



Facility Name & ID Number ASPEN RIDGE CARE CENTRE

# 0042481 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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	12,057	985	9,152	22,194	8
9	SNF/PED					9
10	ICF	37,629	3,073		40,702	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,686	4,058	9,152	62,896	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.37%**

**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 8,613

Medicare Intermediary WISCONSIN PHYSICIAN SERVICE (WPS)

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	284,521	59,903	18,979	363,403		363,403	(1,527)	361,876		1
2	Food Purchase		296,582		296,582		296,582	(2,820)	293,762		2
3	Housekeeping	216,147	30,368		246,515		246,515	2,091	248,606		3
4	Laundry	93,809	22,023	23	115,855		115,855	(1,954)	113,901		4
5	Heat and Other Utilities			187,091	187,091		187,091		187,091		5
6	Maintenance	58,484	42,637	44,340	145,461		145,461	2,337	147,798		6
7	Other (specify):*			32,181	32,181		32,181		32,181		7
8	<b>TOTAL General Services</b>	652,961	451,513	282,614	1,387,088		1,387,088	(1,873)	1,385,215		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			38,400	38,400		38,400		38,400		9
10	Nursing and Medical Records	2,803,252	185,025	152,597	3,140,874		3,140,874	(98,486)	3,042,388		10
10a	Therapy	42,982		4,738	47,720		47,720		47,720		10a
11	Activities	133,205	9,004	14,073	156,282		156,282	606	156,888		11
12	Social Services	87,534		2,891	90,425		90,425		90,425		12
13	CNA Training										13
14	Program Transportation			681	681		681		681		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,066,973	194,029	213,380	3,474,382		3,474,382	(97,880)	3,376,502		16
	<b>C. General Administration</b>										
17	Administrative	134,953		711,112	846,065		846,065	(711,112)	134,953		17
18	Directors Fees										18
19	Professional Services			536,389	536,389		536,389	(355,760)	180,629		19
20	Dues, Fees, Subscriptions & Promotions			132,191	132,191		132,191	(109,551)	22,640		20
21	Clerical & General Office Expenses	267,622	38,726	56,139	362,487		362,487	202,943	565,430		21
22	Employee Benefits & Payroll Taxes			702,059	702,059		702,059		702,059		22
23	Inservice Training & Education			10,209	10,209		10,209		10,209		23
24	Travel and Seminar			2,737	2,737		2,737	14,155	16,892		24
25	Other Admin. Staff Transportation			10,458	10,458		10,458		10,458		25
26	Insurance-Prop.Liab.Malpractice			176,537	176,537		176,537	7,867	184,404		26
27	Other (specify):*			162,027	162,027		162,027	(162,027)			27
28	<b>TOTAL General Administration</b>	402,575	38,726	2,499,858	2,941,159		2,941,159	(1,113,485)	1,827,674		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,122,509	684,268	2,995,852	7,802,629		7,802,629	(1,213,238)	6,589,391		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	14,730
	REPAIRS & MAINTENANCE	4,249
		0
		18,979
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	23
		0
		23
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	103,891
	ELECTRICITY	60,862
	WATER	22,338
	CABLE TV - LOBBY	0
		0
		187,091
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	9,873
	PAINTING & DECORATING	4,531
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,162
	ELEVATOR MAINTENANCE & REPAIR	7,670
	OUTSIDE LABOR	1,000
	EXTERMINATING SERVICE	5,364
	FIRE SERVICE	5,740
		0
		0
		0
		0
		44,340
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	31,594
	SECURITY SERVICE	587
		0
		0
		32,181
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	38,400
		38,400

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	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	2,280
	PHARMACY CONSULTANT XVIII B 39-2	1,200
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B 48-2	3,075
	RN CONSULTANT XVIII B 38-2	112,472
	ALZHEIMERS CONSULTANT XVIII B 47-2	9,170
	WOUND CARE CONSULTANT XVIII B 46-2	24,400
		152,597
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	2,312
	SPEECH THERAPY SERVICES	431
	OCCUPATIONAL THERAPY SERVICES	750
	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	1,245
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		4,738
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	10,962
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,111
		0
		14,073
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,891
		0
		2,891
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	681
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	711,112
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	23,967
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	512,422
		0
		536,389
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	8,228
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	97,737
	EMPLOYEE WANT ADS XIX F	3,892
	CONTRIBUTIONS VI 20 XIX F	795
	DUES & SUBSCRIPTIONS XIX F	12,484
	LICENSES & PERMITS XIX F	3,401
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,119
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,620
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	915
	PATIENT BACKGROUND CHECKS XIX F	1,000
		132,191
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	329
	EQUIPMENT REPAIR & MAINTENANCE	4,943
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,055
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	42,529
	MESSENGER SERVICE	6,283
		0
		56,139

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	312,243
	UNEMPLOYMENT COMPENSATION XIX D	65,372
	WORKERS COMPENSATION INSURANC XIX D	75,425
	HOSPITALIZATION INSURANCE XIX D	219,543
	EMPLOYEE BENEFITS - OTHER XIX D	15,261
	EMPLOYEE PHYSICAL EXAMS XIX D	5,455
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	8,760
	CHICAGO HEAD TAX XIX D	0
		0
		702,059
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	10,209
		10,209
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	2,737
		2,737
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	10,458
		10,458
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	176,537
		176,537
27	<b>OTHER</b>	
	BAD DEBTS VI 24	162,027
		162,027

GRAND TOTAL COLUMN 3 OTHER

2,995,852

**ASPEN RIDGE CARE CENTRE  
SCHEDULES  
12/31/2007**

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

TOTAL FOOD PURCHASE	296,582
LESS SALES TAX	<u>(2,820)</u>
NET FOOD	293,762

TOTAL PATIENT CENSUS	62,896
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	188,688

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	188,688
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	188,688

NET FOOD	293,762
DIVIDE TOTAL MEALS/YEAR	<u>188,688</u>

COST PER MEAL	1.56
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE

#0042481

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			40,381	40,381		40,381	205,853	246,234		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			876,763	876,763		876,763	477,318	1,354,081		32
33	Real Estate Taxes			73,239	73,239		73,239		73,239		33
34	Rent-Facility & Grounds			744,600	744,600		744,600	(697,206)	47,394		34
35	Rent-Equipment & Vehicles			48,915	48,915		48,915	11,719	60,634		35
36	Other (specify):* <b>STORAGE &amp; MTG INS</b>			5,590	5,590		5,590	35,813	41,403		36
37	<b>TOTAL Ownership</b>			1,789,488	1,789,488		1,789,488	33,497	1,822,985		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		335,112	601,732	936,844		936,844		936,844		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			106,763	106,763		106,763		106,763		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		335,112	708,495	1,043,607		1,043,607		1,043,607		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,122,509	1,019,380	5,493,835	10,635,724		10,635,724	(1,179,741)	9,455,983		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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,010	30		9
10	Interest and Other Investment Income	(4,508)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,820)	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		20		17
18	Fines and Penalties	(2,055)	21		18
19	Entertainment	(8,228)	20		19
20	Contributions	(3,415)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(51)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(162,027)	27		24
25	Fund Raising, Advertising and Promotional	(97,737)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,119)	20		28
29	Other-Attach Schedule	(21,198)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (289,148)		\$	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)	(890,593)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (890,593)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,179,741)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

## ASPEN RIDGE CARE CENTRE

ID# 0042481

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 901	6	1
2	VACATION ACCRUAL	(1,527)	1	2
3	VACATION ACCRUAL	2,091	3	3
4	VACATION ACCRUAL	(1,954)	4	4
5	VACATION ACCRUAL	1,436	6	5
6	VACATION ACCRUAL	(15,077)	10	6
7	VACATION ACCRUAL	606	11	7
8	VACATION ACCRUAL		17	8
9	VACATION ACCRUAL	735	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING	(300)	19	11
12	MEDICARE A BILLING	(240)	19	12
13	MARKETING CONSULTANT	(5,869)	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	<b>Total</b>	(21,198)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASPEN RIDGE CARE CENTRE# 0042481

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(1,527)	0	0	0	0	0	0	0	0	0	0	(1,527)	1
2	Food Purchase	(2,820)	0	0	0	0	0	0	0	0	0	0	(2,820)	2
3	Housekeeping	2,091	0	0	0	0	0	0	0	0	0	0	2,091	3
4	Laundry	(1,954)	0	0	0	0	0	0	0	0	0	0	(1,954)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,337	0	0	0	0	0	0	0	0	0	0	2,337	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,873)</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>(1,873)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(15,077)	0	0	(83,409)	0	0	0	0	0	0	0	(98,486)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	606	0	0	0	0	0	0	0	0	0	0	606	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>	<b>(14,471)</b>	<b>0</b>	<b>0</b>	<b>(83,409)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(97,880)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(533,452)	0	0	(177,660)	0	0	0	0	0	(711,112)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,460)	9,564	(7,147)	918	(350,635)	0	0	0	0	0	0	(355,760)	19
20	Fees, Subscriptions & Promotions	(110,499)	0	256	136	556	0	0	0	0	0	0	(109,551)	20
21	Clerical & General Office Expenses	(1,320)	0	1,658	1,540	201,065	0	0	0	0	0	0	202,943	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	6,367	3,687	4,101	0	0	0	0	0	0	14,155	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	2,203	2,432	3,232	0	0	0	0	0	0	7,867	26
27	Other (specify):*	(162,027)	0	0	0	0	0	0	0	0	0	0	(162,027)	27
28	<b>TOTAL General Administration</b>	<b>(282,306)</b>	<b>9,564</b>	<b>(530,115)</b>	<b>8,713</b>	<b>(141,681)</b>	<b>(177,660)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,113,485)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(298,650)</b>	<b>9,564</b>	<b>(530,115)</b>	<b>(74,696)</b>	<b>(141,681)</b>	<b>(177,660)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,213,238)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	14,010	186,767	239	234	4,603	0	0	0	0	0	0	205,853	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,508)	481,826	0	0	0	0	0	0	0	0	0	477,318	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	1,876	45,518	0	0	0	0	0	0	(697,206)	34
35	Rent-Equipment & Vehicles	0	0	5,168	3,789	2,762	0	0	0	0	0	0	11,719	35
36	Other (specify):*	0	35,813	0	0	0	0	0	0	0	0	0	35,813	36
37	<b>TOTAL Ownership</b>	<b>9,502</b>	<b>(40,194)</b>	<b>5,407</b>	<b>5,899</b>	<b>52,883</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33,497</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(289,148)</b>	<b>(30,630)</b>	<b>(524,708)</b>	<b>(68,797)</b>	<b>(88,798)</b>	<b>(177,660)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,179,741)</b>	<b>45</b>

**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 NURSING 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		"		35,813	35,813	2	
3	V	30 DEPRECIATION - BLDG/IMP		"		179,117	179,117	3	
4	V	30 DEPRECIATION - EQPT		"		7,650	7,650	4	
5	V	32 AMORTIZATION - MTG COST		"		4,624	4,624	5	
6	V	32 INTEREST - MORTGAGE		"		477,202	477,202	6	
7	V	19 ACCOUNTING FEES		"		9,364	9,364	7	
8	V	19 DATA PROCESSING		"		200	200	8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 744,600			\$ 713,970	\$ *	(30,630)	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	\$ 54,998	YORK MANAGEMENT ASSOCIATES, INC		\$ 47,851	\$ (7,147)
16	V	20 DUES & SUBSCRIPTIONS		" "		256	256
17	V	21 CLERICAL		" "		1,658	1,658
18	V	24 TRAVEL		" "		6,367	6,367
19	V	26 INSURANCE		" "		2,203	2,203
20	V	35 RENT - EQPT & VEHICLE		" "		5,168	5,168
21	V	17 ADMINISTRATIVE	533,452	" "			(533,452)
22	V	30 DEPRECIATION		" "		239	239
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		\$ 588,450			\$ 63,742	\$ * (524,708)

\* 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		\$ 29,063	\$ (83,409)
16	V	19 PROFESSIONAL FEES		"		918	918
17	V	20 DUES & SUBSCRIPTIONS		"		136	136
18	V	21 CLERICAL		"		1,540	1,540
19	V	24 TRAVEL		"		3,687	3,687
20	V	26 INSURANCE		"		2,432	2,432
21	V	30 DEPRECIATION		"		234	234
22	V	34 RENT		"		1,876	1,876
23	V	35 RENT - EQPT & VEHICLE		"		3,789	3,789
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			\$ 43,675	\$ * (68,797)

\* 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	\$ 355,438	THE KENSINGTON GROUP, LLC		\$ 4,803	\$ (350,635)
16	V	20 DUES & SUBSCRIPTIONS		" "		556	556
17	V	21 CLERICAL		" "		201,065	201,065
18	V	24 TRAVEL		" "		4,101	4,101
19	V	26 INSURANCE		" "		3,232	3,232
20	V	30 DEPRECIATION		" "		4,603	4,603
21	V	34 RENT		" "		45,518	45,518
22	V	35 RENT - EQPT & VEHICLE		" "		2,762	2,762
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		\$ 355,438			\$ 266,640	\$ * (88,798)

\* 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	\$ 177,660	CHESTERFIELD, LLC		\$	\$ (177,660)
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	<b>Total</b>		\$ 177,660			\$ 0	\$ * (177,660)

\* 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: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007

Ending: 2/31/2007

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 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

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	184,515	4	\$ 140,375	\$ 62,896	\$ 47,851	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	184,515	4	750	62,896	256	2
3	21	CLERICAL	PATIENT DAYS	184,515	4	4,865	62,896	1,658	3
4	24	TRAVEL	PATIENT DAYS	184,515	4	18,678	62,896	6,367	4
5	26	INSURANCE	PATIENT DAYS	184,515	4	6,463	62,896	2,203	5
6	35	RENT - EQPT & VEHICLE	PATIENT DAYS	184,515	4	15,160	62,896	5,168	6
7									7
8	30	DEPRECIATION	PATIENT DAYS	184,515	4	701	62,896	239	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					\$ 186,992	\$	\$ 63,742	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

# 0042481 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 29,063	\$ 29,063	1	\$ 29,063	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	11	8,078	62,896	918	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	1,197	62,896	136	3
4	21	CLERICAL	PATIENT DAYS	553,355	11	13,541	62,896	1,540	4
5	24	TRAVEL	PATIENT DAYS	553,355	11	32,426	62,896	3,687	5
6	26	INSURANCE	PATIENT DAYS	553,355	11	21,389	62,896	2,432	6
7	30	DEPRECIATION	PATIENT DAYS	553,355	11	2,056	62,896	234	7
8	34	RENT	PATIENT DAYS	553,355	11	16,500	62,896	1,876	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	553,355	11	33,327	62,896	3,789	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				\$ 157,577	\$ 29,063		\$ 43,675	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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	553,355	11	\$ 42,255	\$ 62,896	\$ 4,803	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	4,892	62,896	556	2
3	21	CLERICAL	PATIENT DAYS	553,355	11	203,886	62,896	23,174	3
4	24	TRAVEL	PATIENT DAYS	553,355	11	36,083	62,896	4,101	4
5	26	INSURANCE	PATIENT DAYS	553,355	11	28,435	62,896	3,232	5
6	30	DEPRECIATION	PATIENT DAYS	553,355	11	40,500	62,896	4,603	6
7	34	RENT	PATIENT DAYS	553,355	11	400,473	62,896	45,518	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	553,355	11	24,298	62,896	2,762	8
9									9
10	21	CLERICAL	DIRECT HOURS	1	1	177,891	177,891	177,891	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					\$ 958,713	\$ 177,891	\$ 266,640	25

Facility Name & ID Number

ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC						\$	\$			\$	1						
2	GMAC		X	MORTGAGE	\$46,016.00	07/2002	7,480,000	7,128,818	07/2037	6.6600	477,202	2						
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YRS		161,845	136,412			4,624	3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES	3,120,000		DEMAND	VARIES	875,581	7						
8	LETTER OF CREDIT FEE		X								1,182	8						
9	TOTAL Facility Related				\$46,016.00		\$ 10,761,845	\$ 7,265,230			\$ 1,358,589	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 10,761,845	\$ 7,265,230			\$ 1,358,589	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 2006 report.		\$	<b>71,520</b>	<b>1</b>
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.)		\$	<b>71,959</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>439</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>72,800</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>73,239</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>69,633</b>	<b>8</b>
	2003	<b>65,445</b>	<b>9</b>
	2004	<b>67,738</b>	<b>10</b>
	2005	<b>70,736</b>	<b>11</b>
	2006	<b>71,959</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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 2006 TAX BILL.**

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>71,959.34</u>	\$ <u>71,959.34</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>71,959.34</u>	\$ <u>71,959.34</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/2007 Ending:

12/31/2007

**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	<b>TOTALS</b>	<b>90,679</b>		\$	<b>3</b>

Facility Name &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$	\$ 1,617,628	4
5		1997		14,949	544	27.5	544		5,686	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	*****RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC									
10	FIRE DOORS/ALUMINUM SCREENS		1997	3,609	131	27.5	131		1,376	10
11	LANDSCAPING		1997	16,142	587	27.5	587		6,163	11
12	OUTDOOR SIGNS		1997	8,110	295	27.5	295		2,987	12
13	KITCHEN REMODELING - FLOORING/CONCRETE FOOTINGS		1998	18,381	668	27.5	668		6,345	13
14	FENCE		1998	2,350	139	15	157	18	1,768	14
15	ASPHALT PAVEMENT		1998	7,491	442	15	499	57	4,886	15
16	PAVEMENT		1999	4,975	181	27.5	181		1,531	16
17	INSULATING UNIT		1999	6,991	254	27.5	254		2,149	17
18	WALLCOVERINGS/TILES/BLOCK WALLS/CARPET		1999	126,568	4,602	27.5	4,602		38,926	18
19	AWNINGS		1999	7,939	289	27.5	289		2,444	19
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB		2000	64,360	2,340	27.5	2,340		17,453	20
21	INSTALLATION OF ALL DRAPERIES FOR 4 FLOORS		2001	7,828	285	27.5	285		1,852	21
22	PAINT & PREP. ROOMS ON FLOORS 4 & 5		2001	9,525	346	27.5	346		2,249	22
23	REPAIR HOLES, STRIP, SEAL CRACKS IN PARKING LOT		2001	5,950	216	27.5	216		1,404	23
24	INSTALL 41 INSULATING WINDOWS - RESIDENT ROOMS		2001	2,974	108	27.5	108		702	24
25	VCT FLOORING - DINING RM & ADMIN. CORRIDOR		2001	7,165	261	27.5	261		1,697	25
26	REPLACE ELEVATOR DOORS		2001	3,742	136	27.5	136		884	26
27	PATCH AND PREP. WALLS AND PAINT ROOMS ON 2ND, 3RD,									27
28	AND 4TH FLOORS, SECOND AND 4TH FLOOR CORRIDORS		2002	12,983	1,304	7	1,855	551	10,203	28
29	FIRE ALARM - ADD/RELOCATE SMOKE SENSORS		2002	6,027	219	27.5	219		1,232	29
30	INSTALL RUBBER ROOF WITH HALF INCH INSUALTION		2003	12,090	440	27.5	440		1,980	30
31	INSTALL VINYL TILES IN SHOWER ROOMS ON THE 5TH FLOOR		2003	4,041	147	27.5	147		661	31
32	2 PLASTIC LAMINATED & INSULATED METAL STAIRWAY DOOR		2003	3,396	124	27.5	124		558	32
33	PAINT & PREP, NURSES STATIONS, 4TH FLOOR BATHRMS, 3RD FLR									33
34	DOORJAMS, FRAMES & STAIRWELLS, 2ND FLOOR BATHROOMS		2003	9,643	351	27.5	351		1,581	34
35	NURSE CALL SYSTEM WITH 24 LITE PANEL, PULL CORD & BED		2003	31,136	1,132	27.5	1,132		5,094	35
36	PAINT & PREP. & HANG WALLPAPERS		2004	35,000	4,373	7	5,000	627	17,500	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 &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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	\$ 2,083	7	\$ 2,381	\$ 298	\$ 8,334	37
38	SIGNS FOR BUILDING	2004	1,290	161	7	184	23	644	38
39	BORDERS FOR ALL RESIDENT RMS & DINING ROOM	2004	3,335	417	7	476	59	1,666	39
40	REMOVE AND INSTALL NEW FLOOR	2004	8,028	1,003	7	1,147	144	4,014	40
41	4TH FLOOR NURSES STATION/QUARRY TILE COVE BASE	2005	6,357	231	27.5	231		693	41
42	REPLACEMENT OF DOMESTIC HOT WATER HEATER	2005	32,871	1,195	27.5	1,195		3,187	42
43	INSTALLATION OF SPRINKLER SYSTEM	2005	1,325	48	27.5	48		128	43
44	CONCRETE WORK ON SIDE WALK	2005	2,550	170	15	170		425	44
45	COVE BASE/COVE BASE ADHESIVE - KITCHEN	2005	1,157	42	27.5	42		88	45
46	REPAIR ASPHALT PAVEMENT	2006	6,489	616	15	433	(183)	866	46
47	BUILD & INSTALL BASE CABINETS - NURSES STATION	2006	1,129	41	27.5	41		80	47
48	ADDITION OF NEW EMERGENCY CIRCUITS	2006	1,543	56	27.5	56		91	48
49	INSTALL NEW FIRE DAMPERS	2006	4,850	176	27.5	176		198	49
50	INSTALL NEW SHAFT SYSTEM	2006	38,901	1,415	27.5	1,415		1,592	50
51	CUSTOM H.M DOOR AND DOOR SHOE	2007	1,936	59	27.5	59		59	51
52	SHAW TIDEWATER YORKTOWN CARPET	2007	1,093	219	5	110	(109)	110	52
53	99 TON CHILLER SYSTEM	2007	84,851	2,057	27.5	2,057		2,057	53
54	NEW WINDOW SCREENS	2007	1,128	226	5	113	(113)	113	54
55									55
56			ADJ TO SL	1,372			(1,372)		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)		\$ 4,708,319	\$ 179,117		\$ 179,117	\$	\$ 1,781,284	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	\$ 573,209	\$ 28,569	\$ 51,438	\$ 22,869	3-15 YRS	\$ 329,647	71
72	Current Year Purchases	59,060	11,812	2,953	(8,859)	3-15 YRS	2,953	72
73	Fully Depreciated Assets	30,583				3-15 YRS	30,583	73
74	RELATED PARTY		12,726	12,726				74
75	TOTALS	\$ 662,852	\$ 53,107	\$ 67,117	\$ 14,010		\$ 363,183	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,371,171	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 232,224	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 246,234	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,010	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,144,467	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: \$ 31,117 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	ADMINISTRATIVE	2004 CHEVY TRAIL BLAZER	740.74	17,798	18
19					19
20					20
21	TOTAL		\$ 740.74	\$ 17,798	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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**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)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</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	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	\$		\$ 233,093	\$		\$ 233,093	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			70,411			70,411	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			292,846			292,846	4
5	Physician Care	39-3	visits			250			250	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				261,425		261,425	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					73,687		73,687	13
14	TOTAL			\$		\$ 601,732	\$ 335,112		\$ 936,844	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 &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 240,088	\$ 503,483	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,643 )	2,362,212	2,362,212	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,915	122,162	6
7	Other Prepaid Expenses	37,732	37,732	7
8	Accounts Receivable (owners or related parties)	396,961	262,230	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		821,458	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,085,908	\$ 4,109,277	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,838	1,838	12
13	Land		716,400	13
14	Buildings, at Historical Cost		4,059,452	14
15	Leasehold Improvements, at Historical Cost		648,869	15
16	Equipment, at Historical Cost	642,944	1,560,944	16
17	Accumulated Depreciation (book methods)	(561,816)	(3,274,348)	17
18	Deferred Charges		136,412	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): <u>CONST. ON PROGRESS</u>		13,448	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 82,966	\$ 3,863,015	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,168,874	\$ 7,972,292	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,440,367	\$ 1,440,367	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	171,897	171,897	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,056	107,056	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,602	18,602	31
32	Accrued Real Estate Taxes(Sch.IX-B)		72,800	32
33	Accrued Interest Payable	1,321,474	39,565	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>	\$ 3,059,396	\$ 1,850,287	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	12,176,413	4,033,416	39
40	Mortgage Payable		7,128,818	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>	\$ 12,176,413	\$ 11,162,234	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 15,235,809	\$ 13,012,521	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (12,066,935)	\$ (5,040,229)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,168,874	\$ 7,972,292	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(10,822,638)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>REPLACEMENT TAX</b>	<b>1,091</b>	<b>3</b>
<b>4</b>	<b>ROUNDING ADJ.</b>	<b>3</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(10,821,544)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,245,391)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,245,391)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(12,066,935)</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 9,380,423	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,380,423	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		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,680	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>	\$ 2,680	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	4,508	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,508	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS</b>	2,722	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,722	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,390,333	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,387,088	31
32	Health Care	3,474,382	32
33	General Administration	2,941,159	33
	<b>B. Capital Expense</b>		
34	Ownership	1,789,488	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	936,844	35
36	Provider Participation Fee	106,763	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,635,724	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,245,391)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,245,391)	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: 01/01/2007

Ending: 12/31/2007

**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	2,717	3,078	\$ 113,154	\$ 36.76	1
2	Assistant Director of Nursing	458	458	12,168	26.57	2
3	Registered Nurses	5,443	5,977	159,430	26.67	3
4	Licensed Practical Nurses	52,374	57,479	1,232,700	21.45	4
5	CNAs & Orderlies	99,222	106,630	1,165,675	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,532	2,769	42,982	15.52	8
9	Activity Director	878	912	12,891	14.13	9
10	Activity Assistants	11,316	12,448	120,314	9.67	10
11	Social Service Workers	6,367	6,832	87,534	12.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,331	3,903	61,256	15.69	14
15	Cook Helpers/Assistants	24,643	26,461	223,265	8.44	15
16	Dishwashers					16
17	Maintenance Workers	2,605	3,075	58,484	19.02	17
18	Housekeepers	19,971	21,908	216,147	9.87	18
19	Laundry	9,330	10,310	93,809	9.10	19
20	Administrator	2,037	2,596	134,953	51.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,462	13,897	267,622	19.26	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	9,461	10,024	120,125	11.98	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	265,147	288,757	\$ 4,122,509 *	\$ 14.28	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	212	\$ 14,730	1-3	35
36	Medical Director	180	38,400	9-3	36
37	Medical Records Consultant	24	2,280	10-3	37
38	Nurse Consultant	229	112,472	10-3	38
39	Pharmacist Consultant	96	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	16	1,245	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	52	3,111	11-3	44
45	Social Service Consultant	48	2,891	12-3	45
46	Other(specify) <u>WOUND CARE</u>	99	24,400	10-3	46
47	<u>ALZHEIMERS</u>	141	9,170	10-3	47
48	<u>PSYCHIATRIC</u>	20	3,075	10-3	48
49	TOTAL (lines 35 - 48)	1,117	\$ 212,974		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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/2005	\$ 13,171	3	\$	\$ 2,195	\$ 4,390	\$ 4,390	\$ 2,196	\$	\$	\$								
2	PAINT/DECORATING	06/2006	3,127	3			522	1,042	1,042	521										
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18																				
19																				
20	<b>TOTALS</b>		\$ 16,298		\$	\$ 2,195	\$ 4,912	\$ 5,432	\$ 3,238	\$ 521	\$	\$								

Facility Name &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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 - \$10465.20
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,199 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees