

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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.

**I. IDPH Facility ID Number:** 0020438

**Facility Name:** Aspire on Eastern

**Address:** 105 Eastern Avenue Bellwood 6014  
 Number City Zip Code

**County:** Cook

**Telephone Number:** 708-547-3550 **Fax #** 708-547-4067

**HFS ID Number:** 362654558-001

**Date of Initial License for Current Owners:** 3/1/75

**Type of Ownership:**

<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
<b>IRS Exemption Code</b> <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	

**In the event there are further questions about this report, please contact:**  
**Name:** Jim O'Brien **Telephone Number:** 708-547-3550

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/05 to 6/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>James O'Brien</u>	
	(Title) <u>VP of Business Admin</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

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

Facility Name & ID Number Aspire on Eastern

# 0020438 Report Period Beginning: 7/1/05 Ending: 6/30/06

**III. STATISTICAL DATA**

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	28,860	137		28,997
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	28,860	137		28,997

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.88%

D. How many bed-hold days during this year were paid by the Department? 276 (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.

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/05 Ending: 6/30/06

**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	
	<b>A. General Services</b>											
1	Dietary	211,680	26,648	11,676	250,004	47	250,051		250,051			1
2	Food Purchase		161,141		161,141	2,527	163,668		163,668			2
3	Housekeeping	171,609	48,284		219,893	4,811	224,704		224,704			3
4	Laundry	88,252	3,158		91,410		91,410		91,410			4
5	Heat and Other Utilities			93,996	93,996	4,182	98,178		98,178			5
6	Maintenance	68,024	23,287	89,290	180,601	15,191	195,792		195,792			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	539,565	262,518	194,962	997,045	26,758	1,023,803		1,023,803			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	344,627	80,459	27,316	452,402		452,402		452,402			10
10a	Therapy											10a
11	Activities	1,647,980	58,259		1,706,239		1,706,239		1,706,239			11
12	Social Services	199,051		56,874	255,925		255,925		255,925			12
13	CNA Training											13
14	Program Transportation	2,914		57,329	60,243		60,243		60,243			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,194,572	138,718	152,019	2,485,309		2,485,309		2,485,309			16
	<b>C. General Administration</b>											
17	Administrative	56,756		151,864	208,620	(151,864)	56,756		56,756			17
18	Directors Fees											18
19	Professional Services			8,784	8,784	50,877	59,661	(15,655)	44,006			19
20	Dues, Fees, Subscriptions & Promotions			5,746	5,746	12,616	18,362		18,362			20
21	Clerical & General Office Expenses	397,270	16,983	28,671	442,924	8,930	451,854		451,854			21
22	Employee Benefits & Payroll Taxes			588,205	588,205		588,205		588,205			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,512	2,512	1,632	4,144	(2,232)	1,912			24
25	Other Admin. Staff Transportation					1,429	1,429		1,429			25
26	Insurance-Prop.Liab.Malpractice			17,416	17,416	426	17,842		17,842			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	454,026	16,983	803,198	1,274,207	(75,954)	1,198,253	(17,887)	1,180,366			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,188,163	418,219	1,150,179	4,756,561	(49,196)	4,707,365	(17,887)	4,689,478			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: 7/1/05 Ending: 6/30/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			165,611	165,611	10,901	176,512	(64,196)	112,316			30
31	Amortization of Pre-Op. & Org.			1,821	1,821		1,821		1,821			31
32	Interest			39,470	39,470	38,295	77,765		77,765			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,486	5,486		5,486		5,486			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			212,388	212,388	49,196	261,584	(64,196)	197,388			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			277,616	277,616		277,616		277,616			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			277,616	277,616		277,616		277,616			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,188,163	418,219	1,640,183	5,246,565		5,246,565	(82,083)	5,164,482			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: 7/1/05

Ending: 6/30/06

**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	(64,196)	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	(15,655)			17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,232)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (82,083)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (82,083)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Aspire on Eastern

ID# 0020438  
 Report Period Beginning: 7/1/05  
 Ending: 6/30/06

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aspire on Eastern# 0020438

Report Period Beginning:

7/1/05

Ending:

6/30/06

**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	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	(2,232)	0	0	0	0	0	0	0	0	0	0	(2,232)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(2,232)	0	0	0	0	0	0	0	0	0	0	(2,232)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(2,232)	0	0	0	0	0	0	0	0	0	0	(2,232)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(64,196)	0	0	0	0	0	0	0	0	0	0	(64,196)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(64,196)</b>	<b>0</b>	<b>(64,196)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(66,428)</b>	<b>0</b>	<b>(66,428)</b>	<b>45</b>									

Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/05

Ending:

6/30/06

**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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

Aspire on Eastern

#

0020438

Report Period Beginning:

7/1/05

Ending:

6/30/06

## 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:

7/1/05

Ending: 6/30/06

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Kitchen Supplies	Direct Cost	16,013,231	30	\$ 142	\$ 5,275,655	\$ 47	1
2	2	Food/Beverage	Direct Cost	16,013,231	30	7,669	5,275,655	2,527	2
3	3	Housekeeping Supplies	Direct Cost	16,013,231	30	2,508	5,275,655	826	3
4	3	Hskp. Other	Direct Cost	16,013,231	30	12,097	5,275,655	3,985	4
5	5	Utilities	Direct Cost	16,013,231	30	12,693	5,275,655	4,182	5
6	6	Maint. Supplies	Direct Cost	16,013,231	30	2,881	5,275,655	949	6
7	6	Maint. Other	Direct Cost	16,013,231	30	43,228	5,275,655	14,242	7
8	19	Prof. Services	Direct Cost	16,013,231	30	154,426	5,275,655	50,877	8
9	20	Dues, Fees, Other	Direct Cost	16,013,231	30	38,293	5,275,655	12,616	9
10	21	Clerical Supplies	Direct Cost	16,013,231	30	13,680	5,275,655	4,507	10
11	21	Telephone	Direct Cost	16,013,231	30	13,424	5,275,655	4,423	11
12	24	Travel Seminar	Direct Cost	16,013,231	30	4,954	5,275,655	1,632	12
13	25	Staff Travel	Direct Cost	16,013,231	30	4,337	5,275,655	1,429	13
14	26	Insurance	Direct Cost	16,013,231	30	1,293	5,275,655	426	14
15	30	Depreciation	Direct Cost	16,013,231	30	33,088	5,275,655	10,901	15
16	32	Interest	Direct Cost	16,013,231	30	116,237	5,275,655	38,295	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 460,950	\$	\$ 151,864	25

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Banco Popular		x		\$23,273.00	8/22/03	\$ 3,000,000			5.0000	\$ 39,470	1								
2	Illinois Facilities		x		\$4,631.00	10/13/99	495,000			7.6500	6,571	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Banco Popular		x								31,724	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$27,904.00		\$ 3,495,000				\$ 77,765	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 3,495,000	\$			\$ 77,765	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.)



**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 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 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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 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 Aspire on Eastern

# 0020438 Report Period Beginning:

7/1/05 Ending:

6/30/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 28,330 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 1

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).

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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	<u>Land</u>	<u>195,000</u>	<u>1975</u>	<u>\$ 175,000</u>	1
2					2
3	<b>TOTALS</b>	<b>195,000</b>		<b>\$ 175,000</b>	<b>3</b>

Facility Name &amp; ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	82		1975	1975	\$ 835,850	\$ 20,896	40	\$ 20,896	\$	\$ 626,662	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
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	1,295	30	260	(1,035)	5,330	25
26		Tiling		1986	1,125	280	20	56	(224)	1,148	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	2,324	20	332	(1,992)	6,474	30
31		Electrical		1987	28,350	7,090	20	1,418	(5,672)	27,641	31
32		Water Heater		1987	1,422	145	15		(145)	1,422	32
33		HVAC		1988	6,534		8			6,534	33
34		Electrical		1988	11,456		20	572	572	10,582	34
35		Water Cond		1988	1,900		15			1,900	35
36		Paving		1989	18,732	4,372	15			18,732	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 &amp; ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/05

Ending:

6/30/06

**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	\$ 167	12	\$	\$ (167)	\$ 2,000	37
38	HVAC	1989	9,774		8			9,774	38
39	Walk-in Cooler	1989	23,330	4,665	25	934	(3,731)	15,411	39
40	Front Enclosure	1989	3,595		20	180	180	3,150	40
41	Bldg. Addition	1992	464,250	15,474	30	15,474		232,110	41
42	Bldg. Addition	1993	13,070	436	30	436		6,104	42
43	Doors	1990	5,072		10			5,072	43
44	HVAC	1990	7,878		8			7,878	44
45	Sink	1991	3,150	790	20	158	(632)	2,465	45
46	HVAC	1991	6,872		8			6,872	46
47	Roof	1992	30,828	7,705	20	1,541	(6,164)	23,887	47
48	Sealcoating	1993	2,650	331	8		(331)	2,650	48
49	Hot Water Heater	1993	3,075	1,435	15	205	(1,230)	2,973	49
50	HVAC	1993	6,230	779	8		(779)	6,230	50
51	Security System	1993	1,365	341	10	137	(204)	985	51
52	HVAC	1995	3,250	1,016	8		(1,016)	3,250	52
53	Water Heater	1995	2,500	1,125	10		(1,125)	2,500	53
54	Ventilators	1995	3,145	1,376	8		(1,376)	3,145	54
55	Bathroom Tile	1995	4,278	1,070	20	214	(856)	2,568	55
56	Bathtub	1995	12,353	4,135	15	824	(3,311)	9,888	56
57	HVAC	1995	6,906	2,198	8		(2,198)	6,906	57
58	Paving Bus Area	1984	3,990	1,330	15	266	(1,064)	3,192	58
59	Front End	1998	13,115	2,622	30	438	(2,184)	9,854	59
60	Carpeting	1995	16,348		8			16,348	60
61	Roof Cooler	1995	1,300		8			1,300	61
62	Hot Water Heater	1996	2,500	1,093	8		(1,093)	2,500	62
63	Remodeling	1996	7,221	362	20	362		3,620	63
64	Canopy	1996	12,300	1,230	10	1,230		12,300	64
65	HVAC	1997	2,246		8			2,246	65
66	Soffit & Facia	1997	12,782	1,278	10	1,278		12,780	66
67	Sealcoating	1997	11,000		8			11,000	67
68	Fence	1997	5,091	254	20	254		2,540	68
69	Water Heater	1998	8,300	519	8		(519)	8,300	69
70	TOTAL (lines 4 thru 69)		\$ 1,715,080	\$ 88,133		\$ 47,465	\$ (36,296)	\$ 1,231,756	70

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

Facility Name &amp; ID Number Aspire on Eastern

# 0020438

Report Period Beginning:

7/1/05

Ending:

6/30/06

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,715,080	\$ 88,133		\$ 47,465	\$ (40,668)	\$ 1,231,756	1
2	Nurses Station	1998	3,880	194	20	194		1,746	2
3	HVAC	1998	5,635	704	8	704		5,635	3
4	Sealcoating	1998	11,000	1,375	8	1,375		11,000	4
5	Electrical	1998	6,368	318	20	318		2,862	5
6	A/C	1999	6,800	680	10	680		5,440	6
7	Security System	1999	1,200	120	10	120		960	7
8	Patio Cover	1999	11,205	560	20	560		4,480	8
9	HVAC	2000	2,450	306	8	306		2,142	9
10	Roof	2000	1,250	83	15	83		654	10
11	Parking Lot	2001	29,300	2,930	10	2,930		16,115	11
12	Screen in Canopy	2002	16,486	824	30	824		4,120	12
13	Slope renovation	2002	14,500	484	30	484		2,178	13
14	Sidewalk	2002	1,900	126	30	126		567	14
15	Women Shower	2002	60,000	2,000	30	2,000		9,000	15
16	Bathroom renovation	2002	198,403	6,612	30	6,612		29,754	16
17	Kitchen renovation	2003	182,098	6,070	30	6,070		21,245	17
18	Windows replacement	2003	52,500	2,625	20	2,625		9,187	18
19	Sewer	2004	3,900	195	20	195		585	19
20	Electrical	2004	13,759	688	20	688		2,064	20
21	HVAC	2004	1,895	189	10	189		567	21
22	Fire Door	2004	10,700	535	20	535		1,605	22
23	Windows replacement	2004	70,062	3,503	20	3,503		10,509	23
24	HVAC	2005	2,165	98	8	98		196	24
25	Landscaping	2005	5,475	547	10	547		1,094	25
26	Hallway Renovation	2005	150,827	5,028	30	5,028		10,056	26
27	Carpeting	2006	41,192	2,060	10	4,119	2,059	4,119	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,620,030	\$ 126,987		\$ 88,378	\$ (38,609)	\$ 1,389,636	34

\*\*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: 7/1/05 Ending: 6/30/06

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	\$ 216,504	\$ 18,074	\$ 18,074	\$		\$ 190,365	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	229,693						73
74								74
75	TOTALS	\$ 446,197	\$ 18,074	\$ 18,074	\$		\$ 190,365	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	2005 GM Van	2005	\$ 29,319	\$ 5,864	\$ 5,864	\$	5	\$ 5,824	76
77										77
78										78
79										79
80	TOTALS			\$ 29,319	\$ 5,864	\$ 5,864	\$		\$ 5,824	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)	\$ 3,270,546	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 150,925	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 112,316	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (38,609)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,585,825	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Aspire on Eastern

# 0020438

Report Period Beginning: 7/1/05

Ending: 6/30/06

**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	<b>TOTAL</b>				\$			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 5,486      Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/05 Ending: 6/30/06

**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 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. <u>CLASSROOM PORTION:</u></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>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		13,360		13,360
4	Clinical Wages (b)		26,720		26,720
5	In-House Trainer Wages (c)		5,500		5,500
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 45,580	\$	\$ 45,580
10	SUM OF line 9, col. 1 and 2 (e)	\$	45,580		

**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	40
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>40</b>

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			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 prescrpts													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	<b>TOTAL</b>			\$		\$		\$		\$		\$				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 Aspire on Eastern# 0020438Report Period Beginning: 7/1/05

Ending:

6/30/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 43,358	1
2	Cash-Patient Deposits		64,074	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )		1,757,439	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		71,421	6
7	Other Prepaid Expenses		6,808	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 1,943,100	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,713,082	13
14	Buildings, at Historical Cost		13,083,825	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		3,291,880	16
17	Accumulated Depreciation (book methods)		(6,977,406)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 11,111,381	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 13,054,481	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 184,527	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		64,074	28
29	Short-Term Notes Payable		1,112,571	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)		708,508	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ 2,069,680	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,470,443	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,470,443	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ 8,540,123	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (313,047)	\$ 4,514,358	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (313,047)	\$ 13,054,481	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(313,047)	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)	\$ (313,047)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (313,047)	24 *

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

Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/05Ending: 6/30/06**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,636,150	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,636,150	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	139,510	10
11	CNA Training Reimbursements	73,218	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 212,728	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	47,497	24
25	Interest and Other Investment Income***	10,435	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 57,932	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	26,708	27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 26,708	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,933,518	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	997,045	31
32	Health Care	2,485,309	32
33	General Administration	1,274,207	33
<b>B. Capital Expense</b>			
34	Ownership	212,388	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	277,616	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,246,565	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(313,047)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (313,047)	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

# 0020438

Report Period Beginning: 7/1/05

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,740	2,080	\$ 58,574	\$ 28.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	12,158	13,661	286,053	20.94	4
5	CNAs & Orderlies					5
6	CNA Trainees	4,800	4,800	40,080	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	993	1,257	17,871	14.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,672	21,462	193,809	9.03	15
16	Dishwashers					16
17	Maintenance Workers	4,436	5,099	68,024	13.34	17
18	Housekeepers	15,103	16,597	171,609	10.34	18
19	Laundry	8,446	9,708	88,252	9.09	19
20	Administrator	1,828	2,080	56,756	27.29	20
21	Assistant Administrator	6,856	7,881	252,819	32.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,200	11,500	144,451	12.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,191	12,574	199,051	15.83	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	127,099	146,808	1,607,900	10.95	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>prog transp</u>	275	275	2,914	10.60	33
34	TOTAL (lines 1 - 33)	222,797	255,782	\$ 3,188,163 *	\$ 12.46	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	254	\$ 11,676	1	35
36	Medical Director	58	8,700	9	36
37	Medical Records Consultant	32	800	10	37
38	Nurse Consultant	192	5,760	10	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	223	11,174	12	40
41	Occupational Therapy Consultant	99	4,934	12	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	257	12,861	12	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psycharist</u>	279	27,905	12	46
47	<u>Neurologist</u>	12	1,800	9	47
48					48
49	TOTAL (lines 35 - 48)	1,406	\$ 85,610		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	576	20,756	10	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	576	\$ 20,756		53

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**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 Striegel	administrator	0	\$ 56,756	Workers' Compensation Insurance	\$ 36,657	IDPH License Fee	\$		
				Unemployment Compensation Insurance	608	Advertising: Employee Recruitment	1,644		
				FICA Taxes	243,894	Health Care Worker Background Check			
				Employee Health Insurance	279,065	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Membership/Dues/License	16,075		
				403 b	27,981	Subscription/Ref Materials	643		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 56,756						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
See Schedule VIII			\$ 151,864				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,912	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 151,864	TOTAL			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,362
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)		\$ 1,912
C. Professional Services									
Vendor/Payee	Type		Amount						
Clifton Gunderson	Audit		\$ 5,784						
Winston Strawn	Legal		3,000						
TOTAL (agree to Schedule V, line 19, column 3)									
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,784						

\* Attach copy of IMRF notifications

\*\*See instructions.



**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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,101 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 277,616  
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.