

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0042481</u></p> <p>Facility Name: <u>ASPEN RIDGE CARE CENTRE</u></p> <p>Address: <u>2530 NORTH MONROE STREET</u> <u>DECATUR</u> <u>62526</u> Number City Zip Code</p> <p>County: <u>MACON</u></p> <p>Telephone Number: <u>(217) 875-0920</u> Fax # <u>(217) 876-9351</u></p> <p>HFS ID Number: <u>36-4121314</u></p> <p>Date of Initial License for Current Owners: <u>02/01/1997</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHAEL BELLOWS</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>MANAGEMENT CONSULTANT</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>SHAEL BELLOWS</u>			(Title) <u>MANAGEMENT CONSULTANT</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	71,370	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	71,370	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	12,926	935	7,832	21,693	8
9	SNF/PED					9
10	ICF	39,881	2,886	1,033	43,800	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,807	3,821	8,865	65,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.77%

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 7,497

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES (WPS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	286,725	53,279	23,957	363,961		363,961	248	364,209		1
2	Food Purchase		363,810		363,810		363,810	(2,695)	361,115		2
3	Housekeeping	206,118	28,033		234,151		234,151	(2,909)	231,242		3
4	Laundry	102,193	25,556	1,330	129,079		129,079	1,768	130,847		4
5	Heat and Other Utilities			224,021	224,021		224,021		224,021		5
6	Maintenance	54,150	44,204	44,230	142,584		142,584	(7,066)	135,518		6
7	Other (specify):*			38,897	38,897		38,897		38,897		7
8	TOTAL General Services	649,186	514,882	332,435	1,496,503		1,496,503	(10,654)	1,485,849		8
	B. Health Care and Programs										
9	Medical Director			38,400	38,400		38,400		38,400		9
10	Nursing and Medical Records	2,882,722	182,932	147,152	3,212,806		3,212,806	(89,286)	3,123,520		10
10a	Therapy	44,994		25,033	70,027		70,027		70,027		10a
11	Activities	142,483	11,973	11,222	165,678		165,678	(1,741)	163,937		11
12	Social Services	80,245		3,046	83,291		83,291		83,291		12
13	CNA Training										13
14	Program Transportation			1,282	1,282		1,282		1,282		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,150,444	194,905	226,135	3,571,484		3,571,484	(91,027)	3,480,457		16
	C. General Administration										
17	Administrative	173,983		782,769	956,752		956,752	(782,769)	173,983		17
18	Directors Fees										18
19	Professional Services			501,749	501,749		501,749	(315,161)	186,588		19
20	Dues, Fees, Subscriptions & Promotions			126,422	126,422		126,422	(105,618)	20,804		20
21	Clerical & General Office Expenses	227,795	44,399	49,075	321,269		321,269	211,545	532,814		21
22	Employee Benefits & Payroll Taxes			711,332	711,332		711,332		711,332		22
23	Inservice Training & Education			6,352	6,352		6,352		6,352		23
24	Travel and Seminar			955	955		955	11,465	12,420		24
25	Other Admin. Staff Transportation			13,986	13,986		13,986		13,986		25
26	Insurance-Prop.Liab.Malpractice			105,193	105,193		105,193	21,355	126,548		26
27	Other (specify):*			776,692	776,692		776,692	(776,692)			27
28	TOTAL General Administration	401,778	44,399	3,074,525	3,520,702		3,520,702	(1,735,875)	1,784,827		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,201,408	754,186	3,633,095	8,588,689		8,588,689	(1,837,556)	6,751,133		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	16,827
	REPAIRS & MAINTENANCE	7,130
		0
		23,957
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,330
		0
		1,330
5	HEAT & OTHER UTILITIES	
	GAS HEAT	101,421
	ELECTRICITY	98,726
	WATER	23,874
	CABLE TV - LOBBY	0
		0
		224,021
6	MAINTENANCE	
	GROUNDS MAINTENANCE	352
	PAINTING & DECORATING	10,228
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	14,075
	ELEVATOR MAINTENANCE & REPAIR	8,939
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,070
	FIRE SERVICE	6,566
		0
		0
		0
		0
		44,230
7	OTHER	
	SCAVENGER	38,277
	SECURITY SERVICE	620
		0
		0
		38,897
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	38,400
		38,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,215
	PHARMACY CONSULTANT XVIII B 39-2	1,200
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	112,472
	ALZHEIMERS CONSULTANT XVIII B 47-2	8,265
	WOUND CARE CONSULTANT XVIII B 46-2	24,000
		147,152
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	130
	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	24,903
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		25,033
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	8,341
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,881
		0
		11,222
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,046
		0
		3,046
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,282
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	782,769
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	24,760
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	476,989
		0
		501,749
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	73,825
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	24,081
	EMPLOYEE WANT ADS XIX F	3,804
	CONTRIBUTIONS VI 20 XIX F	550
	DUES & SUBSCRIPTIONS XIX F	12,833
	LICENSES & PERMITS XIX F	544
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	344
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	7,541
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	740
	PATIENT BACKGROUND CHECKS XIX F	2,160
		126,422
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	5,856
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	6,877
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	30,783
	MESSENGER SERVICE	5,559
		0
		49,075

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	315,465
	UNEMPLOYMENT COMPENSATION XIX D	55,030
	WORKERS COMPENSATION INSURANC XIX D	84,899
	HOSPITALIZATION INSURANCE XIX D	231,879
	EMPLOYEE BENEFITS - OTHER XIX D	9,972
	EMPLOYEE PHYSICAL EXAMS XIX D	2,125
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	11,962
	CHICAGO HEAD TAX XIX D	0
		0
		711,332
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	6,352
		6,352
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	955
		955
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	13,986
		13,986
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	105,193
		105,193
27	OTHER	
	BAD DEBTS VI 24	776,692
		776,692

GRAND TOTAL COLUMN 3 OTHER

3,633,095

**ASPEN RIDGE CARE CENTRE
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	363,810
LESS SALES TAX	<u>(2,695)</u>
NET FOOD	361,115

TOTAL PATIENT CENSUS	65,493
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	196,479

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	196,479
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	196,479

NET FOOD	361,115
DIVIDE TOTAL MEALS/YEAR	<u>196,479</u>

COST PER MEAL	1.84
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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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			54,528	54,528		54,528	183,029	237,557		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			970,084	970,084		970,084	475,086	1,445,170		32
33	Real Estate Taxes			77,360	77,360		77,360		77,360		33
34	Rent-Facility & Grounds			744,600	744,600		744,600	(700,211)	44,389		34
35	Rent-Equipment & Vehicles			43,582	43,582		43,582	9,653	53,235		35
36	Other (specify):* STORAGE & MTG INS			8,066	8,066		8,066	35,426	43,492		36
37	TOTAL Ownership			1,898,220	1,898,220		1,898,220	2,983	1,901,203		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		365,993	673,845	1,039,838		1,039,838		1,039,838		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			107,056	107,056		107,056		107,056		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		365,993	780,901	1,146,894		1,146,894		1,146,894		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,201,408	1,120,179	6,312,216	11,633,803		11,633,803	(1,834,573)	9,799,230		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	128	30		9
10	Interest and Other Investment Income	(1,570)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,695)	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	(6,877)	21		18
19	Entertainment	(73,825)	20		19
20	Contributions	(8,091)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(776,692)	27		24
25	Fund Raising, Advertising and Promotional	(24,081)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(344)	20		28
29	Other-Attach Schedule	(18,068)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (912,115)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(922,458)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (922,458)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,834,573)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ASPEN RIDGE CARE CENTRE

ID# 0042481

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (6,990)	6	1
2	VACATION ACCRUAL	248	1	2
3	VACATION ACCRUAL	(2,909)	3	3
4	VACATION ACCRUAL	1,768	4	4
5	VACATION ACCRUAL	(76)	6	5
6	VACATION ACCRUAL	(4,445)	10	6
7	VACATION ACCRUAL	(1,741)	11	7
8	VACATION ACCRUAL	0	17	8
9	VACATION ACCRUAL	(185)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING		19	11
12	MEDICARE A BILLING	(303)	19	12
13	MARKETING CONSULTANT	(1,435)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,068)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	248	0	0	0	0	0	0	0	0	0	0	248	1
2	Food Purchase	(2,695)	0	0	0	0	0	0	0	0	0	0	(2,695)	2
3	Housekeeping	(2,909)	0	0	0	0	0	0	0	0	0	0	(2,909)	3
4	Laundry	1,768	0	0	0	0	0	0	0	0	0	0	1,768	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,066)	0	0	0	0	0	0	0	0	0	0	(7,066)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,654)	0	0	0	0	0	0	0	0	0	0	(10,654)	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	(4,445)	0	0	(84,841)	0	0	0	0	0	0	0	(89,286)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,741)	0	0	0	0	0	0	0	0	0	0	(1,741)	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	(6,186)	0	0	(84,841)	0	0	0	0	0	0	0	(91,027)	16
	C. General Administration													
17	Administrative	0	0	(587,076)	0	0	(195,693)	0	0	0	0	0	(782,769)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,738)	10,423	12,505	88	(334,439)	0	0	0	0	0	0	(315,161)	19
20	Fees, Subscriptions & Promotions	(106,341)	0	106	184	433	0	0	0	0	0	0	(105,618)	20
21	Clerical & General Office Expenses	(7,062)	0	18,376	3,227	197,004	0	0	0	0	0	0	211,545	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	1,308	4,704	5,453	0	0	0	0	0	0	11,465	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,971	2,446	16,938	0	0	0	0	0	0	21,355	26
27	Other (specify):*	(776,692)	0	0	0	0	0	0	0	0	0	0	(776,692)	27
28	TOTAL General Administration	(893,833)	10,423	(552,810)	10,649	(114,611)	(195,693)	0	0	0	0	0	(1,735,875)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(910,673)	10,423	(552,810)	(74,192)	(114,611)	(195,693)	0	0	0	0	0	(1,837,556)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASPEN RIDGE CARE CENTRE# 0042481

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	128	177,677	212	227	4,785	0	0	0	0	0	0	183,029	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,570)	476,656	0	0	0	0	0	0	0	0	0	475,086	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	0	44,389	0	0	0	0	0	0	(700,211)	34
35	Rent-Equipment & Vehicles	0	0	3,817	3,920	1,916	0	0	0	0	0	0	9,653	35
36	Other (specify):*	0	35,426	0	0	0	0	0	0	0	0	0	35,426	36
37	TOTAL Ownership	(1,442)	(54,841)	4,029	4,147	51,090	0	0	0	0	0	0	2,983	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(912,115)	(44,418)	(548,781)	(70,045)	(63,521)	(195,693)	0	0	0	0	0	(1,834,573)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		ASPEN RIDGE MONROE STREET, LLC		
					MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED 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		"		35,426	35,426	2	
3	V	30 DEPRECIATION - BLDG/IMP		"		177,677	177,677	3	
4	V	30 DEPRECIATION - EQPT		"				4	
5	V	32 AMORTIZATION - MTG COST		"		4,624	4,624	5	
6	V	32 INTEREST - MORTGAGE		"		472,032	472,032	6	
7	V	19 ACCOUNTING FEES		"		10,229	10,229	7	
8	V	19 DATA PROCESSING		"		194	194	8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 744,600			\$ 700,182	\$ *	(44,418)	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	\$ 42,776	YORK MANAGEMENT ASSOCIATES, LLC		\$ 55,281	\$ 12,505	15
16	V	20 DUES & SUBSCRIPTIONS		"		106	106	16
17	V	21 CLERICAL		"		18,376	18,376	17
18	V	24 TRAVEL		"		1,308	1,308	18
19	V	26 INSURANCE		"		1,971	1,971	19
20	V	35 RENT - EQPT & VEHICLE		"		3,817	3,817	20
21	V	17 ADMINISTRATIVE	587,076	"			(587,076)	21
22	V	30 DEPRECIATION		"		212	212	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 629,852			\$ 81,071	\$ * (548,781)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 112,472	CARLYLE NURSING ASSOCIATES, LLC		\$ 27,631	\$ (84,841)
16	V	19 PROFESSIONAL FEES				88	88
17	V	20 DUES & SUBSCRIPTIONS				184	184
18	V	21 CLERICAL				3,227	3,227
19	V	24 TRAVEL				4,704	4,704
20	V	26 INSURANCE				2,446	2,446
21	V	30 DEPRECIATION				227	227
22	V	34 RENT					
23	V	35 RENT - EQPT & VEHICLE				3,920	3,920
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			\$ 42,427	\$ * (70,045)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 350,875	THE KENSINGTON GROUP, LLC		\$ 16,436	\$ (334,439)
16	V	20 DUES & SUBSCRIPTIONS		"		433	433
17	V	21 CLERICAL		"		197,004	197,004
18	V	24 TRAVEL		"		5,453	5,453
19	V	26 INSURANCE		"		16,938	16,938
20	V	30 DEPRECIATION		"		4,785	4,785
21	V	34 RENT		"		44,389	44,389
22	V	35 RENT - EQPT & VEHICLE		"		1,916	1,916
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		\$ 350,875			\$ 287,354	\$ * (63,521)

* 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	\$ 195,693	CHESTERFIELD, LLC		\$	\$ (195,693)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 195,693			\$ 0	\$ * (195,693)

* 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: 01/01/2008 Ending: 12/31/2008

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: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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	19	PROFESSIONAL FEES	PATIENT DAYS	195,921	4	\$ 165,375	\$ 65,493	\$ 55,281	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	195,921	4	316	65,493	106	2
3	21	CLERICAL	PATIENT DAYS	195,921	4	4,912	65,493	1,642	3
4	24	TRAVEL	PATIENT DAYS	195,921	4	3,912	65,493	1,308	4
5	26	INSURANCE	PATIENT DAYS	195,921	4	5,896	65,493	1,971	5
6	35	RENT - EQPT & VEHICLE	PATIENT DAYS	195,921	4	11,418	65,493	3,817	6
7	30	DEPRECIATION	PATIENT DAYS	195,921	4	635	65,493	212	7
8	21	CLERICAL	DIRECT HOURS	1	1	16,734	16,734	1	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					\$ 209,198	\$ 16,734	\$ 81,071	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 27,631	\$ 27,631	1	\$ 27,631	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	744		65,493	88	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	1,552		65,493	184	3
4	21	CLERICAL	PATIENT DAYS	554,294	27,317		65,493	3,227	4
5	24	TRAVEL	PATIENT DAYS	554,294	39,814		65,493	4,704	5
6	26	INSURANCE	PATIENT DAYS	554,294	20,700		65,493	2,446	6
7	30	DEPRECIATION	PATIENT DAYS	554,294	1,923		65,493	227	7
8	34	RENT	PATIENT DAYS	554,294			65,493		8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	554,294	33,179		65,493	3,920	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				\$ 152,860	\$ 27,631		\$ 42,427	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	554,294	11	\$ 139,104	\$ 65,493	\$ 16,436	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	3,659	65,493	433	2
3	21	CLERICAL	PATIENT DAYS	554,294	11	182,061	65,493	21,512	3
4	24	TRAVEL	PATIENT DAYS	554,294	11	46,149	65,493	5,453	4
5	26	INSURANCE	PATIENT DAYS	554,294	11	143,346	65,493	16,938	5
6	30	DEPRECIATION	PATIENT DAYS	554,294	11	40,500	65,493	4,785	6
7	34	RENT	PATIENT DAYS	554,294	11	375,668	65,493	44,389	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	554,294	11	16,218	65,493	1,916	8
9	21	CLERICAL	DIRECT HOURS	1	1	175,492	175,492	1	175,492
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					\$ 1,122,197	\$ 175,492	\$ 287,354	25

Facility Name & ID Number

ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
A. Directly Facility Related											
Long-Term											
1	RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC						\$	\$			\$
2	GMAC		X	MORTGAGE	\$46,016.00	07/2002	7,480,000	7,049,003	07/2037	6.6600	472,032
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YRS		161,845	131,788			4,624
4											
5											
Working Capital											
6											
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES	3,120,000	12,292,351	DEMAND	VARIES	970,084
8	LETTER OF CREDIT FEE		X								
9	TOTAL Facility Related				\$46,016.00		\$ 10,761,845	\$ 19,473,142			\$ 1,446,740
B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							
11											
12											
13											
14	TOTAL Non-Facility Related						\$	\$			\$
15	TOTALS (line 9+line14)						\$ 10,761,845	\$ 19,473,142			\$ 1,446,740

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 2007 report.		\$	72,800	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.)		\$	74,660	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,860	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,500	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.		\$	77,360	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	65,445	8
	2004	67,738	9
	2005	70,736	10
	2006	71,959	11
	2007	74,660	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED

ON ~101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2007 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>74,659.54</u>	\$ <u>74,659.54</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>74,659.54</u>	\$ <u>74,659.54</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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		\$ 1,765,244	4
5		1997		14,949	544	27.5	544		6,230	5
6										6
7										7
8										8
	Improvement Type**									
9	*****RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC									
10	FIRE DOORS/ALUMINUM SCREENS	1997		3,609	131	27.5	131		1,507	10
11	LANDSCAPING	1997		16,142	587	27.5	587		6,750	11
12	OUTDOOR SIGNS	1997		8,110	295	27.5	295		3,282	12
13	KITCHEN REMODELING - FLOORING/CONCRETE FOOTINGS	1998		18,381	668	27.5	668		7,013	13
14	FENCE	1998		2,350	139	15	157	18	1,925	14
15	ASPHALT PAVEMENT	1998		7,491	442	15	499	57	5,385	15
16	PAVEMENT	1999		4,975	181	27.5	181		1,712	16
17	INSULATING UNIT	1999		6,991	254	27.5	254		2,403	17
18	WALLCOVERINGS/TILES/BLOCK WALLS/CARPET	1999		126,568	4,602	27.5	4,602		43,528	18
19	AWNINGS	1999		7,939	289	27.5	289		2,733	19
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB	2000		64,360	2,340	27.5	2,340		19,793	20
21	INSTALLATION OF ALL DRAPERIES FOR 4 FLOORS	2001		7,828	285	27.5	285		2,137	21
22	PAINT & PREP. ROOMS ON FLOORS 4 & 5	2001		9,525	346	27.5	346		2,595	22
23	REPAIR HOLES, STRIP, SEAL CRACKS IN PARKING LOT	2001		5,950	216	27.5	216		1,620	23
24	INSTALL 41 INSULATING WINDOWS - RESIDENT ROOMS	2001		2,974	108	27.5	108		810	24
25	VCT FLOORING - DINING RM & ADMIN. CORRIDOR	2001		7,165	261	27.5	261		1,958	25
26	REPLACE ELEVATOR DOORS	2001		3,742	136	27.5	136		1,020	26
27	PATCH AND PREP. WALLS AND PAINT ROOMS ON 2ND, 3RD, AND 4TH FLOORS, SECOND AND 4TH FLOOR CORRIDORS	2002		12,983	1,304	7	1,298	(6)	11,501	28
29	FIRE ALARM - ADD/RELOCATE SMOKE SENSORS	2002		6,027	219	27.5	219		1,451	29
30	INSTALL RUBBER ROOF WITH HALF INCH INSULATION	2003		12,090	440	27.5	440		2,420	30
31	INSTALL VINYL TILES IN SHOWER ROOMS ON THE 5TH FLOOR	2003		4,041	147	27.5	147		808	31
32	2 PLASTIC LAMINATED & INSULATED METAL STAIRWAY DOOR	2003		3,396	123	27.5	123		681	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		1,932	34
35	NURSE CALL SYSTEM WITH 24 LITE PANEL, PULL CORD & BED	2003		31,136	1,132	27.5	1,132		6,226	35
36	PAINT & PREP. & HANG WALLPAPERS	2004		35,000	3,124	7	3,500	376	21,000	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$ 1,488	7	\$ 1,667	\$ 179	\$ 10,001	37
38	SIGNS FOR BUILDING	2004	1,290	115	7	129	14	773	38
39	BORDERS FOR ALL RESIDENT RMS & DINING ROOM	2004	3,335	298	7	334	36	2,000	39
40	REMOVE AND INSTALL NEW FLOOR	2004	8,028	716	7	803	87	4,817	40
41	4TH FLOOR NURSES STATION/QUARRY TILE COVE BASE	2005	6,357	231	27.5	231		924	41
42	REPLACEMENT OF DOMESTIC HOT WATER HEATER	2005	32,871	1,195	27.5	1,195		4,382	42
43	INSTALLATION OF SPRINKLER SYSTEM	2005	1,325	48	27.5	48		176	43
44	CONCRETE WORK ON SIDE WALK	2005	2,550	170	15	170		595	44
45	COVE BASE/COVE BASE ADHESIVE - KITCHEN	2005	1,157	42	27.5	42		130	45
46	REPAIR ASPHALT PAVEMENT	2006	6,489	555	15	433	(122)	1,299	46
47	BUILD & INSTALL BASE CABINETS - NURSES STATION	2006	1,129	41	27.5	41		121	47
48	ADDITION OF NEW EMERGENCY CIRCUITS	2006	1,543	56	27.5	56		147	48
49	INSTALL NEW FIRE DAMPERS	2006	4,850	176	27.5	176		374	49
50	INSTALL NEW SHAFT SYSTEM	2006	38,901	1,417	27.5	1,417		3,009	50
51	CUSTOM H.M DOOR AND DOOR SHOE	2007	1,936	70	27.5	70		129	51
52	SHAW TIDEWATER YORKTOWN CARPET	2007	1,093	350	5	109	(241)	219	52
53	99 TON CHILLER SYSTEM	2007	84,851	3,085	27.5	3,085		5,142	53
54	NEW WINDOW SCREENS	2007	1,128	361	5	113	(248)	226	54
55	REPLACE ENTRY DOOR	2008	2,317	63	27.5	63		63	55
56	INSTALL HANDRAIL, PAINT AND WALLPAPER RES. RMS	2008	2,872	215	10	215		215	56
57	FLOORING FOR THERAPY ROOM	2008	3,956	108	27.5	108		108	57
58	AWNING	2008	1,479	27	27.5	27		27	58
59	COVE BASE/COVE BASE ADHESIVE - THERAPY RM	2008	960	12	27.5	12		12	59
60	PATCHING, PAINTING & WALLPAPERING RESIDENT RMS	2008	48,904	408	10	408		408	60
61									61
62									62
63			ADJ. TO SL	150			(150)		63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,768,807	\$ 177,677		\$ 177,677	\$	\$ 1,958,961	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	\$ 615,639	\$ 35,187	\$ 53,044	\$ 17,857	3-15 YRS	\$ 369,015	71
72	Current Year Purchases	32,235	19,341	1,612	(17,729)	3-15 YRS	1,612	72
73	Fully Depreciated Assets	27,302				3-15YRS	27,302	73
74	RELATED PARTY		5,224	5,224				74
75	TOTALS	\$ 675,176	\$ 59,752	\$ 59,880	\$ 128		\$ 397,929	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)	\$ 5,443,983	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 237,429	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 237,557	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 128	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,356,890	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: \$ 34,693 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	ADMINISTRATIVE	2004 CHEVY TRAIL BLA	\$ 740.74	\$ 8,889	17
18					18
19					19
20					20
21	TOTAL		\$ 740.74	\$ 8,889	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 266,545	\$		\$ 266,545	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			53,318			53,318	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			348,850			348,850	4
5	Physician Care	39-3	visits							5
6	Dental Care	39-3	visits			5,132			5,132	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				247,828		247,828	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	X-RAY, LAB, RENTALS & Other (specify): <u>I.V. THERAPY</u>	39-2					118,165		118,165	13
14	TOTAL			\$		\$ 673,845	\$ 365,993		\$ 1,039,838	14

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ (26,104)	\$ 225,185	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>622,789</u>)	2,792,639	2,792,639	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,500	108,048	6
7	Other Prepaid Expenses	24,727	24,727	7
8	Accounts Receivable (owners or related parties)	280,228	320,706	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		764,645	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,119,990	\$ 4,235,950	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,838	1,838	12
13	Land		726,241	13
14	Buildings, at Historical Cost		4,059,452	14
15	Leasehold Improvements, at Historical Cost		699,515	15
16	Equipment, at Historical Cost	675,178	675,178	16
17	Accumulated Depreciation (book methods)	(616,344)	(2,588,403)	17
18	Deferred Charges		145,236	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 60,672	\$ 3,719,057	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,180,662	\$ 7,955,007	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,348,565	\$ 2,352,319	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	239,627	239,627	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,283	140,283	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,818	18,818	31
32	Accrued Real Estate Taxes(Sch.IX-B)		75,500	32
33	Accrued Interest Payable	2,033,411	41,091	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO DPA</u>	24,195	24,195	36
37	<u>MANAGEMENT FEES</u>	238,451	238,451	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,043,350	\$ 3,130,284	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,292,351	4,149,354	39
40	Mortgage Payable		7,049,003	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)	\$ 12,292,351	\$ 11,198,357	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 17,335,701	\$ 14,328,641	46
47	TOTAL EQUITY(page 18, line 24)	\$ (14,155,039)	\$ (6,373,634)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,180,662	\$ 7,955,007	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (12,066,935)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	(6)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (12,066,941)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,088,098)	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)	\$ (2,088,098)	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)	\$ (14,155,039)	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	\$ 9,543,236	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,543,236	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,570	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,570	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	899	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 899	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,545,705	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,496,503	31
32	Health Care	3,571,484	32
33	General Administration	3,520,702	33
	B. Capital Expense		
34	Ownership	1,898,220	34
	C. Ancillary Expense		
35	Special Cost Centers	1,039,838	35
36	Provider Participation Fee	107,056	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,633,803	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,088,098)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,088,098)	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: 01/01/2008

Ending: 12/31/2008

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	2,184	2,360	\$ 78,665	\$ 33.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,416	8,077	217,822	26.97	3
4	Licensed Practical Nurses	48,439	52,995	1,262,356	23.82	4
5	CNAs & Orderlies	94,504	102,599	1,190,849	11.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,498	2,743	44,994	16.40	8
9	Activity Director	2,164	2,326	29,626	12.74	9
10	Activity Assistants	10,223	11,100	112,857	10.17	10
11	Social Service Workers	5,231	5,654	80,245	14.19	11
12	Dietician					12
13	Food Service Supervisor	3,685	4,004	55,733	13.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,388	26,762	230,992	8.63	15
16	Dishwashers					16
17	Maintenance Workers	2,391	2,641	54,150	20.50	17
18	Housekeepers	18,503	19,819	206,118	10.40	18
19	Laundry	9,702	11,272	102,193	9.07	19
20	Administrator	2,041	2,411	173,983	72.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,997	4,461	85,843	19.24	23
24	Clerical	6,840	7,453	141,952	19.05	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	3,775	4,059	46,412	11.43	31
32	Other Health Care(specify)					32
33	Other(specify) <u>WARD CLERK</u>	5,861	6,462	86,618	13.40	33
34	TOTAL (lines 1 - 33)	254,842	277,198	\$ 4,201,408 *	\$ 15.16	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	243	\$ 16,827	1-3	35
36	Medical Director	180	38,400	9-3	36
37	Medical Records Consultant	12	1,215	10-3	37
38	Nurse Consultant	236	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	375	24,903	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	47	2,881	11-3	44
45	Social Service Consultant	50	3,046	12-3	45
46	Other(specify) <u>WOUND CARE</u>	96	24,000	10-3	46
47	<u>ALZHEIMERS</u>	138	8,265	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,473	\$ 233,209		49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
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																
3																									
4																									
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20	TOTALS		\$ 16,298		\$ 2,195	\$ 4,912	\$ 5,432	\$ 3,238	\$ 521																

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 - \$14729
- (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. \$ 6,442 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. \$ 107,056
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