Ending: 6/30/05

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2004 report.			\$	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.)			\$	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	3
4.	Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	_____	8	
		2001	_____	9	
		2002	_____	10	
		2003	_____	11	
		2004	_____	12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2004		\$		13
14	PLUS APPEAL COST FROM LINE 5		\$		14
15	LESS REFUND FROM LINE 6		\$		15
16	AMOUNT TO USE FOR RATE CALCULATION		\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aspire on Eastern COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020438

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 NO

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Aspire on Eastern# 0020438 Report Period Beginning:7/1/04 Ending:6/30/05**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 28,330 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land	195,000	1975	\$ 175,000	1
2					2
3	TOTALS	195,000		\$ 175,000	3

Facility Name & ID Number Aspire on Eastern# 0020438

Report Period Beginning:

7/1/04

Ending:

6/30/05**XL 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	\$	\$ 605,766	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Remodeling	1975		4,485					4,485	9
10	Bldg Improvements	1976		7,736					7,736	10
11	Bldg Improvements	1979		290					290	11
12	Bldg Improvements	1980		6,047					6,047	12
13	Bldg Improvements	1981		9,890					9,890	13
14	Bldg Improvements	1982		2,925					2,925	14
15	Bldg Improvements	1984		1,012					1,012	15
16	Blacktopping	1980		11,625		15			11,625	16
17	Remodeling	1982		16,244		20			16,244	17
18	Patio	1983		4,095		10			4,095	18
19	Nurses Station	1983		2,065		10			2,065	19
20	Fan Shut Down	1983		2,136		10			2,136	20
21	Intercom	1984		1,412		10			1,412	21
22	Fence	1985		4,658		10			4,658	22
23	fire alarm	1985		1,358		10			1,358	23
24	Booster Water Temp	1985		1,415		10			1,415	24
25	Laundry Room	1986		7,775		30	260	260	5,070	25
26	Tiling	1986		1,125		20	56	56	1,092	26
27	Garbage Disposal	1986		1,159		10			1,159	27
28	A/C	1986		3,075		10			3,075	28
29	HVAC	1986		1,906		8			1,906	29
30	Insulation	1987		6,639		20	332	332	6,142	30
31	Electrical	1987		28,350		20	1,418	1,418	26,223	31
32	Water Heater	1987		1,422		15			1,422	32
33	HVAC	1988		6,534		8			6,534	33
34	Electrical	1988		11,456		20	572	572	10,010	34
35	Water Cond	1988		1,900		15			1,900	35
36	Paving	1989		18,732		15			18,732	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning:

7/1/04

Ending:

6/30/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Water Softner	1989	\$ 2,000	\$	12	\$	\$	\$ 2,000	37
38	Hvac	1989	9,774		8			9,774	38
39	Walk-in Cooler	1989	23,330		25	934	934	15,411	39
40	Frint Enclosure	1989	3,595		20	180	180	2,970	40
41	Bldg. Addition	1992	464,250	15,474	30	15,474		216,636	41
42	Bldg. Adddition	1993	13,070	436	30	436		5,668	42
43	Doors	1990	5,072		10			5,072	43
44	HVAC	1990	7,878		8			7,878	44
45	Sink	1991	3,150		20	158	158	2,307	45
46	HVAC	1991	6,872		8			6,872	46
47	Roof	1992	30,828		20	1,541	1,541	22,346	47
48	Sealcoating	1993	2,650		8			2,650	48
49	Hot Water Heater	1993	3,075		15	205	205	2,768	49
50	HVAC	1993	6,230		8			6,230	50
51	Security System	1993	1,365		10	137	137	848	51
52	HVAC	1995	3,250		8			3,250	52
53	Water Heater	1995	2,500		10			2,500	53
54	Ventilators	1995	3,145		8			3,145	54
55	Bathroom Tile	1995	4,278		20	214	214	2,354	55
56	Bathub	1995	12,353		15	824	824	9,064	56
57	HVAC	1995	6,906		8			6,906	57
58	Paving Bus Area	1984	3,990		15	266	266	2,926	58
59	Front End	1998	13,115		30	438	438	9,416	59
60	Carpeting	1995	16,348		8			16,348	60
61	Troof Cooler	1995	1,300		8			1,300	61
62	Hot Water Heater	1996	2,500		8			2,500	62
63	Remodeling	1996	7,221	362	20	362		3,258	63
64	Canopy	1996	12,300	1,230	10	1,230		11,070	64
65	HVAC	1997	2,246	6	8	6		2,246	65
66	Soffit & Facia	1997	12,782	1,278	10	1,278		11,502	66
67	Sealcoating	1997	11,000		8			11,000	67
68	Fence	1997	5,091	254	20	254		2,286	68
69	Water Heater	1998	8,300	1,038	8	1,038		8,304	69
70	TOTAL (lines 4 thru 69)		\$ 1,715,080	\$ 40,974		\$ 48,509	\$ 7,535	\$ 1,185,229	70

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

Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning:

7/1/04

Ending:

6/30/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,715,080	\$ 40,974		\$ 48,509	\$ 7,535	\$ 1,185,229	1
2	Nurses Station	1998	3,880	194	20	194		1,552	2
3	HVAC	1998	5,635	704	8	704		5,629	3
4	Sealcoating	1998	11,000	1,375	8	1,375		11,000	4
5	Electrical	1998	6,368	318	20	318		2,544	5
6	A/C	1999	6,800	680	10	680		4,760	6
7	Security System	1999	1,200	120	10	120		840	7
8	Patio Cover	1999	11,205	560	20	560		3,920	8
9	HVAC	2000	2,450	306	8	306		1,836	9
10	Roof	2000	1,250	83	15	83		571	10
11	Parking Lot	2001	29,300	2,930	10	2,930		13,185	11
12	Screen in Canopy	2002	16,486	824	30	824		3,296	12
13	Slope Renovation	2002	14,500	484	30	484		1,694	13
14	sidewalk	2002	1,900	126	30	126		441	14
15	Women Shower	2002	60,000	2,000	30	2,000		7,000	15
16	Bathroom renovation	2002	198,403	6,612	30	6,612		23,142	16
17	Kitchen renovation	2003	182,098	6,070	30	6,070		15,175	17
18	Windows replacement	2003	52,500	2,625	20	2,625		6,562	18
19	Sewer	2004	3,900	195	20	195		390	19
20	Electrical	2004	13,759	688	20	688		1,376	20
21	HVAC	2004	1,895	189	10	189		378	21
22	Fire Door	2004	10,700	535	20	535		1,070	22
23	Windows replacement	2004	70,062	3,503	20	3,503		7,006	23
24	HVAC	2005	2,165	49	8	98	49	98	24
25	Landscaping	2005	5,475	273	10	547	274	547	25
26	Hallway Renovation	2005	150,827	2,514	30	5,028	2,514	5,028	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,578,838	\$ 74,931		\$ 85,303	\$ 10,372	\$ 1,304,269	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 202,736	\$ 11,303	\$ 11,303	\$		\$ 170,915	71
72	Current Year Purchases	13,768	688	1,376	688		1,376	72
73	Fully Depreciated Assets	229,693					229,693	73
74								74
75	TOTALS	\$ 446,197	\$ 11,991	\$ 12,679	\$ 688		\$ 401,984	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1997 Dodge Van	1998	\$ 22,800	\$	\$	\$		\$ 22,800	76
77										77
78										78
79										79
80	TOTALS			\$ 22,800	\$	\$	\$		\$ 22,800	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)	\$ 3,222,835	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,922	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,982	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,060	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,729,053	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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: \$ 6,343 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	TOTAL		\$	\$	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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>2. CLASSROOM PORTION:</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 CNA <u>50</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</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)		6,750		6,750
4	Clinical Wages (b)		10,800		10,800
5	In-House Trainer Wages (c)		5,500		5,500
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	23,050	\$	23,050
10	SUM OF line 9, col. 1 and 2 (e)	\$	23,050		

- (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.

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	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	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 CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning: 7/1/04

Ending:

6/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/05

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,083	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,799,645	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments	170,808	5
6	Prepaid Insurance	53,659	6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,034,195	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	1,713,082	13
14	Buildings, at Historical Cost	12,644,089	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	3,012,051	16
17	Accumulated Depreciation (book methods)	(6,290,014)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	100,440	20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):	5,086	22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,184,734	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,218,929	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 423,330	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	1,576,300	29
30	Accrued Salaries Payable	727,317	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
Other Current Liabilities(specify):			
36			36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,726,947	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable	7,137,526	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)	\$ 7,137,526	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,864,473	46
47	TOTAL EQUITY(page 18, line 24)	\$ 726,904	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,218,929	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,130,736	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,130,736	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(403,832)	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)	\$ (403,832)	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)	\$ 726,904	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,626,896	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,626,896	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	22,440	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)	\$ 22,440	23
D. Non-Operating Revenue			
24	Contributions	21,268	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,268	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)	\$ 4,670,604	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	982,528	31
32	Health Care	2,471,184	32
33	General Administration	1,234,047	33
B. Capital Expense			
34	Ownership	149,426	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	237,251	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,074,436	40
41	Income before Income Taxes (line 30 minus line 40)**	(403,832)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (403,832)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes 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.

Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/04Ending: 6/30/05

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	1,717	\$ 56,004	\$ 26.93	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	15,294	291,962	21.94	4
5	CNAs & Orderlies				5
6	CNA Trainees	2,760	23,050	8.35	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	1,209	21,608	14.18	13
14	Head Cook				14
15	Cook Helpers/Assistants	18,034	173,087	8.35	15
16	Dishwashers				16
17	Maintenance Workers	5,453	81,673	13.03	17
18	Housekeepers	16,583	191,180	10.03	18
19	Laundry	6,980	67,872	8.46	19
20	Administrator	1,784	49,922	24.00	20
21	Assistant Administrator	2,374	64,472	23.62	21
22	Other Administrative	7,024	233,415	28.91	22
23	Office Manager				23
24	Clerical	7,041	84,084	10.39	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	10,486	183,205	15.20	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	138,007	1,653,211	10.39	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>prog transp</u>	317	4,117	11.28	33
34	TOTAL (lines 1 - 33)	235,063	\$ 3,178,862 *	\$ 11.94	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	265	\$ 12,171	1	35
36	Medical Director	58	8,700	9	36
37	Medical Records Consultant	29	735	10	37
38	Nurse Consultant	139	3,480	10	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	122	6,125	12	40
41	Occupational Therapy Consultant	209	10,437	12	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	236	11,785	12	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psycharist</u>	275	27,455	12	46
47	<u>Neurologist</u>	12	1,800	9	47
48					48
49	TOTAL (lines 35 - 48)	1,345	\$ 82,688		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Vicki Pollick	administrator	0	\$ 49,922	Workers' Compensation Insurance	\$ 67,606	IDPH License Fee	\$	
				Unemployment Compensation Insurance	20,663	Advertising: Employee Recruitment	13,111	
				FICA Taxes	243,030	Health Care Worker Background Check	1,771	
				Employee Health Insurance	233,561	(Indicate # of checks performed <u>71</u>)		
				Employee Meals		Membership/Dues/License	250	
				Illinois Municipal Retirement Fund (IMRF)*		Subscription/Ref Materials	2,250	
				403 b	29,646			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,922			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
See Schedule VIII			\$ 123,802			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,382	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 594,506			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 123,802	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Clifton Gunderson	Audit		\$ 5,784				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	1,516
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 5,784	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 1,516

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/04Ending: 6/30/05**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. \$ 28,034 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 x 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. \$ 237,251
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. \$ _____ Has any meal income been offset against related costs? _____ 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? yes
Firm Name: Clifton Gunderson 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.