

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	195	Skilled (SNF)	195	71,175	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	195	TOTALS	195	71,175	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,248	705	7,223	18,176	8
9	SNF/PED					9
10	ICF	39,920	2,745	386	43,051	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,168	3,450	7,609	61,227	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.02%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/97 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 195 and days of care provided 6,719

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	287,659	55,424	19,003	362,086		362,086	(2,480)	359,606		1
2	Food Purchase		299,099		299,099	0	299,099	(2,456)	296,643		2
3	Housekeeping	194,647	26,476	0	221,123		221,123	(10,763)	210,360		3
4	Laundry	98,367	15,289	236	113,892	0	113,892	(12,784)	101,108		4
5	Heat and Other Utilities			196,147	196,147		196,147	0	196,147		5
6	Maintenance	74,466	43,063	52,608	170,137		170,137	(2,954)	167,183		6
7	Other (specify):*			26,109	26,109		26,109	0	26,109		7
8	TOTAL General Services	655,139	439,351	294,103	1,388,593	0	1,388,593	(31,437)	1,357,156		8
	B. Health Care and Programs										
9	Medical Director	0		38,400	38,400		38,400	0	38,400		9
10	Nursing and Medical Records	2,569,666	75,200	128,943	2,773,809		2,773,809	(87,519)	2,686,290		10
10a	Therapy	33,744		7,109	40,853		40,853	0	40,853		10a
11	Activities	120,108	10,587	13,462	144,157		144,157	558	144,715		11
12	Social Services	81,984		3,606	85,590		85,590	0	85,590		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			83	83		83	0	83		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	2,805,502	85,787	191,603	3,082,892	0	3,082,892	(86,961)	2,995,931		16
	C. General Administration										
17	Administrative	110,629		626,769	737,398		737,398	(625,810)	111,588		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			547,253	547,253		547,253	(267,060)	280,193		19
20	Dues, Fees, Subscriptions & Promotions			130,706	130,706		130,706	(108,448)	22,258		20
21	Clerical & General Office Expenses	285,958	41,149	44,087	371,194		371,194	212,847	584,041		21
22	Employee Benefits & Payroll Taxes			693,566	693,566	0	693,566	0	693,566		22
23	Inservice Training & Education			11,881	11,881		11,881	0	11,881		23
24	Travel and Seminar			651	651		651	10,432	11,083		24
25	Other Admin. Staff Transportation			13,492	13,492		13,492	0	13,492		25
26	Insurance-Prop.Liab.Malpractice			206,138	206,138		206,138	5,523	211,661		26
27	Other (specify):*			80,876	80,876		80,876	(80,876)	0		27
28	TOTAL General Administration	396,587	41,149	2,355,419	2,793,155	0	2,793,155	(853,392)	1,939,763		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,857,228	566,287	2,841,125	7,264,640	0	7,264,640	(971,790)	6,292,850		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	15,912
	REPAIRS & MAINTENANCE	3,091
		0
		19,003
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	236
		0
		236
5	HEAT & OTHER UTILITIES	
	GAS HEAT	98,149
	ELECTRICITY	74,020
	WATER	23,978
	CABLE TV - LOBBY	0
		0
		196,147
6	MAINTENANCE	
	GROUNDS MAINTENANCE	11,519
	PAINTING & DECORATING	3,127
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	12,976
	ELEVATOR MAINTENANCE & REPAIR	10,617
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	7,563
	FIRE SERVICE	6,806
		0
		0
		0
		0
		52,608
7	OTHER	
	SCAVENGER	25,552
	SECURITY SERVICE	557
		0
		0
		26,109
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	38,400
		38,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,875
	PHARMACY CONSULTANT XVIII B 39-2	1,200
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	112,472
	ALZHEIMERS CONSULTANT XVIII B 46-2	7,771
	WOUND CARE CONSULTANT XVIII B 47-2	5,625
		128,943
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	3,764
	SPEECH THERAPY SERVICES	1,205
	OCCUPATIONAL THERAPY SERVICES	1,255
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	885
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		7,109
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	10,306
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,156
		0
		13,462
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,606
		0
		3,606
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	83
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	626,769
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	32,034
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	515,219
		0
		547,253
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	102,251
	EMPLOYEE WANT ADS XIX F	2,327
	CONTRIBUTIONS VI 20 XIX F	764
	DUES & SUBSCRIPTIONS XIX F	13,149
	LICENSES & PERMITS XIX F	1,100
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,525
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,338
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,130
	PATIENT BACKGROUND CHECKS XIX F	3,122
		130,706
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	4,237
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,006
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	30,279
	MESSENGER SERVICE	6,565
		0
		44,087

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	290,051
	UNEMPLOYMENT COMPENSATION XIX D	81,035
	WORKERS COMPENSATION INSURANC XIX D	99,576
	HOSPITALIZATION INSURANCE XIX D	202,637
	EMPLOYEE BENEFITS - OTHER XIX D	13,746
	EMPLOYEE PHYSICAL EXAMS XIX D	833
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,688
	CHICAGO HEAD TAX XIX D	0
		0
		693,566
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	11,881
		11,881
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	651
		651
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	13,492
		13,492
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	206,138
		206,138
27	OTHER	
	BAD DEBTS VI 24	80,876
		80,876

GRAND TOTAL COLUMN 3 OTHER

2,841,125

ASPEN RIDGE CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	299,099	PATIENT MEALS	183681
LESS SALES TAX	(2,456)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	296,643	TOTAL MEALS/YEAR	183681
TOTAL PATIENT CENSUS	61,227	NET FOOD	296643
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	183681

TOTAL PATIENT MEALS	183681	COST PER MEAL	1.61
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

#0042481

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			39,558	39,558		39,558	282,469	322,027			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			771,649	771,649		771,649	486,654	1,258,303			32
33	Real Estate Taxes			73,772	73,772		73,772	0	73,772			33
34	Rent-Facility & Grounds			744,600	744,600		744,600	(706,799)	37,801			34
35	Rent-Equipment & Vehicles			50,660	50,660		50,660	10,662	61,322			35
36	Other (specify):* STORAGE & INS			6,886	6,886		6,886	36,176	43,062			36
37	TOTAL Ownership			1,687,125	1,687,125	0	1,687,125	109,162	1,796,287			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		242,561	357,247	599,808		599,808	0	599,808			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			106,763	106,763		106,763	0	106,763			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	242,561	464,010	706,571	0	706,571	0	706,571			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,857,228	808,848	4,992,260	9,658,336	0	9,658,336	(862,628)	8,795,708			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	11,534	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,456)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(3,006)	21		18
19	Entertainment	0	20		19
20	Contributions	(6,102)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(150)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,876)	27		24
25	Fund Raising, Advertising and Promotional	(102,251)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,525)	20		28
29	Other-Attach Schedule	(46,570)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (231,404)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(631,224)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (631,224)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (862,628)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

ASPEN RIDGE CARE CENTRE

ID# 0042481

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2,240	6	1
2	VACATION ACCRUAL	(2,480)	1	2
3	VACATION ACCRUAL	(10,763)	3	3
4	VACATION ACCRUAL	(12,784)	4	4
5	VACATION ACCRUAL	(5,194)	6	5
6	VACATION ACCRUAL	(8,212)	10	6
7	VACATION ACCRUAL	558	11	7
8	VACATION ACCRUAL	224	17	8
9	VACATION ACCRUAL	(529)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING	(3,065)	19	11
12	MEDICARE A BILLING	(665)	19	12
13	MARKETING CONSULTANT	(3,900)	19	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	(46,570)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASPEN RIDGE CARE CENTRE# 0042481

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(2,480)	0	0	0	0	0	0	0	0	0	0	(2,480)	1
2	Food Purchase	(2,456)	0	0	0	0	0	0	0	0	0	0	(2,456)	2
3	Housekeeping	(10,763)	0	0	0	0	0	0	0	0	0	0	(10,763)	3
4	Laundry	(12,784)	0	0	0	0	0	0	0	0	0	0	(12,784)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,954)	0	0	0	0	0	0	0	0	0	0	(2,954)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(31,437)	0	0	0	0	0	0	0	0	0	0	(31,437)	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	(8,212)	0	0	(79,307)	0	0	0	0	0	0	0	(87,519)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	558	0	0	0	0	0	0	0	0	0	0	558	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	(7,654)	0	0	(79,307)	0	0	0	0	0	0	0	(86,961)	16
	C. General Administration													
17	Administrative	224	0	(470,077)	0	735	(156,692)	0	0	0	0	0	(625,810)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,780)	0	90,013	729	(348,022)	0	0	0	0	0	0	(267,060)	19
20	Fees, Subscriptions & Promotions	(109,878)	0	194	661	575	0	0	0	0	0	0	(108,448)	20
21	Clerical & General Office Expenses	(3,535)	0	24,302	4,317	187,763	0	0	0	0	0	0	212,847	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	2,359	3,999	4,074	0	0	0	0	0	0	10,432	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	1,970	2,019	1,534	0	0	0	0	0	0	5,523	26
27	Other (specify):*	(80,876)	0	0	0	0	0	0	0	0	0	0	(80,876)	27
28	TOTAL General Administration	(203,845)	0	(351,239)	11,725	(153,341)	(156,692)	0	0	0	0	0	(853,392)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(242,936)	0	(351,239)	(67,582)	(153,341)	(156,692)	0	0	0	0	0	(971,790)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASPEN RIDGE CARE CENTRE# 0042481

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	11,534	266,956	368	215	3,396	0	0	0	0	0	0	282,469	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2)	486,656	0	0	0	0	0	0	0	0	0	486,654	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(744,600)	0	1,775	36,026	0	0	0	0	0	0	(706,799)	34
35	Rent-Equipment & Vehicles	0	0	5,683	2,464	2,515	0	0	0	0	0	0	10,662	35
36	Other (specify):*	0	36,176	0	0	0	0	0	0	0	0	0	36,176	36
37	TOTAL Ownership	11,532	45,188	6,051	4,454	41,937	0	0	0	0	0	0	109,162	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(231,404)	45,188	(345,188)	(63,128)	(111,404)	(156,692)	0	0	0	0	0	(862,628)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		ASPEN RIDGE MONROE STREET, LLC	MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED BUSINESS ENTITIES		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 744,600	ASPEN RIDGE MONROE STREET, LLC		\$	(744,600)	1
2	V	36 MORTGAGE INSURANCE		" "		36,176	36,176	2
3	V	30 DEPRECIATION - BLDG/IMP		" "		175,156	175,156	3
4	V	30 DEPRECIATION -EQPT		" "		91,800	91,800	4
5	V	32 AMORTIZATION - MTG COST		" "		4,624	4,624	5
6	V	32 INTEREST - MORTGAGE		" "		482,032	482,032	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 744,600			\$ 789,788	\$ * 45,188	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 PROFESSIONAL FEES	\$	YORK MANAGEMENT ASSOCIATES, IN.C		\$ 90,013	\$ 90,013	15
16	V	20 DUES & SUBSCRIPTIONS		" "		194	194	16
17	V	21 CLERICAL		" "		24,302	24,302	17
18	V	24 TRAVEL		" "		2,359	2,359	18
19	V	26 INSURANCE		" "		1,970	1,970	19
20	V	35 RENT - EQPT & VEHICLE		" "		5,683	5,683	20
21	V	17 ADMINISTRATIVE	470,077	" "			(470,077)	21
22	V	30 DEPRECIATION		" "		368	368	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 470,077			\$ 124,889	\$ * (345,188)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 112,472	CARLYLE NURSING ASSOCIATES, LLC		\$ 33,165	\$ (79,307)
16	V	19 PROFESSIONAL FEES		"		729	729
17	V	20 DUES & SUBSCRIPTIONS		"		661	661
18	V	21 CLERICAL		"		4,317	4,317
19	V	24 TRAVEL		"		3,999	3,999
20	V	26 INSURANCE		"		2,019	2,019
21	V	30 DEPRECIATION		"		215	215
22	V	34 RENT		"		1,775	1,775
23	V	35 RENT - EQPT & VEHICLE		"		2,464	2,464
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 112,472			\$ 49,344	\$ * (63,128)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 350,875	THE KENSINGTON GROUP, LLC		\$ 2,853	\$ (348,022)
16	V	20 DUES & SUBSCRIPTIONS		"		575	575
17	V	21 CLERICAL		"		187,763	187,763
18	V	24 TRAVEL		"		4,074	4,074
19	V	26 INSURANCE		"		1,534	1,534
20	V	30 DEPRECIATION		"		3,396	3,396
21	V	34 RENT		"		36,026	36,026
22	V	35 RENT - EQPT & VEHICLE		"		2,515	2,515
23	V	17 ADMINISTRATIVE		"		735	735
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 350,875			\$ 239,471	\$ * (111,404)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$ 156,692	CHESTERFIELD, LLC		\$	\$ (156,692)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 156,692			\$ 0	\$ * (156,692)

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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									\$		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 ASPEN RIDGE CARE CENTRE

0042481 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization YORK MANAGEMENT ASSOC. LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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	19	PROFESSIONAL FEES	PATIENT DAYS	176,808	4	\$ 259,936	\$ 61,227	\$ 90,013	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	176,808	4	560	61,227	194	2
3	21	CLERICAL	PATIENT DAYS	176,808	4	3,152	61,227	1,091	3
4	24	TRAVEL	PATIENT DAYS	176,808	4	6,813	61,227	2,359	4
5	26	INSURANCE	PATIENT DAYS	176,808	4	5,690	61,227	1,970	5
6	35	RENT - EQPT & VEHICLE	PATIENT DAYS	176,808	4	16,410	61,227	5,683	6
7	21	CLERICAL	DIRECT HOURS	1	1	23,211	23,211	1	7
8	30	DEPRECIATION	PATIENT DAYS	176,808	4	1,064	61,227	368	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 316,836	\$ 23,211	\$ 124,889	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 CARLYLE NURSING ASSOCIATES, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 33,165	\$ 33,165	1	\$ 33,165	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	6,221	61,227	729	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	5,639	61,227	661	3
4	21	CLERICAL	PATIENT DAYS	522,604	11	36,838	61,227	4,317	4
5	24	TRAVEL	PATIENT DAYS	522,604	11	34,123	61,227	3,999	5
6	26	INSURANCE	PATIENT DAYS	522,604	11	17,224	61,227	2,019	6
7	30	DEPRECIATION	PATIENT DAYS	522,604	11	1,834	61,227	215	7
8	34	RENT	PATIENT DAYS	522,604	11	15,145	61,227	1,775	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	522,604	11	21,023	61,227	2,464	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 171,212	\$ 33,165		\$ 49,344	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 THE KENSINGTON GROUP, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	\$ 24,352	\$ 61,227	\$ 2,853	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	4,910	61,227	575	2
3	21	CLERICAL	PATIENT DAYS	522,604	11	162,920	61,227	19,088	3
4	24	TRAVEL	PATIENT DAYS	522,604	11	34,777	61,227	4,074	4
5	26	INSURANCE	PATIENT DAYS	522,604	11	13,097	61,227	1,534	5
6	30	DEPRECIATION	PATIENT DAYS	522,604	11	28,982	61,227	3,396	6
7	34	RENT	PATIENT DAYS	522,604	11	307,494	61,227	36,026	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	522,604	11	21,468	61,227	2,515	8
9	17	ADMINISTRATIVE	DIRECT HOURS	1	1	735	735	735	9
10	21	CLERICAL	DIRECT HOURS	1	1	168,675	168,675	168,675	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 767,410	\$ 169,410	\$ 239,471	25

Facility Name & ID Number

ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC						\$	\$			\$	1						
2	GMAC		X	MORTGAGE	\$46,016.00	07/2002	7,480,000	7,203,503	07/2037	6.6600	482,032	2						
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YRS		161,845	141,036			4,624	3						
4												4						
5												5						
Working Capital																		
6												6						
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES	3,120,000	10,248,597	DEMAND	VARIES	770,467	7						
8	LETTER OF CREDIT FEE		X								1,182	8						
9	TOTAL Facility Related				\$46,016.00		\$ 10,761,845	\$ 17,593,136			\$ 1,258,305	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 10,761,845	\$ 17,593,136			\$ 1,258,305	15						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	68,484	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.)		\$	70,736	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,252	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	71,520	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.		\$	73,772	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	64,976	8
	2002	69,633	9
	2003	65,445	10
	2004	67,738	11
	2005	70,736	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASPEN RIDGE CARE CENTRE COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042481

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

	(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.	<u>04-12-03-251-014</u>	<u>NURSING HOME</u>	\$ <u>70,735.72</u>	\$ <u>70,735.72</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>70,735.72</u>	\$ <u>70,735.72</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,720 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 5

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>90,679</u>		\$	<u>1</u>
2					<u>2</u>
3	TOTALS	90,679		\$ 0	3

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	195	1997		\$ 4,059,452	\$ 147,616	27.5	\$ 147,616	\$	\$ 1,470,012	4
5		1997		14,949	544	27.5	544		5,142	5
6										6
7										7
8										8
	Improvement Type**									
9	*****RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC									
10	FIRE DOORS/ALUMINUM SCREENS		1997	3,609	131	27.5	131		1,245	10
11	LANDSCAPING		1997	16,142	587	27.5	587		5,576	11
12	OUTDOOR SIGNS		1997	8,110	295	27.5	295		2,692	12
13	KITCHEN REMODELING - FLOORING/CONCRETE FOOTINGS		1998	18,381	668	27.5	668		5,677	13
14	FENCE		1998	2,350	139	15	157	18	1,611	14
15	ASPHALT PAVEMENT		1998	7,491	442	15	499	57	4,387	15
16	PAVEMENT		1999	4,975	181	27.5	181		1,350	16
17	INSULATING UNIT		1999	6,991	254	27.5	254		1,895	17
18	WALLCOVERINGS/TILES/BLOCK WALLS/CARPET		1999	126,568	4,602	27.5	4,602		34,324	18
19	AWNINGS		1999	7,939	289	27.5	289		2,155	19
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB		2000	64,360	2,340	27.5	2,340		15,113	20
21	INSTALLATION OF ALL DRAPERIES FOR 4 FLOORS		2001	7,828	285	27.5	285		1,567	21
22	PAINT & PREP. ROOMS ON FLOORS 4 & 5		2001	9,525	346	27.5	346		1,903	22
23	REPAIR HOLES, STRIP, SEAL CRACKS IN PARKING LOT		2001	5,950	216	27.5	216		1,188	23
24	INSTALL 41 INSULATING WINDOWS - RESIDENT ROOMS		2001	2,974	108	27.5	108		594	24
25	VCT FLOORING - DINING RM & ADMIN. CORRIDOR		2001	7,165	261	27.5	261		1,436	25
26	REPLACE ELEVATOR DOORS		2001	3,742	136	27.5	136		748	26
27	PATCH AND PREP. WALLS AND PAINT ROOMS ON 2ND, 3RD, AND 4TH FLOORS, SECOND AND 4TH FLOOR CORRIDORS		2002	12,983	1,304	7	1,855	551	8,348	28
29	FIRE ALARM - ADD/RELOCATE SMOKE SENOSRS		2002	6,027	219	27.5	219		1,013	29
30	INSTALL RUBBER ROOF WITH HALF INCH INSULATION		2003	12,090	440	27.5	440		1,540	30
31	INSTALL VINYL TILES IN SHOWER ROOMS ON THE 5TH FLR		2003	4,041	147	27.5	147		514	31
32	2 PLASTIC LAMINATED & INSULATED METAL STAIRWAY DOOR		2003	3,396	124	27.5	124		434	32
33	PAINT & PREP. NURSES STATIONS, 4TH FLOOR BATHRMS, 3RD FLOOR									33
34	DOORJAMS, FRAMES & STAIRWELLS, 2ND FLOOR BATHROOMS		2003	9,643	351	27.5	351		1,230	34
35	NURSE CALL SYSTEM WITH 24 LITE PANEL, PULL CORD & BED		2003	31,136	1,132	27.5	1,132		3,962	35
36	PAINT & PREP. & HANG WALLPAPERS		2004	35,000	6,123	7	5,000	(1,123)	12,500	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	BORDER, VINYL FLOORS FOR 2ND FLOOR DINING RM	2004	\$ 16,669	\$ 2,916	7	\$ 2,381	\$ (535)	\$ 5,953	37
38	SIGNS FOR BUILDING	2004	1,290	226	7	184	(42)	460	38
39	BORDERS FOR ALL RESIDENT RMS & DINING ROOM	2004	3,335	583	7	476	(107)	1,190	39
40	REMOVE AND INSTALL NEW FLOOR	2004	8,028	1,404	7	1,147	(257)	2,867	40
41	4TH FLOOR NURSES STATION/QUARRY TILE COVE BASE	2005	6,357	231	27.5	231		462	41
42	REPLACEMENT OF DOMESTIC HOT WATER HEATER	2005	32,871	1,195	27.5	996	(199)	1,992	42
43	INSTALLATION OF SPRINKLER SYSTEM	2005	1,325	48	27.5	40	(8)	80	43
44	CONCRETE WORK ON SIDE WALK	2005	2,550	170	15	170		255	44
45	COVE BASE/COVE BASE ADHESIVE - KITCHEN	2005	1,157	42	27.5	42		46	45
46	REPAIR ASPHALT PAVEMENT	2006	6,489	325	15	433	108	433	46
47	BUILD & INSTALL BASE CABINETS - NURSES STATION	2006	1,129	39	27.5	39		39	47
48	ADDITION OF NEW EMERGENCY CIRCUITS	2006	1,543	35	27.5	35		35	48
49	INSTALL NEW FIRE DAMPERS	2006	4,850	22	27.5	22		22	49
50	INSTALL NEW SHAFT SYSTEM	2006	38,901	177	27.5	177		177	50
51									51
52			ADJ TO SL	(1,537)			1,537		52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,619,311	\$ 175,156		\$ 175,156	\$ 0	\$ 1,602,167	70

**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	\$ 546,978	\$ 34,000	\$ 49,247	\$ 15,247	3-15 YRS	\$ 237,789	71
72	Current Year Purchases	36,903	5,558	1,845	(3,713)	3-15 YRS		72
73	Fully Depreciated Assets	19,911			0	3-15 YRS	19,911	73
74	RELATED PARTIES		95,779	95,779	0			74
75	TOTALS	\$ 603,792	\$ 135,337	\$ 146,871	\$ 11,534		\$ 257,700	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,223,103	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 310,493	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 322,027	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,534	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,859,867	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 RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy: YES NO Terms: _____ *

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: \$ 40,865 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	\$ 295.13	\$ 2,172	17
18	ADMINISTRATIVE	2004 CHEVY TRAIL BLZR	599.85	7,623	18
19					19
20					20
21	TOTAL		\$ 894.98	\$ 9,795	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 137,099	\$		\$ 137,099	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			54,402			54,402	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			160,614			160,614	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			5,132			5,132	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				188,871		188,871	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS & Other (specify): <u>I.V. THERAPY</u>	39-2					53,690		53,690	13
14	TOTAL			\$		\$ 357,247	\$ 242,561		\$ 599,808	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ (244,421)	\$ 138,278	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 85,017)	1,652,004	1,652,004	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,838	1,838	5
6	Prepaid Insurance	50,743	138,587	6
7	Other Prepaid Expenses	60,503	60,503	7
8	Accounts Receivable (owners or related parties)	280,792	207,234	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		849,495	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,801,459	\$ 3,047,939	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		716,400	13
14	Buildings, at Historical Cost		4,059,452	14
15	Leasehold Improvements, at Historical Cost		559,860	15
16	Equipment, at Historical Cost	583,882	1,501,882	16
17	Accumulated Depreciation (book methods)	(521,435)	(3,056,222)	17
18	Deferred Charges	770	141,806	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 63,217	\$ 3,923,178	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,864,676	\$ 6,971,117	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,156,609	\$ 1,156,609	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	98,352	98,352	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,282	95,282	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,319	19,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)		71,520	32
33	Accrued Interest Payable	1,069,155	39,979	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)	\$ 2,438,717	\$ 1,481,061	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,248,597	2,781,781	39
40	Mortgage Payable		7,203,503	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,248,597	\$ 9,985,284	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,687,314	\$ 11,466,345	46
47	TOTAL EQUITY(page 18, line 24)	\$ (10,822,638)	\$ (4,495,228)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,864,676	\$ 6,971,117	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,850,827)	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ.	(2)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,850,829)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,971,809)	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)	\$ (1,971,809)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (10,822,638)	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	\$ 7,684,251	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,684,251	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)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	2,274	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,274	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,686,527	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,388,593	31
32	Health Care	3,082,892	32
33	General Administration	2,793,155	33
	B. Capital Expense		
34	Ownership	1,687,125	34
	C. Ancillary Expense		
35	Special Cost Centers	599,808	35
36	Provider Participation Fee	106,763	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,658,336	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,971,809)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,971,809)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	3,436	3,693	\$ 148,437	\$ 40.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,391	3,601	86,667	24.07	3
4	Licensed Practical Nurses	52,826	57,360	1,164,147	20.30	4
5	CNAs & Orderlies	94,814	102,096	1,062,119	10.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,172	2,407	33,744	14.02	8
9	Activity Director	1,382	1,519	22,664	14.92	9
10	Activity Assistants	9,347	10,199	97,444	9.55	10
11	Social Service Workers	5,857	6,247	81,984	13.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,409	2,570	57,543	22.39	14
15	Cook Helpers/Assistants	26,529	28,135	230,116	8.18	15
16	Dishwashers					16
17	Maintenance Workers	4,242	4,837	74,466	15.40	17
18	Housekeepers	18,764	20,351	194,647	9.56	18
19	Laundry	10,732	11,705	98,367	8.40	19
20	Administrator	2,021	2,251	110,629	49.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,998	14,468	285,958	19.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,524	9,300	108,296	11.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	259,444	280,739	\$ 3,857,228 *	\$ 13.74	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	227	\$ 15,912	1-3	35
36	Medical Director	180	38,400	9-3	36
37	Medical Records Consultant	36	1,875	10-3	37
38	Nurse Consultant	547	112,472	10-3	38
39	Pharmacist Consultant	240	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	12	885	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	55	3,156	11-3	44
45	Social Service Consultant	63	3,606	12-3	45
46	Other(specify) <u>ALZHEIMERS</u>	102	7,771	10-3	46
47	<u>WOUND CARE CONSULTANT</u>	112	5,625	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,574	\$ 190,902		49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	06/2003	\$ 2,732	3	\$ 455	\$ 911	\$ 911	\$ 455	\$	\$	\$	\$												
2	PAINT/DECORATING	06/2005	13,171	3			2,195	4,390	4,390	2,196														
3	PAINT/DECORATING	06/2006	3,127	3				522	1,042	1,042	521													
4																								
5																								
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20	TOTALS		\$ 19,030		\$ 455	\$ 911	\$ 3,106	\$ 5,367	\$ 5,432	\$ 3,238	\$ 521	\$												

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL. COUNCIL ON LTC - \$10465
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,210 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES 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. \$ 106,763
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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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