

Facility Name & ID Number Aspire on Eastern

0020438 Report Period Beginning: 7/1/2008 Ending: 6/30/2009

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	82	Intermediate/DD	82	29,930	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	29,111	365		29,476	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,111	365		29,476	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.48%

D. How many bed-hold days during this year were paid by the Department? 236 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 03/01/1975

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/2008 Ending: 6/30/2009

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	227,785		7,514	235,299	7	235,306		235,306		1
2	Food Purchase		183,504		183,504	2,908	186,412		186,412		2
3	Housekeeping	186,866	57,480		244,346	10,930	255,276		255,276		3
4	Laundry	70,768	18,524		89,292		89,292		89,292		4
5	Heat and Other Utilities			117,808	117,808	10,696	128,504		128,504		5
6	Maintenance	98,061	27,682	37,582	163,325	10,041	173,366		173,366		6
7	Other (specify):*										7
8	TOTAL General Services	583,480	287,190	162,904	1,033,574	34,582	1,068,156		1,068,156		8
	B. Health Care and Programs										
9	Medical Director			10,500	10,500		10,500		10,500		9
10	Nursing and Medical Records	361,190	95,715	6,695	463,600		463,600		463,600		10
10a	Therapy										10a
11	Activities	1,623,596	47,624		1,671,220		1,671,220		1,671,220		11
12	Social Services	209,277		83,684	292,961		292,961		292,961		12
13	CNA Training	36,365			36,365		36,365		36,365		13
14	Program Transportation	2,109	35,383		37,492		37,492		37,492		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,232,537	178,722	100,879	2,512,138		2,512,138		2,512,138		16
	C. General Administration										
17	Administrative	125,421		182,658	308,079	(182,658)	125,421		125,421		17
18	Directors Fees										18
19	Professional Services			11,602	11,602	60,097	71,699		71,699		19
20	Dues, Fees, Subscriptions & Promotions			532	532	3,913	4,445	(1,087)	3,358		20
21	Clerical & General Office Expenses	308,189	5,894	22,016	336,099	33,665	369,764		369,764		21
22	Employee Benefits & Payroll Taxes			574,576	574,576		574,576		574,576		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,321	6,321	754	7,075	(5,255)	1,820		24
25	Other Admin. Staff Transportation					3,408	3,408		3,408		25
26	Insurance-Prop.Liab.Malpractice			34,457	34,457	778	35,235		35,235		26
27	Other (specify):*										27
28	TOTAL General Administration	433,610	5,894	832,162	1,271,666	(80,043)	1,191,623	(6,342)	1,185,281		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,249,627	471,806	1,095,945	4,817,378	(45,461)	4,771,917	(6,342)	4,765,575		29

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

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

Facility Name & ID Number Aspire on Eastern

#0020438

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			124,974	124,974	11,441	136,415		136,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,190	37,190	34,020	71,210		71,210			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,983	2,983		2,983		2,983			35
36	Other (specify):*											36
37	TOTAL Ownership			165,147	165,147	45,461	210,608		210,608			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			266,976	266,976		266,976		266,976			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			266,976	266,976		266,976		266,976			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,249,627	471,806	1,528,068	5,249,501		5,249,501	(6,342)	5,243,159			45

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

Aspire on Eastern

ID# 0020438

Report Period Beginning: 7/1/2008

Ending: 6/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22	Marketing Materails	1,087	20	22
23				23
24				24
25				25
26	Non-Direct Care staff travel & local transportation	5,255	24	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	6,342		49

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

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

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

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

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

Facility Name & ID Number

Aspire on Eastern

0020438

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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 Aspire on Eastern

0020438

Report Period Beginning:

7/1/2008

Ending: 5/30/2009

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Kitchen Supplies	Direct Cost	16105524	30	\$ 22	\$ 5,328,521	7	1
2	2	Food/Beverage	Direct Cost	16105524	30	8,789	5,328,521	2,908	2
3	3	Housekeeping Supplies	Direct Cost	16105524	30	4,381	5,328,521	1,449	3
4	3	Hskp. Other	Direct Cost	16105524	30	28,656	5,328,521	9,481	4
5	5	Utilities	Direct Cost	16105524	30	32,330	5,328,521	10,696	5
6	6	Maint. Supplies	Direct Cost	16105524	30	3,736	5,328,521	1,236	6
7	6	Maint. Other	Direct Cost	16105524	30	26,612	5,328,521	8,805	7
8	19	Prof. Services	Direct Cost	16105524	30	181,645	5,328,521	60,097	8
9	20	Dues, Fees, Other	Direct Cost	16105524	30	11,828	5,328,521	3,913	9
10	21	Clerical Supplies	Direct Cost	16105524	30	82,201	5,328,521	27,196	10
11	21	Telephone	Direct Cost	16105524	30	19,554	5,328,521	6,469	11
12	24	Travel Seminar	Direct Cost	16105524	30	2,280	5,328,521	754	12
13	25	Staff Travel	Direct Cost	16105524	30	10,301	5,328,521	3,408	13
14	26	Insurance	Direct Cost	16105524	30	2,351	5,328,521	778	14
15	30	Depreciation	Direct Cost	16105524	30	34,580	5,328,521	11,441	15
16	32	Interest	Direct Cost	16105524	30	102,826	5,328,521	34,020	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 552,092	\$	\$ 182,658	25

Facility Name & ID Number

Aspire on Eastern

0020438

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Banco Popular		X		\$22,610.67	8/23/03	\$ 3,000,000	\$		5.0000	\$ 36,046	1								
2	Illinois Facilities		X		\$4,294.12	10/31/99	495,000			7.6500	4,326	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Banco Popular										30,389	6								
7												7								
8												8								
9	TOTAL Facility Related				\$26,904.79		\$ 3,495,000	\$			\$ 70,761	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 3,495,000	\$			\$ 70,761	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>	<u>195,000</u>	<u>1975</u>	<u>\$ 175,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	195,000		\$ 175,000	3

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	81		1975	1975	\$ 835,850	\$ 20,896	40	\$ 20,896	\$	\$ 731,147	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		REMODELING	1976		4,485	112	40	112		3,642	9
10		FRONT ENCLOSURE	1984		13,115	437	30	437		10,716	10
11		FENCE	1985		4,658		10			4,658	11
12		LAUNDRY ROOM ADDITION	1986		7,775	259	30	259		5,835	12
13		TILE IN STOVE AREA	1986		1,125		20			1,125	13
14		ELECTRICAL WORK	1987		28,350		20			28,350	14
15		INSULATION	1987		6,639		20			6,639	15
16		ELECTRICAL	1988		5,000		20			5,000	16
17		FRONT ENCLOSURE	1989		3,595	89	20	89		3,595	17
18		PAVING	1989		18,732		15			18,732	18
19		WALK-IN COOLER	1989		23,330	933	25	933		18,198	19
20		WATER SOFTNER	1989		2,000		12			2,000	20
21		DRAPES	1989		3,667		10			3,667	21
22		BUILDING ADDITION	1991		320,606	10,687	30	10,687		187,020	22
23		SINK	1991		3,150	158	20	158		2,759	23
24		BUILDING ADDITION	1992		143,644	4,788	30	4,788		83,792	24
25		ROOF	1992		30,828	1,541	20	1,541		25,432	25
26		DRAPERIES	1993		4,360		10			4,360	26
27		BUILDING ADDITION	1993		13,070	436	30	436		7,189	27
28		HOT WATER HEATER	1993		3,075		15			3,075	28
29		HVAC-7	1993		6,230		8			6,230	29
30		SEALCOATING	1995		2,650		8			2,650	30
31		CARPETING	1995		4,225		5			4,225	31
32		2 VENTILATORS	1995		3,145		8			3,145	32
33		AIR COND	1995		3,250		8			3,250	33
34		HVAC	1995		6,906		8			6,906	34
35		NEW BATHTUB	1995		12,353	824	15	824		11,135	35
36		PAVING BUS AREA	1995		3,990	266	15	266		3,591	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 Aspire on Eastern

0020438

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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	TILE BATHROOM	1995	\$ 4,278	\$ 214	20	\$ 214	\$	\$ 2,889	37
38	WATER HEATER	1995	2,500		10			2,500	38
39	HOT WATER HEATER	1996	2,500		8			2,500	39
40	ROOF COOLER	1996	1,300		8			1,300	40
41	CARPETING	1996	16,348		8			16,348	41
42	ARCHITECTURAL	1997	7,221	361	20	361		4,514	42
43	CANOPY	1997	12,300		10			12,300	43
44	FENCE	1997	5,091	255	20	255		3,181	44
45	HVAC	1997	2,246	0	8	0		2,246	45
46	SEALCOATING	1997	11,000		8			11,000	46
47	SOFFIT & FACIA	1997	12,782		10			12,782	47
48	ELECTRICAL	1998	6,368	318	20	318		3,662	48
49	HVAC	1998	5,635		8			5,635	49
50	NURSES STATION	1998	3,880	194	20	194		2,231	50
51	PLUMBING-WATER HEATER	1998	8,300		8			8,300	51
52	REMODEL CAFETERIA	1998	28,076	1,404	20	1,404		16,144	52
53	SEALCOATING	1998	11,000		8			11,000	53
54	CARPETING	1998	7,814		5			7,814	54
55	HVAC	1999	6,800	340	10	340		6,800	55
56	PATIO COVER	1999	11,205	560	20	560		5,883	56
57	SECURITY SYSTEM	1999	1,200	60	10	60		1,200	57
58	ARCHITECT	1999	2,087	104	20	104		1,096	58
59	HVAC	2000	2,450		8			2,450	59
60	ROOF	2000	1,250	83	15	83		792	60
61	ARCHITECT-LATER IN LIFE	2000	22,803	1,140	20	1,140		10,831	61
62	SCREEN IN CANOPY	2001	16,486	824	20	824		7,007	62
63	PARKING LOT	2001	29,300	2,930	10	2,930		24,905	63
64	BATHROOM RENOVATION-EASTERN	2002	198,403	6,613	30	6,613		49,600	64
65	MEN SHOWER-RENOVATION	2002	51,289	1,710	30	1,710		12,809	65
66	SIDEWALK	2002	1,900	63	30	63		506	66
67	SLOPE-RENOVATION	2002	14,500	483	30	483		3,625	67
68	WOMEN SHOWER-RENOVATION	2002	60,000	2,000	30	2,000		15,000	68
69	KITCHEN RENOVATION	2002	11,411	380	30	380		2,663	69
70	TOTAL (lines 4 thru 69)		\$ 2,099,526	\$ 61,464		\$ 61,464	\$	\$ 1,469,572	70

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

Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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	
1	Totals from Page 12A, Carried Forward		\$ 2,099,526	\$ 61,464		\$ 61,464	\$	\$ 1,469,572	1
2	SECURITY SYSTEM	2003	7,776	778	10	778		5,054	2
3	KITCHEN RENOVATION	2003	182,098	6,070	30	6,070		39,455	3
4	WINDOW REPLACEMENT	2003	52,500	2,625	20	2,625		17,063	4
5	KITCHEN RENOVATION	2003	24,985	1,249	20	1,249		8,120	5
6	CARPETING	2003	1,143	143	8	143		929	6
7	ELECTRICAL	2004	13,759	688	20	688		3,784	7
8	FIRE DOORS	2004	10,700	535	20	535		2,943	8
9	HVAC	2004	1,895	190	10	190		1,042	9
10	SEWER	2004	3,900	195	20	195		1,073	10
11	HALLWAY RENOVATION	2004	2,562	85	30	85		512	11
12	windows replacement	2004	67,500	3,375	20	3,375		18,562	12
13	CARPETING	2004	4,453	445	5	445		4,453	13
14	HVAC	2005	2,165	271	8	271		1,218	14
15	LANDSCAPING	2005	1,775	178	10	178		799	15
16	LANDSCAPING	2005	3,700	370	10	370		1,665	16
17	HALLWAY RENOVATION	2005	150,827	5,028	30	5,028		22,624	17
18	CARPETING	2006	41,192	4,119	10	4,119		14,417	18
19	HVAC	2007	17,502	1,750	10	1,750		4,376	19
20	AWNING	2008	28,975	1,449	20	1,449		1,569	20
21	Canopy	2009	1,200	40	10	40		40	21
22	Heat Exchanger	2009	5,500	46	10	46		46	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,725,633	\$ 91,092		\$ 91,092	\$	\$ 1,619,314	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 367,715	\$ 19,214	\$ 19,214	\$		\$ 132,851	71
72	Current Year Purchases	2,720	317	317			317	72
73	Fully Depreciated Assets	98,887					98,887	73
74								74
75	TOTALS	\$ 469,322	\$ 19,531	\$ 19,531	\$		\$ 232,055	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	05 GM VAN	2005 GM Van	2005	\$ 29,319	\$ 5,864	\$ 5,864	\$	5	\$ 23,455	76
77										77
78										78
79										79
80	TOTALS			\$ 29,319	\$ 5,864	\$ 5,864	\$		\$ 23,455	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,399,274	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,487	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 116,487	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,874,825	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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: \$ 2,943 Description: Various one time rentals

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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 \$ _____

* 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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

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)		9,686		9,686
4	Clinical Wages (b)		21,794		21,794
5	In-House Trainer Wages (c)		4,885		4,885
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 36,365	\$	\$ 36,365
10	SUM OF line 9, col. 1 and 2 (e)	\$	36,365		

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	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	29

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/2008Ending: 6/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2009

(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	\$	\$ 112,262	1
2	Cash-Patient Deposits		105,431	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>16,000</u>)		3,394,610	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		444,416	5
6	Prepaid Insurance		18,921	6
7	Other Prepaid Expenses		7,237	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 4,082,877	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,713,082	13
14	Buildings, at Historical Cost		13,328,299	14
15	Leasehold Improvements, at Historical Cost		62,571	15
16	Equipment, at Historical Cost		2,449,560	16
17	Accumulated Depreciation (book methods)		(7,344,335)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Closing Costs</u>		106,595	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 10,315,772	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 14,398,649	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 476,095	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		105,431	28
29	Short-Term Notes Payable		1,350,000	29
30	Accrued Salaries Payable		629,299	30
31	Accrued Taxes Payable (excluding real estate taxes)		434,594	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Deferred Revenue</u>		68,352	36
37	<u>Accrued Expenses</u>		72,729	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 3,136,500	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		236,081	39
40	Mortgage Payable		6,780,738	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)	\$	\$ 7,016,819	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 10,153,319	46
47	TOTAL EQUITY(page 18, line 24)	\$ (12,147)	\$ 4,245,330	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (12,147)	\$ 14,398,649	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(12,147)	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)	\$ (12,147)	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)	\$ (12,147)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/2008Ending: 6/30/2009

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,929,708	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,929,708	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	180,408	10
11	CNA Training Reimbursements	44,299	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)	\$ 224,707	23
D. Non-Operating Revenue			
24	Contributions	82,939	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 82,939	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,237,354	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,033,574	31
32	Health Care	2,512,138	32
33	General Administration	1,271,666	33
B. Capital Expense			
34	Ownership	165,147	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	266,976	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,249,501	40
41	Income before Income Taxes (line 30 minus line 40)**	(12,147)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (12,147)	43

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

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

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

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

Facility Name & ID Number Aspire on Eastern

0020438

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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	1,740	2,080	\$ 61,499	\$ 29.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	11,724	12,882	299,691	23.26	4
5	CNAs & Orderlies					5
6	CNA Trainees	3,811	3,811	36,365	9.54	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,784	2,063	31,122	15.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,476	18,835	196,663	10.44	15
16	Dishwashers					16
17	Maintenance Workers	5,802	6,376	98,061	15.38	17
18	Housekeepers	14,372	16,149	186,866	11.57	18
19	Laundry	6,521	7,410	70,768	9.55	19
20	Administrator	1,936	2,075	65,541	31.59	20
21	Assistant Administrator	2,290	2,545	59,970	23.56	21
22	Other Administrative	3,721	4,065	171,221	42.12	22
23	Office Manager					23
24	Clerical	11,265	12,501	136,968	10.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,303	12,601	209,277	16.61	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	132,520	146,815	1,623,596	11.06	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Program Transpo</u>	173	194	2,109	10.87	33
34	TOTAL (lines 1 - 33)	226,438	250,402	\$ 3,249,717 *	\$ 12.98	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	164	\$ 7,514	1	35
36	Medical Director	58	8,700	9	36
37	Medical Records Consultant	19	455	10	37
38	Nurse Consultant	208	6,240	10	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	43	2,148	12	40
41	Occupational Therapy Consultant	332	16,613	12	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	215	13,513	12	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	465	51,410	12	46
47	<u>Neurologist</u>	12	1,800	9	47
48					48
49	TOTAL (lines 35 - 48)	1,516	\$ 108,393		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Vicki Striegel	Administrative		\$ 65,541	Workers' Compensation Insurance	\$ 68,302	IDPH License Fee	\$		
Peggy Kiefer	Administrative		44,818	Unemployment Compensation Insurance	21,969	Advertising: Employee Recruitment			
Patty Scollville	Administrative		6,839	FICA Taxes	249,404	Health Care Worker Background Check	3,358		
Barbara Embry	Administrative		2,752	Employee Health Insurance	209,117	(Indicate # of checks performed <u>105</u>)			
Bettye Robinson	Administrative		2,729	Employee Meals		Patient Background Checks			
LeLar Sampson	Administrative		2,742	Illinois Municipal Retirement Fund (IMRF)*					
				403B retirement	26,993				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,421						
B. Administrative - Other									
Description			Amount						
See Schedule VIII			\$ 182,658						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 182,658						
C. Professional Services									
Vendor/Payee	Type		Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Clifton Gunderson	Audit		\$ 9,872	Description	Line #	Amount	Description	Amount	
Winston Strawn	Legal		1,730			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,820	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,602	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,820	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aspire on Eastern# 0020438Report Period Beginning: 7/1/2008Ending: 6/30/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,457 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 266,976
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. \$ NO Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 85%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson
- (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