

Facility Name & ID Number Aspire on Eastern# 0020438 Report Period Beginning: 7/1/06 Ending: 6/30/07

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	<u>82</u>	Intermediate/DD	<u>82</u>	<u>29,930</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>82</u>	TOTALS	<u>82</u>	<u>29,930</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>29,058</u>			<u>29,058</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,058</u>			<u>29,058</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.09%D. How many bed-hold days during this year were paid by the Department?
528 (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? yesG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO I. On what date did you start providing long term care at this location?
Date started 03/01/1975J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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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
A. General Services											
1	Dietary	220,011	8,942	9,005	237,958	4	237,962	237,962			1
2	Food Purchase		185,360		185,360	1,515	186,875	186,875			2
3	Housekeeping	169,232	45,138		214,370	9,636	224,006	224,006			3
4	Laundry	77,915	18,460		96,375		96,375	96,375			4
5	Heat and Other Utilities			103,914	103,914	5,877	109,791	109,791			5
6	Maintenance	92,824	58,396	50,186	201,406	7,807	209,213	209,213			6
7	Other (specify):*										7
8	TOTAL General Services	559,982	316,296	163,105	1,039,383	24,839	1,064,222	1,064,222			8
B. Health Care and Programs											
9	Medical Director		90,963	37,364	128,327		128,327	128,327			9
10	Nursing and Medical Records	368,199		1,600	369,799		369,799	369,799			10
10a	Therapy										10a
11	Activities	1,719,256	61,843		1,781,099		1,781,099	1,781,099			11
12	Social Services	197,699			197,699		197,699	197,699			12
13	CNA Training	28,960			28,960		28,960	28,960			13
14	Program Transportation	2,548	48,364		50,912		50,912	50,912			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,316,662	201,170	38,964	2,556,796		2,556,796	2,556,796			16
C. General Administration											
17	Administrative	53,660		171,773	225,433	(171,773)	53,660	53,660			17
18	Directors Fees										18
19	Professional Services			9,019	9,019	47,798	56,817	56,817			19
20	Dues, Fees, Subscriptions & Promotions			2,362	2,362	7,945	10,307	(5,010)	5,297		20
21	Clerical & General Office Expenses	420,244	7,481	61,075	488,800	29,634	518,434	518,434			21
22	Employee Benefits & Payroll Taxes			623,191	623,191		623,191	623,191			22
23	Inservice Training & Education										23
24	Travel and Seminar					1,775	1,775	1,775			24
25	Other Admin. Staff Transportation		6,093		6,093	2,046	8,139	8,139			25
26	Insurance-Prop.Liab.Malpractice			36,791	36,791	306	37,097	37,097			26
27	Other (specify):*										27
28	TOTAL General Administration	473,904	13,574	904,211	1,391,689	(82,269)	1,309,420	(5,010)	1,304,410		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,350,548	531,040	1,106,280	4,987,868	(57,430)	4,930,438	(5,010)	4,925,428		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

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			122,024	122,024	10,509	132,533	(20,450)	112,083			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,919	36,919	46,921	83,840		83,840			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,964	6,967		6,967		6,967			35
36	Other (specify):*											36
37	TOTAL Ownership			165,907	165,910	57,430	223,340	(20,450)	202,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			284,982	284,982		284,982		284,982			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			284,982	284,982		284,982		284,982			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,350,548	531,040	1,557,169	5,438,760		5,438,760	(25,460)	5,413,300			45

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

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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	(20,450)	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				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	(5,010)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,460)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (25,460)		37

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

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

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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

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

Ending:

6/30/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,010)	0	0	0	0	0	0	0	0	0	0	(5,010)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(5,010)	0	0	0	0	0	0	0	0	0	0	(5,010)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,010)	0	0	0	0	0	0	0	0	0	0	(5,010)	29

Facility Name & ID Number Aspire on Eastern

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VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

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

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

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

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

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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: 7/1/06 Ending: 6/30/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Kitchen Supplies	Direct Cost	16,428,947	30	\$ 13	\$ 5,458,626	\$ 4	1
2	2	Food/Beverage	Direct Cost	16,428,947	30	4,559	5,458,626	1,515	2
3	3	Housekeeping Supplies	Direct Cost	16,428,947	30	3,445	5,458,626	1,145	3
4	3	Hskp. Other	Direct Cost	16,428,947	30	25,555	5,458,626	8,491	4
5	5	Utilities	Direct Cost	16,428,947	30	17,688	5,458,626	5,877	5
6	6	Maint. Supplies	Direct Cost	16,428,947	30	6,951	5,458,626	2,310	6
7	6	Maint. Other	Direct Cost	16,428,947	30	16,544	5,458,626	5,497	7
8	19	Prof. Services	Direct Cost	16,428,947	30	143,858	5,458,626	47,798	8
9	20	Dues, Fees, Other	Direct Cost	16,428,947	30	23,911	5,458,626	7,945	9
10	21	Clerical Supplies	Direct Cost	16,428,947	30	68,358	5,458,626	22,712	10
11	21	Telephone	Direct Cost	16,428,947	30	21,978	5,458,626	7,302	11
12	24	Travel Seminar	Direct Cost	16,428,947	30	4,200	5,458,626	1,395	12
13	25	Staff travel	Direct Cost	16,428,947	30	6,158	5,458,626	2,046	13
14	26	Insurance	Direct Cost	16,428,947	30	920	5,458,626	306	14
15	30	Depreciation	Direct Cost	16,428,947	30	31,628	5,458,626	10,509	15
16	32	Interest	Direct Cost	16,428,947	30	141,218	5,458,626	46,921	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 516,984	\$		\$ 171,773	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	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Banco Popular		x		\$23,273.00	8/23/03	\$ 3,000,000				5.0000	\$ 36,476	1					
2		Illinois Facilities		x		\$4,631.00	10/13/99	495,000				7.6500	4,547	2					
3														3					
4														4					
5														5					
		Working Capital																	
6		Banco Popular		x									42,817	6					
7														7					
8														8					
9		TOTAL Facility Related				\$27,904.00		\$ 3,495,000	\$			\$	83,840	9					
		B. Non-Facility Related*																	
10														10					
11														11					
12														12					
13														13					
14		TOTAL Non-Facility Related						\$	\$			\$		14					
15		TOTALS (line 9+line14)						\$ 3,495,000	\$			\$	83,840	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$	#VALUE!	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	#VALUE!	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2002 _____ 8			
		2003 _____ 9			
		2004 _____ 10			
		2005 _____ 11			
		2006 _____ 12			
			FOR BHF USE ONLY		
			13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 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 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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Aspire on Eastern# 0020438 Report Period Beginning:7/1/06 Ending:6/30/07**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 28,330 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Aspire on Eastern# 0020438

Report Period Beginning:

7/1/06

Ending:

6/30/07**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82	1975	1975	\$ 835,850	\$ 20,896	40	\$ 20,896	\$	\$ 647,558	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Remodeling	1975		4,485					4,485	9
10	Bldg Improvements	1976		7,736					7,736	10
11	Bldg Improvements	1979		290					290	11
12	Bldg Improvements	1980		6,047					6,047	12
13	Bldg Improvements	1981		9,890					9,890	13
14	Bldg Improvements	1982		2,925					2,925	14
15	Bldg Improvements	1984		1,012					1,012	15
16	Blacktopping	1980		11,625		15			11,625	16
17	Remodeling	1982		16,244		20			16,244	17
18	Patio	1983		4,095		10			4,095	18
19	Nurses Station	1983		2,065		10			2,065	19
20	Fan Shut Down	1983		2,136		10			2,136	20
21	Intercom	1984		1,412		10			1,412	21
22	Fence	1985		4,658		10			4,658	22
23	fire Alarm	1985		1,358		10			1,358	23
24	Booster Water Temp	1985		1,415		10			1,415	24
25	Laundry Room	1986		7,775	1,295	30	260	(1,035)	5,590	25
26	tiling	1986		1,125	280	20	56	(224)	1,204	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	165	(2,159)	6,639	30
31	Electrical	1987		28,350	7,090	20	709	(6,381)	28,350	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	11,154	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.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning:

7/1/06

Ending:

6/30/07

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 Coller	1989	23,330	4,665	25	934	(3,731)	16,345	39	
40	Front Enclosure	1989	3,595		20	180	180	3,330	40	
41	Bldg. Addition	1992	464,250	15,474	30	15,474		247,584	41	
42	Bldg. Addition	1993	13,070	436	30	436		6,540	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)	2,623	45	
46	HVAC	1991	6,872		8			6,872	46	
47	Roof	1992	30,828	7,705	20	1,541	(6,164)	25,428	47	
48	Sealcoating	1993	2,650	331	8		(331)	2,650	48	
49	Hot Water Heater	1993	3,075	1,435	15	102	(1,333)	3,075	49	
50	HVAC	1993	6,230	779	8		(779)	6,230	50	
51	Security System	1993	1,365	341	10	137	(204)	1,122	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)	2,782	55	
56	Bathub	1995	12,353	4,135	15	824	(3,311)	10,712	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)	3,458	58	
59	Front End	1998	13,115	2,622	30	438	(2,184)	10,292	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		3,982	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	2	(1,276)	12,782	66	
67	Sealcoating	1997	11,000		8			11,000	67	
68	Fence	1997	5,091	254	20	254		2,794	68	
69	Water Heater	1998	8,300	519	8		(519)	8,300	69	
70	TOTAL (lines 4 thru 69)		\$ 1,715,080	\$ 88,133		\$ 45,210	\$ (38,551)	\$ 1,275,736	70	

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

Facility Name & ID Number Aspire on Eastern# 0020438

Report Period Beginning:

7/1/06

Ending:

6/30/07**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 1,715,080	\$ 88,133		\$ 45,210	\$ (42,923)	\$ 1,275,736		1
2	Nurses Station	1998 3,880	194	20	194		1,940		2
3	HVAC	1998 5,635	704	8	704		6,339		3
4	Sealcoating	1998 11,000	1,375	820		(1,375)	11,000		4
5	Electrical	1998 6,368	318	10	318		3,180		5
6	A/C	1999 6,800	680	10	680		6,120		6
7	Security System	1999 1,200	120	20	120		1,080		7
8	Patio Cover	1999 11,205	560	8	560		5,040		8
9	HVAC	2000 2,450	306	15	308	2	2,450		9
10	Roof	2000 1,250	83	10	83		737		10
11	Parking lot	2001 29,300	2,930	30	2,930		19,045		11
12	Screen in Canopy	2002 16,486	824	30	824		4,944		12
13	Slope Renovation	2002 14,500	484	30	484		2,662		13
14	Sidewalk	2002 1,900	126	30	126		693		14
15	Women Shower	2002 60,000	2,000	30	2,000		11,000		15
16	Bathroom renovation	2002 198,403	6,612	30	6,612		36,366		16
17	Kitchen renovation	2003 182,098	6,070	30	6,070		27,315		17
18	Windows replacement	2004 52,500	2,625	20	2,625		11,812		18
19	Sewer	2004 3,900	195	20	195		780		19
20	Electrical	2004 13,759	688	20	688		2,752		20
21	HVAC	2004 1,895	189	10	189		756		21
22	Fire Door	2004 10,700	535	20	535		2,140		22
23	Windows replacement	2004 70,062	3,503	20	3,503		14,012		23
24	HVAC	2005 2,165	98	8	98		294		24
25	Landscaping	2005 5,475	547	10	547		1,641		25
26	Hallway renovation	2005 150,827	5,028	30	5,028		15,084		26
27	Carpeting	2006 41,192	4,119	10	4,119		8,238		27
28	HVAC	2007 17,502	1,094	8	2,188	1,094	2,188		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,637,532	\$ 130,140		\$ 86,938	\$ (43,202)	\$ 1,475,344		34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 216,504	\$ 15,443	\$ 15,443	\$	5	\$ 205,708	71
72	Current Year Purchases	19,193	1,919	3,838	1,919	5	3,838	72
73	Fully Depreciated Assets	229,693				5		73
74								74
75	TOTALS	\$ 465,390	\$ 17,362	\$ 19,281	\$ 1,919		\$ 209,546	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	\$ 11,688	76
77										77
78										78
79										79
80	TOTALS			\$ 29,319	\$ 5,864	\$ 5,864	\$		\$ 11,688	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 12L, if applicable)	\$ 3,307,241	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12L, if applicable)	\$ 153,366	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12L, if applicable)	\$ 112,083	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12L, if applicable)	\$ (41,283)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L, if applicable)	\$ 1,696,578	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 6,964 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	TOTAL		\$	\$	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		7,820		7,820
4	Clinical Wages (b)		15,640		15,640
5	In-House Trainer Wages (c)		5,500		5,500
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 28,960	\$	\$ 28,960
10	SUM OF line 9, col. 1 and 2 (e)	\$	28,960		

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	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	23

- (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	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning: 7/1/06

Ending:

6/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/07

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$	\$ 172,124	1
2 Cash-Patient Deposits		64,074	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,456,193	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance		75,509	6
7 Other Prepaid Expenses		6,808	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 1,774,708	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		1,713,082	13
14 Buildings, at Historical Cost		13,112,745	14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost		2,281,733	16
17 Accumulated Depreciation (book methods)		(5,982,491)	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): closing costs		89,383	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 11,214,452	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 12,989,160	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$	\$ 346,614	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits		64,074	28
29 Short-Term Notes Payable		1,904,129	29
30 Accrued Salaries Payable		736,657	30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 3,051,474	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable		381,359	39
40 Mortgage Payable		5,558,035	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,939,394	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 8,990,868	46
47 TOTAL EQUITY(page 18, line 24)	\$ (424,989)	\$ 3,998,292	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (424,989)	\$ 12,989,160	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
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(424,989)	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)	\$ (424,989)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (424,989)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,684,433	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,684,433	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	154,003	10
11	CNA Training Reimbursements	36,011	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 190,014	23
D. Non-Operating Revenue			
24	Contributions	117,175	24
25	Interest and Other Investment Income***	22,149	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 139,324	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,013,771	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,039,383	31
32	Health Care	2,556,796	32
33	General Administration	1,391,689	33
B. Capital Expense			
34	Ownership	165,910	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	284,982	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,438,760	40
41	Income before Income Taxes (line 30 minus line 40)**	(424,989)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (424,989)	43

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

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

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

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

Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/06Ending: 6/30/07

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	1,763	\$ 60,897	\$ 29.28	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	10,894	307,302	21.72	4
5	CNAs & Orderlies				5
6	CNA Trainees	2,760	23,460	8.50	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers	1,329	29,301	17.86	11
12	Dietician				12
13	Food Service Supervisor	1,610	29,090	14.68	13
14	Head Cook				14
15	Cook Helpers/Assistants	16,929	190,920	9.36	15
16	Dishwashers				16
17	Maintenance Workers	5,095	92,824	14.94	17
18	Housekeepers	14,282	169,232	10.19	18
19	Laundry	7,400	77,915	8.95	19
20	Administrator	1,443	53,660	28.21	20
21	Assistant Administrator	3,007	83,933	25.12	21
22	Other Administrative	4,318	188,296	38.37	22
23	Office Manager				23
24	Clerical	9,136	148,017	13.61	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	9,772	173,898	15.66	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	144,418	1,719,256	10.00	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>prog transp</u>	240	2,547	10.61	33
34	TOTAL (lines 1 - 33)	234,396	\$ 3,350,548 *	\$ 12.02	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	196	\$ 9,005	1	35
36	Medical Director	58	8,700	9	36
37	Medical Records Consultant	30	752	10	37
38	Nurse Consultant	272	8,160	10	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	247	12,375	12	40
41	Occupational Therapy Consultant	94	4,700	12	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	313	15,655	12	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	150	15,005	12	46
47	<u>Neurologist</u>	12	1,800	9	47
48					48
49	TOTAL (lines 35 - 48)	1,372	\$ 76,152		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Vicki Strigel	administrator		\$ 53,660	Workers' Compensation Insurance	\$ 85,615	IDPH License Fee	\$	
				Unemployment Compensation Insurance	7,650	Advertising: Employee Recruitment	2,362	
				FICA Taxes	256,285	Health Care Worker Background Check	2,034	
				Employee Health Insurance	243,080	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	70	
				Illinois Municipal Retirement Fund (IMRF)*		Membership/Dues/License	295	
				403 b	30,561	Subscription/Ref Materials	606	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 53,660					
B. Administrative - Other								
Description			Amount					
See Schedule VIII			\$ 171,773					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 171,773					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Clifton Gunderson	audit		\$ 7,476				Out-of-State Travel	\$
Winston Stawn	legal		1,543					
							In-State Travel	
							Seminar Expense	1,775
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	\$ 1,775
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 9,019					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/06Ending: 6/30/07**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. \$ 30,195 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 284,982
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. \$ N/A 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 \$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.