

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	195	Skilled (SNF)	195	71,175	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	195	TOTALS	195	71,175	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,533	433	7,672	14,638	8
9	SNF/PED					9
10	ICF	47,192	3,129	678	50,999	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,725	3,562	8,350	65,637	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.22%

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 7,579

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES (WPS)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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	295,473	55,083	26,211	376,767		376,767	(1,415)	375,352		1
2	Food Purchase		379,582		379,582		379,582	(2,607)	376,975		2
3	Housekeeping	234,582	36,803		271,385		271,385	2,589	273,974		3
4	Laundry	107,512	37,031	512	145,055		145,055	2,325	147,380		4
5	Heat and Other Utilities			228,530	228,530		228,530		228,530		5
6	Maintenance	57,531	44,847	59,248	161,626		161,626	(8,403)	153,223		6
7	Other (specify):*			43,310	43,310		43,310		43,310		7
8	TOTAL General Services	695,098	553,346	357,811	1,606,255		1,606,255	(7,511)	1,598,744		8
	B. Health Care and Programs										
9	Medical Director			42,400	42,400		42,400		42,400		9
10	Nursing and Medical Records	3,037,505	136,107	148,562	3,322,174		3,322,174	(58,553)	3,263,621		10
10a	Therapy	176,543		3,325	179,868		179,868		179,868		10a
11	Activities	148,990	10,765	17,470	177,225		177,225	1,749	178,974		11
12	Social Services			2,692	2,692		2,692		2,692		12
13	CNA Training										13
14	Program Transportation			6,704	6,704		6,704		6,704		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,363,038	146,872	221,153	3,731,063		3,731,063	(56,804)	3,674,259		16
	C. General Administration										
17	Administrative	231,387		426,572	657,959		657,959	(426,572)	231,387		17
18	Directors Fees										18
19	Professional Services			502,749	502,749		502,749	(328,351)	174,398		19
20	Dues, Fees, Subscriptions & Promotions			126,177	126,177		126,177	(101,357)	24,820		20
21	Clerical & General Office Expenses	250,393	51,381	56,927	358,701		358,701	240,921	599,622		21
22	Employee Benefits & Payroll Taxes			802,233	802,233		802,233		802,233		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,143	9,143		9,143	12,374	21,517		24
25	Other Admin. Staff Transportation			9,915	9,915		9,915		9,915		25
26	Insurance-Prop.Liab.Malpractice			278,904	278,904		278,904	6,921	285,825		26
27	Other (specify):*			208,397	208,397		208,397	(208,397)			27
28	TOTAL General Administration	481,780	51,381	2,421,017	2,954,178		2,954,178	(804,461)	2,149,717		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,539,916	751,599	2,999,981	8,291,496		8,291,496	(868,776)	7,422,720		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	18,162
	REPAIRS & MAINTENANCE	8,049
		0
		26,211
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	512
		0
		512
5	HEAT & OTHER UTILITIES	
	GAS HEAT	105,614
	ELECTRICITY	96,016
	WATER	26,900
	CABLE TV - LOBBY	0
		0
		228,530
6	MAINTENANCE	
	GROUNDS MAINTENANCE	17,379
	PAINTING & DECORATING	9,975
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,583
	ELEVATOR MAINTENANCE & REPAIR	6,988
	OUTSIDE LABOR	1,268
	EXTERMINATING SERVICE	6,040
	FIRE SERVICE	7,015
		0
		0
		0
		0
		59,248
7	OTHER	
	SCAVENGER	42,656
	SECURITY SERVICE	654
		0
		0
		43,310
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	42,400
		42,400

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	9,675
	WOUND CARE CONSULTANT XVIII B 46-2	24,000
		148,562
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	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	3,325
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,325
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	14,778
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,692
		0
		17,470
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,692
		0
		2,692
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	6,704
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	426,572
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	22,876
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	479,873
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	70,818
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	24,395
	EMPLOYEE WANT ADS XIX F	3,173
	CONTRIBUTIONS VI 20 XIX F	676
	DUES & SUBSCRIPTIONS XIX F	14,284
	LICENSES & PERMITS XIX F	4,207
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	352
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,237
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	660
	PATIENT BACKGROUND CHECKS XIX F	1,375
		126,177
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	7,483
	EQUIPMENT REPAIR & MAINTENANCE	295
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	5,241
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	39,443
	MESSENGER SERVICE	4,465
		0
		56,927

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	338,371
	UNEMPLOYMENT COMPENSATION XIX D	42,777
	WORKERS COMPENSATION INSURANC XIX D	90,953
	HOSPITALIZATION INSURANCE XIX D	297,319
	EMPLOYEE BENEFITS - OTHER XIX D	13,133
	EMPLOYEE PHYSICAL EXAMS XIX D	1,600
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	18,080
	CHICAGO HEAD TAX XIX D	0
		0
		802,233
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	9,143
	TRAVEL XIX G	0
		9,143
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,915
		9,915
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	278,904
		278,904
27	OTHER	
	BAD DEBTS VI 24	208,397
		208,397

GRAND TOTAL COLUMN 3 OTHER **2,999,981**

ASPEN RIDGE CARE CENTRE
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	379,582
LESS SALES TAX	<u>(2,607)</u>
NET FOOD	376,975

TOTAL PATIENT CENSUS	65,637
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	196,911

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

PATIENT MEALS	196,911
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	196,911

NET FOOD	376,975
DIVIDE TOTAL MEALS/YEAR	<u>196,911</u>

COST PER MEAL	1.91
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE

#0042481

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

12/31/2009

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			129,682	129,682		129,682	121,183	250,865			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			135,067	135,067		135,067	441,596	576,663			32
33	Real Estate Taxes			76,855	76,855		76,855		76,855			33
34	Rent-Facility & Grounds			744,600	744,600		744,600	(691,382)	53,218			34
35	Rent-Equipment & Vehicles			61,416	61,416		61,416	11,999	73,415			35
36	Other (specify):* STORAGE & MTG. INS			8,291	8,291		8,291	35,085	43,376			36
37	TOTAL Ownership			1,155,911	1,155,911		1,155,911	(81,519)	1,074,392			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		389,498	868,006	1,257,504		1,257,504		1,257,504			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			106,763	106,763		106,763		106,763			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		389,498	974,769	1,364,267		1,364,267		1,364,267			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,539,916	1,141,097	5,130,661	10,811,674		10,811,674	(950,295)	9,861,379			45

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	(67,993)	30		9
10	Interest and Other Investment Income	(29,446)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,607)	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	(5,241)	21		18
19	Entertainment	(70,818)	20		19
20	Contributions	(6,913)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(667)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(208,397)	27		24
25	Fund Raising, Advertising and Promotional	(24,395)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(352)	20		28
29	Other-Attach Schedule	12,733			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (404,096)		\$	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)	(546,199)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (546,199)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (950,295)		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: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ -9454	6	1
2	VACATION ACCRUAL	(1,415)	1	2
3	VACATION ACCRUAL	2,589	3	3
4	VACATION ACCRUAL	2,325	4	4
5	VACATION ACCRUAL	1,051	6	5
6	VACATION ACCRUAL	18,052	10	6
7	VACATION ACCRUAL	1,749	11	7
8	VACATION ACCRUAL		17	8
9	VACATION ACCRUAL	532	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11				11
12	MEDICARE A BILLING	(36)	19	12
13	MARKETING CONSULTANT	(660)	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		12,733	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,415)	0	0	0	0	0	0	0	0	0	0	(1,415)	1
2	Food Purchase	(2,607)	0	0	0	0	0	0	0	0	0	0	(2,607)	2
3	Housekeeping	2,589	0	0	0	0	0	0	0	0	0	0	2,589	3
4	Laundry	2,325	0	0	0	0	0	0	0	0	0	0	2,325	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(8,403)	0	0	0	0	0	0	0	0	0	0	(8,403)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,511)	0	0	0	0	0	0	0	0	0	0	(7,511)	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	18,052	0	0	(76,605)	0	0	0	0	0	0	0	(58,553)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,749	0	0	0	0	0	0	0	0	0	0	1,749	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	19,801	0	0	(76,605)	0	0	0	0	0	0	0	(56,804)	16
	C. General Administration													
17	Administrative	0	0	(213,286)	0	0	(213,286)	0	0	0	0	0	(426,572)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,363)	11,968	9,813	1,154	(347,923)	0	0	0	0	0	0	(328,351)	19
20	Fees, Subscriptions & Promotions	(102,478)	0	332	72	717	0	0	0	0	0	0	(101,357)	20
21	Clerical & General Office Expenses	(4,709)	0	11,617	2,568	231,445	0	0	0	0	0	0	240,921	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	252	5,104	7,018	0	0	0	0	0	0	12,374	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	1,525	2,248	3,148	0	0	0	0	0	0	6,921	26
27	Other (specify):*	(208,397)	0	0	0	0	0	0	0	0	0	0	(208,397)	27
28	TOTAL General Administration	(318,947)	11,968	(189,747)	11,146	(105,595)	(213,286)	0	0	0	0	0	(804,461)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(306,657)	11,968	(189,747)	(65,459)	(105,595)	(213,286)	0	0	0	0	0	(868,776)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASPEN RIDGE CARE CENTRE# 0042481

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(67,993)	183,538	135	441	5,062	0	0	0	0	0	0	121,183	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,446)	471,042	0	0	0	0	0	0	0	0	0	441,596	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(744,600)	0	1,945	51,273	0	0	0	0	0	0	(691,382)	34
35	Rent-Equipment & Vehicles	0	0	4,526	5,854	1,619	0	0	0	0	0	0	11,999	35
36	Other (specify):*	0	35,085	0	0	0	0	0	0	0	0	0	35,085	36
37	TOTAL Ownership	(97,439)	(54,935)	4,661	8,240	57,954	0	0	0	0	0	0	(81,519)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(404,096)	(42,967)	(185,086)	(57,219)	(47,641)	(213,286)	0	0	0	0	0	(950,295)	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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		"		35,085	35,085	2
3	V	30 DEPRECIATION - BLDG/IMP		"		183,538	183,538	3
4	V							4
5	V	32 AMORTIZATION - MTG COST		"		4,624	4,624	5
6	V	32 INTEREST - MORTGAGE		"		466,418	466,418	6
7	V	19 ACCOUNTING FEES		"		11,818	11,818	7
8	V	19 DATA PROCESSING		"		150	150	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 744,600			\$ 701,633	\$ * (42,967)	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	\$ 73,330	YORK MANAGEMENT ASSOCIATES, LLC		\$ 83,143	\$ 9,813	15
16	V	20 DUES & SUBSCRIPTIONS		"		332	332	16
17	V	21 CLERICAL		"		11,617	11,617	17
18	V	24 TRAVEL		"		252	252	18
19	V	26 INSURANCE		"		1,525	1,525	19
20	V	35 RENT - EQPT & VEHICLE		"		4,526	4,526	20
21	V	17 ADMINISTRATIVE	213,286	"			(213,286)	21
22	V	30 DEPRECIATION		"		135	135	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		\$ 286,616			\$ 101,530	\$ * (185,086)	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		\$ 35,867	\$ (76,605)
16	V	19 PROFESSIONAL FEES		"		1,154	1,154
17	V	20 DUES & SUBSCRIPTIONS		"		72	72
18	V	21 CLERICAL		"		2,568	2,568
19	V	24 TRAVEL		"		5,104	5,104
20	V	26 INSURANCE		"		2,248	2,248
21	V	30 DEPRECIATION		"		441	441
22	V	34 RENT		"		1,945	1,945
23	V	35 RENT - EQPT & VEHICLE		"		5,854	5,854
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			\$ 55,253	\$ * (57,219)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 350,875	THE KENSINGTON GROUP, LLC		\$ 2,952	\$ (347,923)
16	V	20 DUES & SUBSCRIPTIONS		" "		717	717
17	V	21 CLERICAL		" "		231,445	231,445
18	V	24 TRAVEL		" "		7,018	7,018
19	V	26 INSURANCE		" "		3,148	3,148
20	V	30 DEPRECIATION		" "		5,062	5,062
21	V	34 RENT		" "		51,273	51,273
22	V	35 RENT - EQPT & VEHICLE		" "		1,619	1,619
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			\$ 303,234	\$ * (47,641)

* 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	\$ 213,286	CHESTERFIELD, LLC		\$	\$ (213,286)
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		\$ 213,286			\$ 0	\$ * (213,286)

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

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:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	193,799	4	\$ 245,485	\$ 65,637	\$ 83,143	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	193,799	4	979	65,637	332	2
3	21	CLERICAL	PATIENT DAYS	193,799	4	3,807	65,637	1,289	3
4	24	TRAVEL	PATIENT DAYS	193,799	4	743	65,637	252	4
5	26	INSURANCE	PATIENT DAYS	193,799	4	4,504	65,637	1,525	5
6	35	RENT - EQPT & VEHICLE	PATIENT DAYS	193,799	4	13,362	65,637	4,526	6
7	30	DEPRECIATION	PATIENT DAYS	193,799	4	400	65,637	135	7
8	21	CLERICAL	DIRECT HOURS	1	1	10,328	10,328	1	10,328
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					\$ 279,608	\$ 10,328	\$ 101,530	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 35,867	\$ 35,867	1	\$ 35,867	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	549,185	11	9,656	65,637	1,154	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	603	65,637	72	3
4	21	CLERICAL	PATIENT DAYS	549,185	11	21,492	65,637	2,568	4
5	24	TRAVEL	PATIENT DAYS	549,185	11	42,708	65,637	5,104	5
6	26	INSURANCE	PATIENT DAYS	549,185	11	18,809	65,637	2,248	6
7	30	DEPRECIATION	PATIENT DAYS	549,185	11	3,694	65,637	441	7
8	34	RENT	PATIENT DAYS	549,185	11	16,279	65,637	1,945	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	549,185	11	48,990	65,637	5,854	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				\$ 198,098	\$ 35,867		\$ 55,253	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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	549,185	11	\$ 24,702	\$ 65,637	\$ 2,952	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	6,002	65,637	717	2
3	21	CLERICAL	PATIENT DAYS	549,185	11	215,149	65,637	25,714	3
4	24	TRAVEL	PATIENT DAYS	549,185	11	58,719	65,637	7,018	4
5	26	INSURANCE	PATIENT DAYS	549,185	11	26,340	65,637	3,148	5
6	30	DEPRECIATION	PATIENT DAYS	549,185	11	42,349	65,637	5,062	6
7	34	RENT	PATIENT DAYS	549,185	11	428,990	65,637	51,273	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	549,185	11	13,546	65,637	1,619	8
9	21	CLERICAL	DIRECT HOURS	1	1	205,731	205,731	1	205,731
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					\$ 1,021,528	\$ 205,731	\$ 303,234	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC						\$	\$		\$	1						
2	GMAC		X	MORTGAGE	\$46,016.00	07/2002	7,840,000	6,963,707	07/2037	6.6600	466,418						
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YEARS		161,845	127,164			4,624						
4											4						
5											5						
Working Capital																	
6											6						
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES	3,120,000		DEMAND	VARIES	133,885						
8	LETTER OF CREDIT FEE		X								1,182						
9	TOTAL Facility Related				\$46,016.00		\$ 11,121,845	\$ 7,090,871			\$ 606,109						
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES							10						
11											11						
12											12						
13											13						
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 11,121,845	\$ 7,090,871			\$ 606,109						

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

1. Real Estate Tax accrual used on 2008 report.		\$	75,500	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.)		\$	75,755	2
3. Under or (over) accrual (line 2 minus line 1).		\$	255	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	76,600	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.		\$	76,855	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	67,738	8	
	2005	70,736	9	
	2006	71,959	10	
	2007	74,660	11	
	2008	75,755	12	

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 2008 TAX BILL				
	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$		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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>75,755.22</u>	\$ <u>75,755.22</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

01/01/2009 Ending:

12/31/2009

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>		\$	1
2					2
3	TOTALS	90,679		\$	3

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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	\$	\$ 1,912,860	4	
5		1997		14,949	544	27.5	544		6,774	5	
6										6	
7										7	
8										8	
Improvement Type**											
9	*****RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC										9
10	FIRE DOORS/ALUMINUM SCREENS		1997	3,609	131	27.5	131		1,638	10	
11	LANDSCAPING		1997	16,142	587	27.5	587		7,337	11	
12	OUTDOOR SIGNS		1997	8,110	295	27.5	295		3,577	12	
13	KITCHEN REMODELING - FLOORING/CONCRETE FOOTINGS		1998	18,381	668	27.5	668		7,681	13	
14	FENCE		1998	2,350	139	15	157	18	2,082	14	
15	ASPHALT PAVEMENT		1998	7,491	442	15	499	57	5,884	15	
16	PAVEMENT		1999	4,975	181	27.5	181		1,893	16	
17	INSULATING UNIT		1999	6,991	254	27.5	254		2,657	17	
18	WALLCOVERINGS/TILES/BLOCK WALLS/CARPET		1999	126,568	4,602	27.5	4,602		48,130	18	
19	AWNINGS		1999	7,939	289	27.5	289		3,022	19	
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB		2000	64,360	2,340	27.5	2,340		22,133	20	
21	INSTALLATION OF ALL DRAPERIES FOR 4 FLOORS		2001	7,828	285	27.5	285		2,422	21	
22	PAINT & PREP. ROOMS ON FLOORS 4&5		2001	9,525	346	27.5	346		2,941	22	
23	REPAIR HOLES, STRIP, SEAL CRACKS IN PARKING LOT		2001	5,950	216	27.5	216		1,836	23	
24	INSTALL 41 INSULATING WINDOWS - RESIDENT ROOMS		2001	2,974	108	27.5	108		918	24	
25	VCT FLOORING - DINING RM & ADMIN. CORRIDOR		2001	7,165	261	27.5	261		2,219	25	
26	REPLACE ELEVATOR DOORS		2001	3,742	136	27.5	136		1,156	26	
27	PATCH AND PREP. WALLS AND PAINT ROOMS ON 2ND, 3RD,									27	
28	AND 4TH FLOORS, SECOND AND 4TH FLOOR CORRIDORS		2002	12,983	652	7	1,298	646	12,799	28	
29	FIRE ALARM - ADD/RELOCATE SMOKE SENSORS		2002	6,027	219	27.5	219		1,670	29	
30	INSTALL RUBBER ROOF WITH HALF INCH INSULATION		2003	12,090	440	27.5	440		2,860	30	
31	INSTALL VINYL TILES IN SHOWER ROOMS ON THE 5TH FLOOR		2003	4,041	147	27.5	147		955	31	
32	2 PLASTIC LAMINATED & INSULATED METAL STAIRWAY DOOR		2003	3,396	123	27.5	123		804	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		2,283	34	
35	NURSE CALL SYSTEM WITH 24 LITE PANEL, PULL CORD & BED		2003	31,136	1,132	27.5	1,132		7,358	35	
36	PAINT & PREP. & HANG WALLPAPERS		2004	35,000	3,124	7	3,500	376	24,500	36	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

0042481

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 11,668	37
38	SIGNS FOR BUILDING	2004	1,290	115	7	129	14	902	38
39	BORDERS FOR ALL RESIDENT RMS & DINING ROOM	2004	3,335	298	7	334	36	2,334	39
40	REMOVE AND INSTALL NEW FLOOR	2004	8,028	716	7	803	87	5,620	40
41	4TH FLOOR NURSES STATION/QUARRY TILE COVE BASE	2005	6,357	231	27.5	231		1,155	41
42	REPLACEMENT OF DOMESTIC HOT WATER HEATER	2005	32,871	1,195	27.5	1,195		5,577	42
43	INSTALLATION OF SPRINKLER SYSTEM	2005	1,325	48	27.5	48		224	43
44	CONCRETE WORK ON SIDE WALK	2005	2,550	170	15	170		765	44
45	COVE BASE/COVE BASE ADHESIVE - KITCHEN	2005	1,157	42	27.5	42		172	45
46	REPAIR ASPHALT PAVEMENT	2006	6,489	499	15	433	(66)	1,732	46
47	BUILD & INSTALL BASE CABINETS - NURSES STATION	2006	1,129	41	27.5	41		162	47
48	ADDITION OF NEW EMERGENCY CIRCUITS	2006	1,543	56	27.5	56		203	48
49	INSTALL NEW FIRE DAMPERS	2006	4,850	176	27.5	176		550	49
50	INSTALL NEW SHAFT SYSTEM	2006	38,901	1,417	27.5	1,417		4,426	50
51	CUSTOM H.M DOOR AND DOOR SHOE	2007	1,936	70	27.5	70		199	51
52	SHAW TIDEWATER YORKTOWN CARPET	2007	1,093	210	5	109	(101)	328	52
53	99 TON CHILLER SYSTEM	2007	84,851	3,085	27.5	3,085		8,227	53
54	NEW WINDOW SCREENS	2007	1,128	217	5	113	(104)	339	54
55	REPLACE ENTRY DOOR	2008	2,317	84	27.5	84		147	55
56	INSTALL HANDRAIL, PAINT AND WALLPAPER RES. RMS	2008	2,872	287	10	287		502	56
57	FLOORING FOR THERAPY ROOM	2008	3,956	144	27.5	144		252	57
58	AWNING	2008	1,479	54	27.5	54		81	58
59	COVE BASE/COVE BASE ADHESIVE - THERAPY RM	2008	960	35	27.5	35		47	59
60	PATCHING, PAINTING & WALLPAPERING RESIDENT RMS	2008	48,904	4,891	10	4,891		5,298	60
61	PATCHING/PAINTING - UTILITY RMS, MED RMS& BATHRN	2009	2,180	182	10	182		182	61
62	INSTALL 4 NEW SPRINKLER HEADS	2009	1,900	46	27.5	46		46	62
63	PAINT RESIDENT RMS & ELEVATOR CEILINGS	2009	3,545	177	10	177		177	63
64	ELEVATOR - NEW CYLINDER WITH SEALED PVC PIPES	2009	44,998	409	27.5	409		409	64
65	REFURBISH 5TH FLOOR COMMON AREAS	2009	49,500	300	27.5	300		300	65
66	CARPET & TILES FOR 5TH FLOOR	2009	9,280	77	10	77		77	66
67	DOORS FOR LOBBY	2009	1,343	8	27.5	8		8	67
68	RENOVATE MEN'S & WOMEN'S WASHROOMS - ALL FLRS	2009	10,620		10				68
69			ADJ. TO SL	1,142			(1,142)		69
70	TOTAL (lines 4 thru 69)		\$ 4,892,173	\$ 183,538		\$ 183,538	\$ (1,142)	\$ 2,142,498	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	\$ 647,874	\$ 25,714	\$ 52,114	\$ 26,400	3-15 YRS	\$ 422,741	71
72	Current Year Purchases	191,502	103,968	9,575	(94,393)	3-15 YRS	9,575	72
73	Fully Depreciated Assets	27,302				3-15 YRS	27,302	73
74	RELATED PARTY		5,638	5,638				74
75	TOTALS	\$ 866,678	\$ 135,320	\$ 67,327	\$ (67,993)		\$ 459,618	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)	\$ 5,758,851	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 318,858	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 250,865	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (67,993)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,602,116	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	WALLPAPER/VALANCES	\$	92
93	AND BORDERS	73,986	93
94			94
95		\$ 73,986	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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 52,527 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	<u>ADMINISTRATIVE</u>	<u>2004 CHEVY TRAIL</u>	\$	\$	17
18		<u>BLAZER</u>	<u>740.74</u>	<u>8,889</u>	18
19					19
20					20
21	TOTAL		\$ <u>740.74</u>	\$ <u>8,889</u>	21

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

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 316,544	\$		\$ 316,544	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			59,181			59,181	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			487,149			487,149	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			5,132			5,132	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				245,443		245,443	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): I.V. THERAPY	39-2					144,055		144,055	13
14	TOTAL			\$		\$ 868,006	\$ 389,498	\$	\$ 1,257,504	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# 0042481Report Period Beginning: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 302,464	\$ 1,103,211	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>492,497</u>)	1,322,020	1,322,020	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,838	1,838	5
6	Prepaid Insurance	47,589	103,191	6
7	Other Prepaid Expenses	14,254	14,598	7
8	Accounts Receivable (owners or related parties)	507,685	280,487	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		545,222	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,195,850	\$ 3,370,567	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		726,241	13
14	Buildings, at Historical Cost		4,882,332	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	866,680	866,680	16
17	Accumulated Depreciation (book methods)	(746,025)	(2,900,480)	17
18	Deferred Charges		127,164	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CONSTRUCTION IN PROG.</u>		73,986	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 120,655	\$ 3,775,923	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,316,505	\$ 7,146,490	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 320,827	\$ 420,741	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	64,542	64,542	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	164,920	164,920	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,405	20,405	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,600	32
33	Accrued Interest Payable	2,033,411	40,618	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO DPA</u>			36
37	<u>MANAGEMENT FEES</u>	379,975	379,975	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,984,080	\$ 1,167,801	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	13,267,292	5,124,295	39
40	Mortgage Payable		6,963,707	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)	\$ 13,267,292	\$ 12,088,002	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,251,372	\$ 13,255,803	46
47	TOTAL EQUITY(page 18, line 24)	\$ (13,934,867)	\$ (6,109,313)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,316,505	\$ 7,146,490	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (14,155,039)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (14,155,038)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	220,171	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)	\$ 220,171	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)	\$ (13,934,867)	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	\$ 11,069,819	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,069,819	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***	29,446	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,446	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	3,295	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,295	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,102,560	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,606,255	31
32	Health Care	3,731,063	32
33	General Administration	2,954,178	33
B. Capital Expense			
34	Ownership	1,155,911	34
C. Ancillary Expense			
35	Special Cost Centers	1,257,504	35
36	Provider Participation Fee	106,763	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	70,715	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,882,389	40
41	Income before Income Taxes (line 30 minus line 40)**	220,171	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 220,171	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: 01/01/2009

Ending: 12/31/2009

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	1,988	2,117	\$ 73,324	\$ 34.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,609	8,384	267,649	31.92	3
4	Licensed Practical Nurses	44,781	49,288	1,296,627	26.31	4
5	CNAs & Orderlies	95,790	103,942	1,248,333	12.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,899	10,751	176,543	16.42	8
9	Activity Director	2,084	2,269	31,409	13.84	9
10	Activity Assistants	9,988	10,964	117,581	10.72	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,340	2,531	45,279	17.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,917	27,134	250,194	9.22	15
16	Dishwashers					16
17	Maintenance Workers	2,336	2,547	57,531	22.59	17
18	Housekeepers	18,943	20,348	234,582	11.53	18
19	Laundry	10,117	11,525	107,512	9.33	19
20	Administrator	2,029	2,372	207,871	87.64	20
21	Assistant Administrator	784	872	23,516	26.97	21
22	Other Administrative					22
23	Office Manager	3,888	4,374	91,611	20.94	23
24	Clerical	7,034	7,927	158,782	20.03	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	3,648	3,965	45,112	11.38	31
32	Other Health C: <u>WARD CLERK</u>	6,899	7,592	106,460	14.02	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	255,074	278,902	\$ 4,539,916 *	\$ 16.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	262	\$ 18,162	1-3	35
36	Medical Director	199	42,400	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	50	3,325	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	44	2,692	11-3	44
45	Social Service Consultant	44	2,692	12-3	45
46	Other(specify) <u>WOUND CARE</u>	96	24,000	10-3	46
47	<u>ALZHEIMERS</u>	161	9,675	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,200	\$ 217,833		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-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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$ 3,127		\$ 522	\$ 1,042	\$ 1,042	\$ 521	\$	\$	\$	\$	\$
2												
3												
4												
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13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$ 3,127		\$ 522	\$ 1,042	\$ 1,042	\$ 521	\$	\$	\$	\$	\$

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 - \$15116.40
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,042 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 106,763
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (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.