

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0020438

Facility Name: Aspire on Eastern

Address: 105 Eastern Ave. Bellwood 60104
Number City Zip Code

County: Cook County

Telephone Number: 708-547-3550 x3578 Fax # 708-547-4067

HFS ID Number:

Date of Initial License for Current Owners: 3/1/75

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501C3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Ken Gaul Telephone Number: 708-547-3550 x 3578
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2010 to 6/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	10/31/11
	(Type or Print Name)	Ken Gaul (Date)
Paid Preparer	(Title)	Chief Financial Officer
	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	
	(Telephone) () Fax # ()	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Aspire on Eastern

0020438 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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 82

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	<u>82</u> Intermediate (ICF)	<u>82</u>	<u>29,930</u>	3
4	Intermediate/DD			4
5	Sheltered Care (SC)			5
6	ICF/DD 16 or Less			6
7	<u>82</u> TOTALS	<u>82</u>	<u>29,930</u>	7

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
8 SNF					8
9 SNF/PED					9
10 ICF	<u>28,387</u>	<u>365</u>	<u>592</u>	<u>29,344</u>	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	<u>28,387</u>	<u>365</u>	<u>592</u>	<u>29,344</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.04%

D. How many bed-hold days during this year were paid by the Department? 288 (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 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

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	234,369		7,034	241,403	6	241,409		241,409			1
2	Food Purchase		202,341		202,341	2,570	204,911		204,911			2
3	Housekeeping	197,071	56,268		253,339	9,660	262,999		262,999			3
4	Laundry	69,370	10,680		80,050		80,050		80,050			4
5	Heat and Other Utilities			111,191	111,191	9,454	120,645		120,645			5
6	Maintenance	49,497	77,070	27,723	154,290	8,874	163,164		163,164			6
7	Other (specify):*											7
8	TOTAL General Services	550,307	346,359	145,948	1,042,614	30,564	1,073,178		1,073,178			8
	B. Health Care and Programs											
9	Medical Director			8,700	8,700		8,700		8,700			9
10	Nursing and Medical Records	439,641	133,945	19,692	593,278		593,278		593,278			10
10a	Therapy											10a
11	Activities	1,621,900	27,480		1,649,380		1,649,380		1,649,380			11
12	Social Services	324,413		57,674	382,087		382,087		382,087			12
13	CNA Training	35,797	751		36,548		36,548		36,548			13
14	Program Transportation		16,339		16,339		16,339		16,339			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,421,751	178,515	86,066	2,686,332		2,686,332		2,686,332			16
	C. General Administration											
17	Administrative	144,958		161,436	306,394	(161,436)	144,958		144,958			17
18	Directors Fees											18
19	Professional Services			26,943	26,943	53,115	80,058		80,058			19
20	Dues, Fees, Subscriptions & Promotions			255	255	3,458	3,713		3,713			20
21	Clerical & General Office Expenses	325,244	7,490	10,603	343,337	29,755	373,092		373,092			21
22	Employee Benefits & Payroll Taxes			611,991	611,991		611,991		611,991			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,569	3,569	667	4,236	(2,652)	1,584			24
25	Other Admin. Staff Transportation					3,012	3,012		3,012			25
26	Insurance-Prop.Liab.Malpractice			28,294	28,294	687	28,981		28,981			26
27	Other (specify):*											27
28	TOTAL General Administration	470,202	7,490	843,091	1,320,783	(70,742)	1,250,041	(2,652)	1,247,389			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,442,260	532,364	1,075,105	5,049,729	(40,178)	5,009,551	(2,652)	5,006,899			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 (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			117,564	117,564	10,111	127,675		127,675			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,442	32,442	30,067	62,509		62,509			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			68	68		68		68			35
36	Other (specify):*											36
37	TOTAL Ownership			150,074	150,074	40,178	190,252		190,252			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)	3,442,260	532,364	1,492,155	5,466,779		5,466,779	(2,652)	5,464,127			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,652)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,652)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,652)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Aspire on Eastern

ID#0020438

Report Period Beginning:7/1/2010

Ending:6/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26	Non-Direct Care Staff Travel & Local Transp.	2,652	2426
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	2,652	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aspire on Eastern# 0020438

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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:	
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			\$			\$	\$	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.

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Kitchen Supplies	Direct Cost	16,158,183	25	\$ 18	\$	5,466,779	\$ 6	1
2	2	Food/Beverage	Direct Cost	16,158,183	25	7,597		5,466,779	2,570	2
3	3	Housekeeping Supplies	Direct Cost	16,158,183	25	3,787		5,466,779	1,281	3
4	3	Hskp. Other	Direct Cost	16,158,183	25	24,767		5,466,779	8,379	4
5	5	Utilities	Direct Cost	16,158,183	25	27,943		5,466,779	9,454	5
6	6	Maint. Supplies	Direct Cost	16,158,183	25	3,229		5,466,779	1,092	6
7	6	Maint. Other	Direct Cost	16,158,183	25	23,000		5,466,779	7,782	7
8	19	Prof. Services	Direct Cost	16,158,183	25	156,992		5,466,779	53,115	8
9	20	Dues, Fees, Other	Direct Cost	16,158,183	25	10,222		5,466,779	3,458	9
10	21	Clerical Supplies	Direct Cost	16,158,183	25	71,045		5,466,779	24,037	10
11	21	Telephone	Direct Cost	16,158,183	25	16,900		5,466,779	5,718	11
12	24	Travel Seminar	Direct Cost	16,158,183	25	1,970		5,466,779	667	12
13	25	Staff Travel	Direct Cost	16,158,183	25	8,903		5,466,779	3,012	13
14	26	Insurance	Direct Cost	16,158,183	25	2,032		5,466,779	687	14
15	30	Depreciation	Direct Cost	16,158,183	25	29,886		5,466,779	10,111	15
16	32	Interest	Direct Cost	16,158,183	25	88,870		5,466,779	30,067	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 477,161	\$		\$ 161,436	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE											
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)											
	1	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	Popular Community Bank		X		\$22,610.67	8/23/03	\$ 3,000,000		5.0000	\$ 32,442	1
2											2
3											3
4											4
5											5
	Working Capital										
6	Popular Community Bank									5,478	6
7											7
8											8
9	TOTAL Facility Related				\$22,610.67		\$ 3,000,000			\$ 37,920	9
	B. Non-Facility Related*										
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related						\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,000,000			\$ 37,920	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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

[illegible]

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aspire on Eastern COUNTY Cook County

FACILITY IDPH LICENSE NUMBER 0020438

CONTACT PERSON REGARDING THIS REPORT Ken Gaul

TELEPHONE 708-547-3550 x3578 FAX #: 708-547-4067

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>Not Applicable</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u></u></u>	\$ <u><u></u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,330

B. General Construction Type: Exterior BrickFrame 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:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			1975	1975	\$ 835,850	\$ 20,896	40	\$ 20,896	\$	\$ 772,939	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODELING			1976		4,485	112	40	112	3,866	9
10	FRONT ENCLOSURE			1984		13,115	437	30	437	11,590	10
11	FENCE		1985		4,658		10			4,658	11
12	LAUNDRY ROOM ADDITION			1986		7,775	259	30	259	6,353	12
13	ELECTRICAL WORK			1987		28,350		20		28,350	13
14	INSULATION			1987		6,639		20		6,639	14
15	ELECTRICAL			1988		5,000		20		5,000	15
16	WATER SOFTNER			1989		2,000		12		2,000	16
17	PAVING		1989		18,732		15			18,732	17
18	FRONT ENCLOSURE			1989		3,595		20		3,595	18
19	WALK-IN COOLER			1989		23,330	933	25	933	20,064	19
20	DRAPES		1989		3,667		10			3,667	20
21	SINK		1991		3,150	233	20	233		3,150	21
22	BUILDING ADDITION			1991		320,606	10,687	30	10,687	208,393	22
23	ROOF		1992		30,828	1,541	20	1,541		28,514	23
24	BUILDING ADDITION			1992		143,644	4,788	30	4,788	93,369	24
25	HVAC-7		1993		6,230		8			6,230	25
26	SEALCOATING			1993		2,650		8		2,650	26
27	HOT WATER HEATER			1993		3,075		15		3,075	27
28	BUILDING ADDITION			1993		13,070	436	30	436	8,060	28
29	2 VENTILATORS			1995		3,145		8		3,145	29
30	AIR COND		1995		3,250		8			3,250	30
31	HVAC		1995		6,906		8			6,906	31
32	WATER HEATER			1995		2,500		10		2,500	32
33	PAVING BUS AREA			1995		3,990		15		3,990	33
34	TILE BATHROOM			1995		4,278	214	20	214	3,316	34
35	HOT WATER HEATER			1996		2,500		8		2,500	35
36	ROOF COOLER			1996		1,300		8		1,300	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number **Aspire on Eastern**# **0020438**

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1			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	HVAC		1997		\$	2,246	\$		8		\$		\$		\$	2,246	37
38	SEALCOATING		1997			11,000			8							11,000	38
39	CANOPY		1997			12,300			10							12,300	39
40	SOFFIT & FACIA		1997			12,782			10							12,782	40
41	ARCHITECTUAL		1997			7,221		361	20		361					5,236	41
42	FENCE		1997			5,091		255	20		255					3,690	42
43	HVAC		1998			5,635			8							5,635	43
44	PLUMBING-WATER HEATER		1998			8,300			8							8,300	44
45	SEALCOATING		1998			11,000			8							11,000	45
46	ELECTRICAL		1998			6,368		318	20		318					4,298	46
47	NURSES STATION		1998			3,880		194	20		194					2,619	47
48	REMODEL CAFETERIA		1998			28,076		1,404	20		1,404					18,951	48
49	HVAC		1999			6,800			10							6,800	49
50	SECURITY SYSTEM		1999			1,200			10							1,200	50
51	ARCHITECT		1999			2,087		104	20		104					1,304	51
52	PATIO COVER		1999			11,205		560	20		560					7,003	52
53	HVAC		2000			2,450			8							2,450	53
54	ROOF		2000			1,250		83	15		83					959	54
55	ARCHITECT-LATER IN LIFE		2000			22,803		1,140	20		1,140					13,112	55
56	SCREEN IN CANOPY		2001			16,486		824	20		824					8,655	56
57	LATER IN LIFE-PROJECT		2001			32,900		1,097	30		1,097					11,515	57
58	PARKING LOT		2001			29,300		1,465	10		1,465					29,300	58
59	BATHROOM RENOVATION-EASTERN		2002			198,403		6,613	30		6,613					62,827	59
60	MEN SHOWER-RENOVATION		2002			51,289		1,710	30		1,710					16,229	60
61	SIDEWALK		2002			1,900		63	30		63					633	61
62	SLOPE-RENOVATION		2002			14,500		483	30		483					4,592	62
63	WOMEN SHOWER-RENOVATION		2002			60,000		2,000	30		2,000					19,000	63
64	#01-053 KITCHEN RENOVATION		2002			11,411		380	30		380					3,423	64
65	SECURITY SYSTEM		2003			7,776		778	10		778					6,610	65
66	RENOVATION		2003			52,500		2,625	20		2,625					22,313	66
67	KITCHEN RENOVATION		2003			182,098		6,070	30		6,070					51,594	67
68	HVAC		2004			1,895		190	10		190					1,421	68
69	ELECTRICAL		2004			13,759		688	20		688					5,160	69
70	TOTAL (lines 4 thru 69)				\$	2,344,229	\$	69,943			\$	69,943	\$		\$	1,641,958	70

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

XI. OWNERSHIP COSTS (continued)								
C. Equipment Costs-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	\$338,220	\$16,651	\$16,651	\$		\$141,411	71
72	Current Year Purchases	7,717	1,999	1,999			1,999	72
73	Fully Depreciated Assets	131,102	653	653			131,102	73
74								74
75	TOTALS	\$477,039	\$19,303	\$19,303	\$		\$274,512	75

D. Vehicle Costs. (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	2010 Ford Bus	2010 Ford Bus	2010	\$57,714	\$5,771	\$5,771	\$		\$5,771	76
77										77
78										78
79										79
80	TOTALS			\$57,714	\$5,771	\$5,771	\$		\$5,771	80

E. Summary of Care-Related Assets		1	2	
		Reference	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)	\$ 3,448,995	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 114,727	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 114,727	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)	\$ 2,014,056	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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:None or 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?
16. Rental Amount for movable equipment: \$68 Description:water cooler
- ☒ YES☐ NO
- (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 EndingAnnual Rent

12. /2012\$

13. /2013\$

14. /2014\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	☒ YES ☐ NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM	IN-HOUSE PROGRAM
		IN OTHER FACILITY	IN OTHER FACILITY
		COMMUNITY COLLEGE	HOURS PER CNA
		HOURS PER CNA	

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	275	476		751
3	Classroom Wages (a)	3,674	6,784		10,458
4	Clinical Wages (b)	7,348	13,568		20,916
5	In-House Trainer Wages (c)	1,375	3,048		4,423
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 12,672	\$ 23,876	\$	\$ 36,548
10	SUM OF line 9, col. 1 and 2 (e)	\$ 36,548			

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	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	11
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.)

	1	2	3	4	5	6	7	8		
	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		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.

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	\$	\$ 114,870	1
2	Cash-Patient Deposits		88,331	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,000)		2,215,776	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		786,847	5
6	Prepaid Insurance		42,202	6
7	Other Prepaid Expenses		29,976	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 3,278,002	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		14,144,367	14
15	Leasehold Improvements, at Historical Cost		62,751	15
16	Equipment, at Historical Cost		2,315,870	16
17	Accumulated Depreciation (book methods)		(8,426,314)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Closing Costs/Bldg Deposits		86,637	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 9,896,393	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 13,174,395	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 337,533	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		88,331	28
29	Short-Term Notes Payable		976,000	29
30	Accrued Salaries Payable		814,464	30
31	Accrued Taxes Payable (excluding real estate taxes)		32,035	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	Deferred Revenue		400	36
37	Accrued Expenses		90,225	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 2,338,988	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		265,772	39
40	Mortgage Payable		5,473,978	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,739,750	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 8,078,738	46
47	TOTAL EQUITY(page 18, line 24)	\$ (344,742)	\$ 5,095,657	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	\$ 13,174,395	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)	(344,742)	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)	\$ (344,742)	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)	\$ (344,742)	24 *

* This must agree with page 17, line 47.

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,784,240	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,784,240	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	227,514	10
11	CNA Training Reimbursements	36,666	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)	\$ 264,180	23
	D. Non-Operating Revenue		
24	Contributions	17,233	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,233	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Insurance proceeds from flood	74,921	28
28a	Loss on disposal of property	(18,537)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 56,384	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,122,037	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,042,614	31
32	Health Care	2,686,332	32
33	General Administration	1,320,783	33
	B. Capital Expense		
34	Ownership	150,074	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)*	\$ 5,466,779	40
41	Income before Income Taxes (line 30 minus line 40)**	(344,742)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (344,742)	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:

7/1/2010

Ending:

6/30/2011**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	1,861	2,033	\$ 63,544	\$ 31.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	16,982	19,260	376,097	19.53	4
5	CNAs & Orderlies					5
6	CNA Trainees	3,480	3,480	31,374	9.02	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	1,850	2,107	35,459	16.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,267	19,293	198,910	10.31	15
16	Dishwashers					16
17	Maintenance Workers	2,957	3,197	49,497	15.48	17
18	Housekeepers	15,280	17,169	197,071	11.48	18
19	Laundry	6,433	7,188	69,370	9.65	19
20	Administrator	1,889	2,080	70,035	33.67	20
21	Assistant Administrator	2,677	2,878	74,923	26.03	21
22	Other Administrative	3,985	4,285	188,144	43.91	22
23	Office Manager					23
24	Clerical	10,950	12,521	137,100	10.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	15,335	16,853	324,413	19.25	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	129,784	146,078	1,626,323	11.13	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	230,730	258,422	\$ 3,442,260 *	\$ 13.32	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	153	\$ 7,034	1	35
36	Medical Director	58	8,700	9	36
37	Medical Records Consultant				37
38	Nurse Consultant	16	480	10	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	254	12,679	12	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	128	8,300	12	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	191	21,056	12	46
47	<u>Neurologist</u>	12	1,800	12	47
48					48
49	TOTAL (lines 35 - 48)	812	\$ 60,049		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	171	\$ 8,572	10	50
51	Licensed Practical Nurses	76	3,212	10	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	247	\$ 11,784		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	Ownership %	Amount		
Vicki Striegel	Facility Director		\$ 70,035		
Peggy Kiefer	Shift Admin		43,038		
Barbara Embry	Shift Admin		15,128		
Patty Scoville	Shift Admin		16,757		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 144,958		
B. Administrative - Other					
Description			Amount		
See Schedule VIII			\$ 161,436		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 161,436		
C. Professional Services					
Vendor/Payee	Type		Amount		
Clifton Gunderson	Audit		\$ 11,848		
Duance Morris	Legal		8,708		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 20,556		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 89,271		
Unemployment Compensation Insurance			22,144		
FICA Taxes			249,221		
Employee Health Insurance			231,347		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)* 403 B			20,008		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 611,991		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description		Line #	Amount		
			\$		
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$		
Advertising: Employee Recruitment					
Health Care Worker Background Check (Indicate # of checks performed)					
Patient Background Checks 76			2,801		
Less: Public Relations Expense			()		
Non-allowable advertising			()		
Yellow page advertising			()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 2,801		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense					
Entertainment Expense			()		
(agree to Sch. V, line 24, col. 8)					
TOTAL			\$		

*** Attach copy of IMRF notifications**

****See instructions.**

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. \$ 52,292 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 benefit 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? 87
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, no personal use
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

2011 State of Illinois
Department of Healthcare and Family Services
Financial and Statistical Report for
Long-Term Care Facilities

Aspire of Illinois Intermediate Care Facility
105 Eastern Avenue
Bellwood, IL 60104

IDPH Facility ID Number 0020438

BOARD OF DIRECTORS

<u>NAME</u>	<u>Title</u>	<u>Provide</u>		<u>Transactions</u>		<u>Ownership in</u>	
		<u>Servcies to ICF</u>		<u>with ICF</u>		<u>business</u>	
		<u>Facility?</u>	<u>Type?</u>	<u>Facility?</u>	<u>Type 2</u>	<u>with ICF?</u>	<u>Type?</u>
Marc Adelman	1st Vice Chair	No	N/A	No	N/A	No	N/A
John D. Berghorst	Director	No	N/A	No	N/A	No	N/A
Candi Carter	Director	No	N/A	No	N/A	No	N/A
Kevin Garvey	Director	No	N/A	No	N/A	Yes	Office supplies
Cynthia Hank Stark	Chair	No	N/A	No	N/A	No	N/A
John T. Iwanski	Director	No	N/A	No	N/A	No	N/A
David Justh	Director	No	N/A	No	N/A	No	N/A
Bernardo Lacayo	Treasurer	No	N/A	No	N/A	No	N/A
Raju N. Patel	Director	No	N/A	No	N/A	No	N/A
Denise Pelletier	Director	No	N/A	No	N/A	No	N/A
Donald Robideau	2nd Vice Chai	No	N/A	No	N/A	No	N/A
Reuben E. Slone	Secretary	No	N/A	No	N/A	No	N/A
Anna Weselak	Director	No	N/A	No	N/A	No	N/A