		FOR BHF USE					

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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. (Number) Bellwood (City) 60104 (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:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501C3

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) (Date) 10/31/11

(Type or Print Name) Ken Gaul

(Title) Chief Financial Officer

Paid Preparer

(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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

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

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

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 [X]

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

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
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.

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

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
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.**

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

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		52

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

		1 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (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	24	26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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 B

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

	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

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

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

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

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

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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

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 [X] NO [ ]

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

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

	1 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

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

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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.)**

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

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

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 provide copies of their original **second installment** tax bill.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (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? [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aspire on Eastern # 0020438 Report Period Beginning: 7/1/2010 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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.**

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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,344,229	$ 69,943		$ 69,943	$	$ 1,641,958	1
2	FIRE DOORS	2004	10,700	535	20	535		4,013	2
3	SEWER	2004	3,900	195	20	195		1,463	3
4	HALLWAY RENOVATION	2004	2,562	85	30	85		683	4
5	WINDOWS REPLACEMENT	2004	67,500	3,375	20	3,375		25,312	5
6	HVAC	2005	2,165	271	8	271		1,759	6
7	LANDSCAPING	2005	1,775	178	10	178		1,154	7
8	LANDSCAPING	2005	3,700	370	10	370		2,405	8
9	HALLWAY RENOVATION	2005	150,827	5,028	30	5,028		32,679	9
10	HVAC	2007	17,502	1,750	10	1,750		7,876	10
11	CANOPIES	2008	28,975	1,449	20	1,449		4,467	11
12	CANOPY	2009	1,200	120	10	120		280	12
13	HEAT EXCHANGER	2009	5,500	550	10	550		1,146	13
14	ROOF	2009	83,203	5,547	15	5,547		8,320	14
15	BLDG IMPROVEMENT	2011	15,504	258	15	258		258	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	**TOTAL (lines 1 thru 33)**		$ 2,739,242	$ 89,653		$ 89,653	$	$ 1,733,773	34

****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)

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 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,448,995	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		$	$	$	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.

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

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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 68 Description: water cooler
(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

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

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

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

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? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

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.

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

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 prescrpts							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.

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2011 (last day of reporting year)

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

		1 Operating	2 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 Operating	2 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.)**

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

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.**

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

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

	Revenue	1 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

	Expenses	2 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 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 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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) Psychiatrist	191	21,056	12	46
47	Neurologist	12	1,800	12	47
48					48
49	TOTAL (lines 35 - 48)	812	$ 60,049		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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

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)	$ 161,436
(Attach a copy of any management service agreement)	

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		$

* Attach copy of IMRF notifications

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	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

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

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 politica
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 fo
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 Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **No** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
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 othe
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
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

NAME	Title	Provide Servcies to ICF Facility?	Type?	Transactions with ICF Facility?	Type 2	Ownership in business transacting with ICF?	Type?
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