



Facility Name & ID Number ASPEN RIDGE CARE CENTRE

# 0042481 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	5,155	380	5,734	11,269	8
9	SNF/PED					9
10	ICF	49,028	3,609	647	53,284	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,183	3,989	6,381	64,553	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.70%

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 02/01/1997

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/1997 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 5,666

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES (WPS)

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	310,499	51,746	33,125	395,370		395,370	1,418	396,788		1
2	Food Purchase		413,194		413,194		413,194	(3,328)	409,866		2
3	Housekeeping	261,868	38,576		300,444		300,444	565	301,009		3
4	Laundry	117,546	18,506	652	136,704		136,704	(3,348)	133,356		4
5	Heat and Other Utilities			207,279	207,279		207,279		207,279		5
6	Maintenance	64,989	81,886	55,642	202,517		202,517	(964)	201,553		6
7	Other (specify):*			71,481	71,481		71,481		71,481		7
8	<b>TOTAL General Services</b>	754,902	603,908	368,179	1,726,989		1,726,989	(5,657)	1,721,332		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			46,400	46,400		46,400		46,400		9
10	Nursing and Medical Records	3,092,500	145,040	145,592	3,383,132		3,383,132	(43,962)	3,339,170		10
10a	Therapy	242,487			242,487		242,487		242,487		10a
11	Activities	161,950	17,486	18,244	197,680		197,680	(654)	197,026		11
12	Social Services			2,936	2,936		2,936		2,936		12
13	CNA Training										13
14	Program Transportation			874	874		874		874		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,496,937	162,526	214,046	3,873,509		3,873,509	(44,616)	3,828,893		16
	<b>C. General Administration</b>										
17	Administrative	208,252		419,024	627,276		627,276	(410,468)	216,808		17
18	Directors Fees										18
19	Professional Services			528,386	528,386		528,386	(291,579)	236,807		19
20	Dues, Fees, Subscriptions & Promotions			103,074	103,074		103,074	(81,386)	21,688		20
21	Clerical & General Office Expenses	352,234	48,486	64,109	464,829		464,829	249,728	714,557		21
22	Employee Benefits & Payroll Taxes			869,842	869,842		869,842		869,842		22
23	Inservice Training & Education			6,399	6,399		6,399		6,399		23
24	Travel and Seminar			401	401		401	12,854	13,255		24
25	Other Admin. Staff Transportation			18,651	18,651		18,651		18,651		25
26	Insurance-Prop.Liab.Malpractice			171,081	171,081		171,081	4,941	176,022		26
27	Other (specify):*			209,749	209,749		209,749	(209,749)			27
28	<b>TOTAL General Administration</b>	560,486	48,486	2,390,716	2,999,688		2,999,688	(725,659)	2,274,029		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,812,325	814,920	2,972,941	8,600,186		8,600,186	(775,932)	7,824,254		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	17,534
	REPAIRS & MAINTENANCE	15,591
		0
		33,125
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	652
		0
		652
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	74,959
	ELECTRICITY	105,401
	WATER	26,919
	CABLE TV - LOBBY	0
		0
		207,279
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	10,343
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,883
	ELEVATOR MAINTENANCE & REPAIR	12,148
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	11,383
	FIRE SERVICE	9,885
		0
		0
		0
		0
		55,642
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	70,791
	SECURITY SERVICE	690
		0
		0
		71,481
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	46,400
		46,400

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,215
	PHARMACY CONSULTANT XVIII B 39-2	10,708
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	103,099
	ALZHEIMERS CONSULTANT XVIII B 47-2	6,570
	WOUND CARE CONSULTANT XVIII B 46-2	24,000
		145,592
<b>10a</b>	<b>THERAPY</b>	
	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	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	15,088
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,156
		0
		18,244
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,936
		0
		2,936
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	874
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	419,024
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	29,582
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	498,804
		0
		528,386
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	56,358
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	16,183
	EMPLOYEE WANT ADS XIX F	356
	CONTRIBUTIONS VI 20 XIX F	1,426
	DUES & SUBSCRIPTIONS XIX F	15,200
	LICENSES & PERMITS XIX F	1,262
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	254
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	8,021
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,300
	PATIENT BACKGROUND CHECKS XIX F	2,714
		103,074
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,845
	EQUIPMENT REPAIR & MAINTENANCE	295
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	6,984
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	1,717
	TELEPHONE	44,482
	MESSENGER SERVICE	4,786
		0
		64,109

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	357,545
	UNEMPLOYMENT COMPENSATION XIX D	45,170
	WORKERS COMPENSATION INSURANC XIX D	94,488
	HOSPITALIZATION INSURANCE XIX D	338,055
	EMPLOYEE BENEFITS - OTHER XIX D	15,129
	EMPLOYEE PHYSICAL EXAMS XIX D	1,783
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	17,672
	CHICAGO HEAD TAX XIX D	0
		0
		869,842
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	6,399
		6,399
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	401
		401
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	18,651
		18,651
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	171,081
		171,081
27	<b>OTHER</b>	
	BAD DEBTS VI 24	209,749
		209,749

GRAND TOTAL COLUMN 3 OTHER

2,972,941

**ASPEN RIDGE CARE CENTRE  
SCHEDULES  
12/31/2010**

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

TOTAL FOOD PURCHASE	413,194
LESS SALES TAX	<u>(3,328)</u>
NET FOOD	409,866

TOTAL PATIENT CENSUS	64,553
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	193,659

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

PATIENT MEALS	193,659
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	193,659

NET FOOD	409,866
DIVIDE TOTAL MEALS/YEAR	<u>193,659</u>

COST PER MEAL	2.12
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			130,050	130,050		130,050	135,048	265,098			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,500	155,500		155,500	441,179	596,679			32
33	Real Estate Taxes			78,736	78,736		78,736		78,736			33
34	Rent-Facility & Grounds			744,600	744,600		744,600	(685,077)	59,523			34
35	Rent-Equipment & Vehicles			66,209	66,209		66,209	11,556	77,765			35
36	Other (specify):* STORAGE & MTG. INS			10,756	10,756		10,756	34,569	45,325			36
37	<b>TOTAL Ownership</b>			1,185,851	1,185,851		1,185,851	(62,725)	1,123,126			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		249,756	785,248	1,035,004		1,035,004		1,035,004			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			106,763	106,763		106,763		106,763			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		249,756	892,011	1,141,767		1,141,767		1,141,767			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,812,325	1,064,676	5,050,803	10,927,804		10,927,804	(838,657)	10,089,147			45

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

Facility Name &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## 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	(64,824)	30		9
10	Interest and Other Investment Income	(24,021)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,328)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(6,984)	21		18
19	Entertainment	(56,358)	20		19
20	Contributions	(9,447)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,150)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(209,749)	27		24
25	Fund Raising, Advertising and Promotional	(16,183)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(254)	20		28
29	Other-Attach Schedule	(3,757)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (396,055)		\$	30

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)	(442,602)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (442,602)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (838,657)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

## BHF USE ONLY

48		49		50		51		52	
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ASPEN RIDGE CARE CENTRE

ID# 0042481

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	VACATION ACCRUAL	1,418	1	2
3	VACATION ACCRUAL	565	3	3
4	VACATION ACCRUAL	(3,348)	4	4
5	VACATION ACCRUAL	(964)	6	5
6	VACATION ACCRUAL	12,903	10	6
7	VACATION ACCRUAL	(654)	11	7
8	VACATION ACCRUAL	8,556	17	8
9	VACATION ACCRUAL	(1,515)	21	9
10	MEDICARE A CONSULTANT	(19,200)	19	10
11	MEDICARE A BILLING		19	11
12	MARKETING CONSULTANT	(1,518)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(3,757)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## 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	1,418	0	0	0	0	0	0	0	0	0	0	1,418	1
2	Food Purchase	(3,328)	0	0	0	0	0	0	0	0	0	0	(3,328)	2
3	Housekeeping	565	0	0	0	0	0	0	0	0	0	0	565	3
4	Laundry	(3,348)	0	0	0	0	0	0	0	0	0	0	(3,348)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(964)	0	0	0	0	0	0	0	0	0	0	(964)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,657)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,657)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	12,903	0	0	(56,865)	0	0	0	0	0	0	0	(43,962)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(654)	0	0	0	0	0	0	0	0	0	0	(654)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>12,249</b>	<b>0</b>	<b>0</b>	<b>(56,865)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(44,616)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	8,556	0	(209,512)	0	0	(209,512)	0	0	0	0	0	(410,468)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,868)	31,430	44,407	3,146	(348,694)	0	0	0	0	0	0	(291,579)	19
20	Fees, Subscriptions & Promotions	(82,242)	250	157	98	351	0	0	0	0	0	0	(81,386)	20
21	Clerical & General Office Expenses	(8,499)	0	15,918	7,080	235,229	0	0	0	0	0	0	249,728	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	5,443	7,411	0	0	0	0	0	0	12,854	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	1,143	2,283	1,515	0	0	0	0	0	0	4,941	26
27	Other (specify):*	(209,749)	0	0	0	0	0	0	0	0	0	0	(209,749)	27
28	<b>TOTAL General Administration</b>	<b>(313,802)</b>	<b>31,680</b>	<b>(147,887)</b>	<b>18,050</b>	<b>(104,188)</b>	<b>(209,512)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(725,659)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(307,210)</b>	<b>31,680</b>	<b>(147,887)</b>	<b>(38,815)</b>	<b>(104,188)</b>	<b>(209,512)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(775,932)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASPEN RIDGE CARE CENTRE# 0042481

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(64,824)	194,722	228	1,058	3,864	0	0	0	0	0	0	135,048	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,021)	465,200	0	0	0	0	0	0	0	0	0	441,179	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	1,926	57,597	0	0	0	0	0	0	(685,077)	34
35	Rent-Equipment & Vehicles	0	0	4,521	5,341	1,694	0	0	0	0	0	0	11,556	35
36	Other (specify):*	0	34,569	0	0	0	0	0	0	0	0	0	34,569	36
37	<b>TOTAL Ownership</b>	<b>(88,845)</b>	<b>(50,109)</b>	<b>4,749</b>	<b>8,325</b>	<b>63,155</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(62,725)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(396,055)	(18,429)	(143,138)	(30,490)	(41,033)	(209,512)	0	0	0	0	0	(838,657)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		ASPEN RIDGE MONROE STREET, LLC		
					MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED NURSING ENTITIES		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 744,600	ASPEN RIDGE MONROE STREET, LLC		\$	(744,600)	1
2	V	36 MORTGAGE INSURANCE		"		34,569	34,569	2
3	V	30 DEPRECIATION - BLDG/IMP		"		194,722	194,722	3
4	V	32 AMORTIZATION - MTG COST		"		4,624	4,624	4
5	V	32 INTEREST - MORTGAGE		"		460,576	460,576	5
6	V	19 ACCOUNTING FEES		"		21,380	21,380	6
7	V	19 DATA PROCESSING		"		50	50	7
8	V	19 OTHER PROFESSIONAL		"		10,000	10,000	8
9	V	20 DUES & SUBSCRIPTIONS		"		250	250	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 744,600			\$ 726,171	\$ * (18,429)	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		\$ 117,737	\$ 44,407
16	V	20 DUES & SUBSCRIPTIONS		"		157	157
17	V	21 CLERICAL		"		15,918	15,918
18	V	24 TRAVEL		"			
19	V	26 INSURANCE		"		1,143	1,143
20	V	35 RENT - EQPT & VEHICLE		"		4,521	4,521
21	V	17 ADMINISTRATIVE	209,512	"			(209,512)
22	V	30 DEPRECIATION		"		228	228
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		\$ 282,842			\$ 139,704	\$ * (143,138)

\* 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	\$ 103,099	CARLYLE NURSING ASSOCIATES, LLC		\$ 46,234	\$ (56,865)
16	V	19 PROFESSIONAL FEES		' "		3,146	3,146
17	V	20 DUES & SUBSCRIPTIONS		' "		98	98
18	V	21 CLERICAL		' "		7,080	7,080
19	V	24 TRAVEL		' "		5,443	5,443
20	V	26 INSURANCE		' "		2,283	2,283
21	V	30 DEPRECIATION		' "		1,058	1,058
22	V	34 RENT		' "		1,926	1,926
23	V	35 RENT - EQPT & VEHICLE		' "		5,341	5,341
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		\$ 103,099			\$ 72,609	\$ * (30,490)

\* 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		\$ 2,181	\$ (348,694)
16	V	20 DUES & SUBSCRIPTIONS		"		351	351
17	V	21 CLERICAL		"		235,229	235,229
18	V	24 TRAVEL		"		7,411	7,411
19	V	26 INSURANCE		"		1,515	1,515
20	V	30 DEPRECIATION		"		3,864	3,864
21	V	34 RENT		"		57,597	57,597
22	V	35 RENT - EQPT & VEHICLE		"		1,694	1,694
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			\$ 309,842	\$ * (41,033)

\* 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	\$ 209,512	CHESTERFIELD, LLC		\$	\$ (209,512)
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		\$ 209,512			\$ 0	\$ * (209,512)

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

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

## 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:

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	191,162	4	\$ 348,655	\$ 64,553	\$ 117,737	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	191,162	4	466	64,553	157	2
3	21	CLERICAL	PATIENT DAYS	191,162	4	3,883	64,553	1,311	3
4	24	TRAVEL	PATIENT DAYS	191,162	4		64,553	0	4
5	26	INSURANCE	PATIENT DAYS	191,162	4	3,386	64,553	1,143	5
6	35	RENT - EQPT & VEHICLE	PATIENT DAYS	191,162	4	13,387	64,553	4,521	6
7	30	DEPRECIATION	PATIENT DAYS	191,162	4	674	64,553	228	7
8	21	CLERICAL	DIRECT HOURS	1	1	14,607	14,607	1	14,607
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					\$ 385,058	\$ 14,607	\$ 139,704	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 46,234	\$ 46,234	1	\$ 46,234	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	552,974	26,955		64,553	3,146	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,974	842		64,553	98	3
4	21	CLERICAL	PATIENT DAYS	552,974	60,665		64,553	7,080	4
5	24	TRAVEL	PATIENT DAYS	552,974	46,637		64,553	5,443	5
6	26	INSURANCE	PATIENT DAYS	552,974	19,567		64,553	2,283	6
7	30	DEPRECIATION	PATIENT DAYS	552,974	9,065		64,553	1,058	7
8	34	RENT	PATIENT DAYS	552,974	16,500		64,553	1,926	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	552,974	45,767		64,553	5,341	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				\$ 272,232	\$ 46,234		\$ 72,609	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

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 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

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	552,954	11	\$ 18,688	\$ 64,533	\$ 2,181	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,954	11	3,004	64,533	351	2
3	21	CLERICAL	PATIENT DAYS	552,954	11	200,775	64,533	23,432	3
4	24	TRAVEL	PATIENT DAYS	552,954	11	63,497	64,533	7,411	4
5	26	INSURANCE	PATIENT DAYS	552,954	11	12,980	64,533	1,515	5
6	30	DEPRECIATION	PATIENT DAYS	552,954	11	33,106	64,533	3,864	6
7	34	RENT	PATIENT DAYS	552,954	11	493,503	64,533	57,597	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	552,954	11	14,513	64,533	1,694	8
9	21	CLERICAL	DIRECT HOURS	1	1	211,797	211,797	1	211,797
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					\$ 1,051,863	\$ 211,797	\$ 309,842	25

Facility Name & ID Number

ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1										1									
2										2									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6										6									
7										7									
8										8									
9										9									
<b>B. Non-Facility Related*</b>																			
10										10									
11										11									
12										12									
13										13									
14										14									
15										15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2009 report.		\$	<b>76,600</b>	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.)		\$	<b>77,236</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>636</b>	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>78,100</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>78,736</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	<b>70,736</b>	8	
	2006	<b>71,959</b>	9	
	2007	<b>74,660</b>	10	
	2008	<b>75,755</b>	11	
	2009	<b>77,236</b>	12	
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>				
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.</b>				
	<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.**



Facility Name & ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

**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).

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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>NURSING</u>	<u>90,679</u>	<u>1997</u>	<u>\$ 726,241</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>90,679</b>		<b>\$ 726,241</b>	<b>3</b>

**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	\$	\$ 2,060,476	4	
5		1997		14,949	544	27.5	544		7,318	5	
6										6	
7										7	
8										8	
<b>Improvement Type**</b>											
9	****RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC										9
10	FIRE DOORS/ALUMINUM SCREENS		1997	3,609	131	27.5	131		1,769	10	
11	LANDSCAPING		1997	16,142	587	27.5	587		7,924	11	
12	OUTDOOR SIGNS		1997	8,110	295	27.5	295		3,872	12	
13	KITCHEN REMODELING - FLOORING/CONCRETE FOOTINGS		1998	18,381	668	27.5	668		8,349	13	
14	FENCE		1998	2,350	139	15	157	18	2,239	14	
15	ASPHALT PAVEMENT		1998	7,491	442	15	499	57	6,383	15	
16	PAVEMENT		1999	4,975	181	27.5	181		2,074	16	
17	INSULATING UNIT		1999	6,991	254	27.5	254		2,911	17	
18	WALLCOVERINGS/TILES/BLOCK WALLS/CARPET		1999	126,568	4,602	27.5	4,602		52,732	18	
19	AWNINGS		1999	7,939	289	27.5	289		3,311	19	
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB		2000	64,360	2,340	27.5	2,340		24,473	20	
21	INSTALLATION OF ALL DRAPERIES FOR 4 FLOORS		2001	7,828	285	27.5	285		2,707	21	
22	PAINT & PREP. ROOMS ON FLOORS 4 & 5		2001	9,525	346	27.5	346		3,287	22	
23	REPAIR HOLES, STRIP, SEAL CRACKS IN PARKING LOT		2001	5,950	216	27.5	216		2,052	23	
24	INSTALL 41 INSULATING WINDOWS - RESIDENT ROOMS		2001	2,974	108	27.5	108		1,026	24	
25	VCT FLOORING - DINING RM & ADMIN. CORRIDOR		2001	7,165	261	27.5	261		2,480	25	
26	REPLACE ELEVATOR DOORS		2001	3,742	136	27.5	136		1,292	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		10	1,298	1,298	14,097	28	
29	FIRE ALARM - ADD/RELOCATE SMOKE SENSORS		2002	6,027	219	27.5	219		1,889	29	
30	INSTALL RUBBER ROOF WITH HALF INCH INSULATION		2003	12,090	440	27.5	440		3,300	30	
31	INSTALL VINYL TILES IN SHOWER ROOMS ON THE 5TH FLOOR		2003	4,041	147	27.5	147		1,102	31	
32	2 PLASTIC LAMINATED & INSULATED METAL STAIRWAY DOOR		2003	3,396	123	27.5	123		927	32	
33	PAINT & PREP. NURSES STATIONS, 4TH FLOOR BATHROOMS, 3RD FLR									33	
34	DOORJAMS, FRAMES & STAIRWELLS, 2ND FLOOR BATHROOMS		2003	9,643	351	27.5	351		2,634	34	
35	NURSE CALL SYSTEM WITH 24 LITE PANEL, PULL CORD & BED		2003	31,136	1,132	27.5	1,132		8,490	35	
36	PAINT & PREP, & HAND WALLPAPERS		2004	35,000	3,124	10	3,500	376	28,000	36	

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

**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	10	\$ 1,667	\$ 179	\$ 13,335	37
38	SIGNS FOR BUILDING	2004	1,290	115	10	129	14	1,031	38
39	BORDERS FOR ALL RESIDENT RMS & DINING ROOM	2004	3,335	298	10	334	36	2,668	39
40	REMOVE AND INSTALL NEW FLOOR	2004	8,028	716	10	803	87	6,423	40
41	4TH FLOOR NURSES STATION/QUARRY TILE COVE BASE	2005	6,357	231	27.5	231		1,386	41
42	REPLACEMENT OF DOMESTIC HOT WATER HEATER	2005	32,871	1,195	27.5	1,195		6,772	42
43	INSTALLATION OF SPRINKLER SYSTEM	2005	1,325	48	27.5	48		272	43
44	CONCRETE WORK ON SIDE WALK	2005	2,550	170	15	170		935	44
45	COVE BASE/COVE BASE ADHESIVE - KITCHEN	2005	1,157	42	27.5	42		214	45
46	REPAIR ASPHALT PAVEMENT	2006	6,489	449	15	433	(16)	2,165	46
47	BUILD & INSTALL BASE CABINETS - NURSES STATION	2006	1,129	41	27.5	41		203	47
48	ADDITION OF NEW EMERGENCY CIRCUITS	2006	1,543	56	27.5	56		259	48
49	INSTALL NEW FIRE DAMPERS	2006	4,850	177	27.5	177		727	49
50	INSTALL NEW SHAFT SYSTEM	2006	38,901	1,415	27.5	1,415		5,841	50
51	CUSTOM H.M DOOR AND DOOR SHOE	2007	1,936	71	27.5	71		270	51
52	SHAW TIDEWATER YORKTOWN CARPET	2007	1,093	126	10	109	(17)	437	52
53	99 TON CHILLER SYSTEM	2007	84,851	3,086	27.5	3,086		11,313	53
54	NEW WINDOW SCREENS	2007	1,128	130	10	113	(17)	452	54
55	REPLACE ENTRY DOOR	2008	2,317	84	27.5	84		231	55
56	INSTALL HANDRAIL, PAINT AND WALLPAPER RES. RMS	2008	2,872	287	10	287		789	56
57	FLOORING FOR THERAPY ROOM	2008	3,956	144	27.5	144		396	57
58	AWNING	2008	1,479	54	27.5	54		135	58
59	COVE BASE/COVE BASE ADHESIVE - THERAPY RM	2008	960	35	27.5	35		82	59
60	PATCHING, PAINTING & WALLPAPERING RESIDENT RMS	2008	48,904	4,890	10	4,890		10,188	60
61	PATCHING/PAINTING - UTILITY RMS, MED RMS & BATHR	2009	2,180	218	10	218		400	61
62	INSTALL 4 NEW SPRINKLER HEADS	2009	1,900	69	27.5	69		115	62
63	PAINT RESIDENT RMS & ELEVATOR CEILINGS	2009	3,545	355	10	355		532	63
64	ELEVATOR - NEW CYLINDER WITH SEALED PVC PIPES	2009	44,998	1,636	27.5	1,636		2,045	64
65	REMODEL FIFTH FLOOR - INSTALL NEW WINDOWS & FIX								65
66	THE WALL AROUND THEM, INSTALL 2 WORKSTATIONS WITH								66
67	CHART RACKS, REPAIR & PAINT WALLS, INSTALL COVE								67
68	BASE, REMOVE & INSTALL NEW FLOORING.	2009	49,500	1,800	27.5	1,800		2,100	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,870,930	\$ 184,402		\$ 186,417	\$ 2,015	\$ 2,328,830	70

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

Facility Name &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,870,930	\$ 184,402		\$ 186,417	\$ 2,015	\$ 2,328,830	1
2	CARPET & TILES FOR FIFTH FLOOR	2009	9,280	928	10	928		1,005	2
3	DOOR FOR LOBBY	2009	1,343	49	27.5	49		57	3
4	REMOVATE ALL MEN'S & WOMEN'S WASHROOMS - REPAIR								4
5	& INSTALL NEW DRYWALL WERE NEEDED, REMOVE OLD								5
6	WALL COVERINGS & PAINT WALLS	2009	10,620	1,062	10	1,062		1,062	6
7	CLEAN/REDRILL EXISTING HOLE & INSTALL NEW								7
8	ELEVATOR	2010	92,221	3,353	27.5	3,214	(139)	3,214	8
9	PATCH, SAND & PAINT KITCHEN CEILING, PAINT 14								9
10	RESIDENT RMS & BATHROOMS, DOOR FRAMES & RAILS	2010	9,290	155	27.5	70	(85)	70	10
11	REMOVE OLD & INSTALL NEW DIPLOMAT COVE BASE	2010	13,237	160	27.5	140	(20)	140	11
12	REMOVE & INSTALL NEW TILES IN 2 SHOWER ROOMS								12
13	ON 5TH FLR, NURSES STATION/PAINT CORRIDORS &								13
14	CENTRAL DINING ROOM/3RD FLR SHOWER RMS	2010	80,321	487	27.5	608	121	608	14
15	HANDRAILS FOR THE THIRD FLOOR	2010	5,972	36	27.5	27	(9)	27	15
16	TILES FOR THIRD FLOOR -SHOWER ROOM/DINING RM	2010	3,328	10	27.5	5	(5)	5	16
17	INTERIOR DESIGN TIME SPECIFICATION FOR 2,3 & 4TH F	2010	4,000	400	10	400		400	17
18	WALLPAPER, VALENCES & BORDER-3RD FLR RES RMS	2010	18,016	1,802	10	1,802		1,802	18
19									19
20									20
21			SL ADJ.	1,878			(1,878)		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	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,118,558	\$ 194,722		\$ 194,722	\$	\$ 2,337,220	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	\$ 592,100	\$ 50,755	\$ 59,894	\$ 9,139	10 YRS	\$ 279,117	71
72	Current Year Purchases	115,140	79,295	5,332	(73,963)	10 YRS	5,332	72
73	Fully Depreciated Assets	274,580					274,580	73
74	RELATED PARTY		5,150	5,150				74
75	TOTALS	\$ 981,820	\$ 135,200	\$ 70,376	\$ (64,824)		\$ 559,029	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)	\$ 6,826,619	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 329,922	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 265,098	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (64,824)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,896,249	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A RELATED PARTY

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

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 36,541 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2004 CHEVY TRAIL	\$	\$	17
18		BLAZER	740.74	29,668	18
19					19
20					20
21	TOTAL		\$ 740.74	\$ 29,668	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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 304,968	\$		\$ 304,968	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			60,417			60,417	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			414,731			414,731	4
5	Physician Care		visits							5
6	Dental Care		visits			5,132			5,132	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				160,884		160,884	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	X-RAY, LAB, RENTALS & Other (specify): <u>I.V. THERAPY</u>	39-2					88,872		88,872	13
14	TOTAL			\$		\$ 785,248	\$ 249,756		\$ 1,035,004	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: 01/01/2010Ending: 12/31/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 28,962	\$ 1,506,290	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>659,130</u> )	(22,969)	(22,969)	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	1,838	1,838	5
6	Prepaid Insurance	51,893	104,509	6
7	Other Prepaid Expenses	613,629	613,629	7
8	Accounts Receivable (owners or related parties)	1,203,788	343,139	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		79,461	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,877,141	\$ 2,625,897	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		716,400	13
14	Buildings, at Historical Cost		4,059,452	14
15	Leasehold Improvements, at Historical Cost		1,059,106	15
16	Equipment, at Historical Cost	981,820	981,820	16
17	Accumulated Depreciation (book methods)	(876,075)	(3,223,374)	17
18	Deferred Charges		122,540	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		315,938	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CONSTRUCTION IN PROG.</u>		13,448	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 105,745	\$ 4,045,330	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,982,886	\$ 6,671,227	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 675,904	\$ 703,836	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,019	53,019	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,287	186,287	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,959	21,959	31
32	Accrued Real Estate Taxes(Sch.IX-B)		78,100	32
33	Accrued Interest Payable	2,034,866	41,567	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>DUE TO DPA</u>			36
37	<u>MANAGEMENT FEES</u>			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,972,035	\$ 1,084,768	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	13,587,292	5,444,295	39
40	Mortgage Payable		6,872,555	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 13,587,292	\$ 12,316,850	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 16,559,327	\$ 13,401,618	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (14,576,441)	\$ (6,730,391)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,982,886	\$ 6,671,227	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(13,934,867)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING ADJ.</b>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(13,934,867)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(641,574)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(641,574)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(14,576,441)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,259,423	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,259,423	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	24,021	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 24,021	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS</b>	2,786	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,786	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,286,230	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,726,989	31
32	Health Care	3,873,509	32
33	General Administration	2,999,688	33
<b>B. Capital Expense</b>			
34	Ownership	1,185,851	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,035,004	35
36	Provider Participation Fee	106,763	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,927,804	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(641,574)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (641,574)	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: **01/01/2010**

Ending:

**12/31/2010**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,081	2,314	\$ 88,063	\$ 38.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,358	7,971	254,731	31.96	3
4	Licensed Practical Nurses	44,470	49,105	1,395,936	28.43	4
5	CNAs & Orderlies	94,567	102,944	1,304,827	12.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,485	12,534	242,487	19.35	8
9	Activity Director	1,943	2,124	30,899	14.55	9
10	Activity Assistants	10,574	11,696	131,051	11.20	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,339	2,702	46,136	17.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,604	27,719	264,363	9.54	15
16	Dishwashers					16
17	Maintenance Workers	2,221	2,574	64,989	25.25	17
18	Housekeepers	19,485	21,538	261,868	12.16	18
19	Laundry	8,888	11,443	117,546	10.27	19
20	Administrator	2,037	2,417	208,252	86.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,870	4,343	107,893	24.84	23
24	Clerical	11,907	13,267	244,341	18.42	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	3,751	4,157	48,943	11.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	252,580	278,848	\$ 4,812,325 *	\$ 17.26	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	292	\$ 17,534	1-3	35
36	Medical Director	218	46,400	9-3	36
37	Medical Records Consultant	12	1,215	10-3	37
38	Nurse Consultant	MONTHLY	103,099	10-3	38
39	Pharmacist Consultant	MONTHLY	10,708	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	52	3,156	11-3	44
45	Social Service Consultant	48	2,936	12-3	45
46	Other(specify) <u>WOUND CARE</u>	96	24,000	10-3	46
47	<u>ALZHEIMERS</u>	110	6,570	10-3	47
48					48
49	TOTAL (lines 35 - 48)	828	\$ 215,618		49

**C. CONTRACT NURSES**

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





Facility Name &amp; ID Number ASPEN RIDGE CARE CENTRE

# 0042481

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

**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 - \$16463.38
- (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. \$ 9,132 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.