FOR BHF USE

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0047613

Facility Name: Assisi Health Care Centerat Clare Oaks

Address: 829 Carillon Drive (Number) Bartlett (City) 60103 (Zip Code)

County: Cook

Telephone Number: 630-372-1983 **Fax #** 630-289-8846

HFS ID Number:

Date of Initial License for Current Owners: 6/2/2008

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: Gigi Walker **Telephone Number:** 630-483-4730
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 7/1/2009 to 6/30/2010 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)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Chad D. Kunze, CPA, Principal
(Firm Name & Address) LarsonAllen LLP, 600 Washington Ave, Suite 1800
(Telephone) 314-925-4321 Fax # 314-925-4350

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 Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

III. STATISTICAL DATA

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

	1 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	5,802	5,391	18,336	29,529	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,802	5,391	18,336	29,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.42%

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

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

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 [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 6/2/2008

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 [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 15,924

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30 Fiscal Year: 6/30

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

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	1,112,472	32,049	155,244	1,299,765		1,299,765	(660,132)	639,633			1
2	Food Purchase		541,148		541,148		541,148	(269,789)	271,359			2
3	Housekeeping	418,081	40,946	97,579	556,606		556,606	(467,683)	88,923			3
4	Laundry											4
5	Heat and Other Utilities			680,606	680,606		680,606	(690,545)	(9,939)			5
6	Maintenance	341,697	24,846	318,232	684,775		684,775	(571,341)	113,434			6
7	Other (specify):* Trash Removal Expense			26,183	26,183		26,183	(19,722)	6,461			7
8	TOTAL General Services	1,872,250	638,989	1,277,844	3,789,083		3,789,083	(2,679,212)	1,109,871			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,965,572	217,408	973,848	5,156,828		5,156,828	(375,644)	4,781,184			10
10a	Therapy			1,432,282	1,432,282		1,432,282		1,432,282			10a
11	Activities	144,649	6,822	47,430	198,901		198,901		198,901			11
12	Social Services	278,840	4,817		283,657		283,657		283,657			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,389,061	229,047	2,453,560	7,071,668		7,071,668	(375,644)	6,696,024			16
	C. General Administration											
17	Administrative	165,083			165,083		165,083	(116,839)	48,244			17
18	Directors Fees											18
19	Professional Services			147,458	147,458		147,458		147,458			19
20	Dues, Fees, Subscriptions & Promotions			2,816	2,816		2,816		2,816			20
21	Clerical & General Office Expenses	309,006	22,883	1,187,062	1,518,951		1,518,951	(1,075,059)	443,892			21
22	Employee Benefits & Payroll Taxes			1,275,062	1,275,062		1,275,062	(446,527)	828,535			22
23	Inservice Training & Education											23
24	Travel and Seminar			54,964	54,964		54,964		54,964			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			249,923	249,923		249,923	(208,523)	41,400			26
27	Other (specify):* Marketing	174,312	3,607	313,787	491,706		491,706	(491,706)				27
28	TOTAL General Administration	648,401	26,490	3,231,072	3,905,963		3,905,963	(2,338,654)	1,567,309			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,909,712	894,526	6,962,476	14,766,714		14,766,714	(5,393,510)	9,373,204			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 Assisi Health Care Centerat Clare Oaks #0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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			3,855,444	3,855,444		3,855,444	(3,495,825)	359,619			30
31	Amortization of Pre-Op. & Org.			925,070	925,070		925,070	(771,831)	153,239			31
32	Interest			6,093,981	6,093,981		6,093,981	(5,084,502)	1,009,479			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			40,000	40,000		40,000	(33,374)	6,626			34
35	Rent-Equipment & Vehicles			49,518	49,518		49,518	(41,148)	8,370			35
36	Other (specify):*											36
37	**TOTAL Ownership**			10,964,013	10,964,013		10,964,013	(9,426,680)	1,537,333			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			792,942	792,942		792,942		792,942			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,528	66,528		66,528		66,528			42
43	Other (specify):* **AL & IL Centers**	57,387		4,840	62,227		62,227	(71,871)	(9,644)			43
44	**TOTAL Special Cost Centers**	57,387		864,310	921,697		921,697	(71,871)	849,826			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,967,099	894,526	18,790,799	26,652,424		26,652,424	(14,892,061)	11,760,363			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 Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

VI. ADJUSTMENT DETAIL

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

	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	(3,280)	3		4
5	Telephone, TV & Radio in Resident Rooms	(37,977)	5		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)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	200	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(209)	21		24
25	Fund Raising, Advertising and Promotional	(491,706)	27		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	(14,359,482)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,892,454)		$	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))**	$ (14,892,454)		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

Assisi Health Care Centerat Clare Oaks

ID# 0047613

Report Period Beginning: 7/1/2009

Ending: 6/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable (AL & IL) Dietary	$ (660,132)	1	1
2	Non-Allowable (AL & IL) Food	(269,861)	2	2
3	Non-Allowable (AL & IL) Housekeeping	(464,403)	3	3
4	Non-Allowable (AL & IL) Utilities	(652,568)	5	4
5	Non-Allowable (AL & IL) Maintenance	(571,341)	6	5
6	Non-Allowable (AL & IL) Nursing	(375,644)	10	6
7	Non-Allowable (AL & IL) Administrative	(116,839)	17	7
8	Non-Allowable (AL & IL) Clerical and Office	(1,075,050)	21	8
9	Non-Allowable (AL & IL) Benefits and Payroll Taxes	(446,527)	22	9
10	Non-Allowable (AL & IL) Property/Liability Insurance	(208,523)	26	10
11	Non-Allowable (AL & IL) Depreciation	(3,495,825)	30	11
12	Non-Allowable (AL & IL) Amortization	(771,831)	31	12
13	Non-Allowable (AL & IL) Interest	(5,084,502)	32	13
14	Non-Allowable (AL & IL) Expenses	(71,871)	43	14
15	Non-Allowable Travel and Seminar		24	15
16	Non-Allowable (AL & IL) Trash Removal Expense	(19,722)	7	16
17	Non-Allowable Food	72	2	17
18	Non-Allowable (AL & IL) Ground Lease Expense	(33,374)	34	18
19	Non-Allowable (AL & IL) Equpment Rental	(41,148)	35	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,359,089)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(660,132)	0	0	0	0	0	0	0	0	0	0	(660,132)	1
2	Food Purchase	(269,789)	0	0	0	0	0	0	0	0	0	0	(269,789)	2
3	Housekeeping	(467,683)	0	0	0	0	0	0	0	0	0	0	(467,683)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(690,545)	0	0	0	0	0	0	0	0	0	0	(690,545)	5
6	Maintenance	(571,341)	0	0	0	0	0	0	0	0	0	0	(571,341)	6
7	Other (specify):*	(19,722)	0	0	0	0	0	0	0	0	0	0	(19,722)	7
8	**TOTAL General Services**	(2,679,212)	0	0	0	0	0	0	0	0	0	0	(2,679,212)	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	(375,644)	0	0	0	0	0	0	0	0	0	0	(375,644)	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**	(375,644)	0	0	0	0	0	0	0	0	0	0	(375,644)	16
	C. General Administration													
17	Administrative	(116,839)	0	0	0	0	0	0	0	0	0	0	(116,839)	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	(1,075,059)	0	0	0	0	0	0	0	0	0	0	(1,075,059)	21
22	Employee Benefits & Payroll Taxes	(446,527)	0	0	0	0	0	0	0	0	0	0	(446,527)	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	(208,523)	0	0	0	0	0	0	0	0	0	0	(208,523)	26
27	Other (specify):*	(491,706)	0	0	0	0	0	0	0	0	0	0	(491,706)	27
28	**TOTAL General Administration**	(2,338,654)	0	0	0	0	0	0	0	0	0	0	(2,338,654)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,393,510)	0	0	0	0	0	0	0	0	0	0	(5,393,510)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(3,495,825)	0	0	0	0	0	0	0	0	0	0	(3,495,825)	30
31	Amortization of Pre-Op. & Org.	(771,831)	0	0	0	0	0	0	0	0	0	0	(771,831)	31
32	Interest	(5,084,502)	0	0	0	0	0	0	0	0	0	0	(5,084,502)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(33,374)	0	0	0	0	0	0	0	0	0	0	(33,374)	34
35	Rent-Equipment & Vehicles	(41,148)	0	0	0	0	0	0	0	0	0	0	(41,148)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,426,680)	0	0	0	0	0	0	0	0	0	0	(9,426,680)	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):*	(71,871)	0	0	0	0	0	0	0	0	0	0	(71,871)	43
44	**TOTAL Special Cost Centers**	(71,871)	0	0	0	0	0	0	0	0	0	0	(71,871)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,892,061)	0	0	0	0	0	0	0	0	0	0	(14,892,061)	45

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sisters of St. Joseph	Stevens Point, WI	Convent

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		32	Interest	$ 155,000	Sisters of St. Joseph	0.00%	$ 155,000	$	1
2	V		6	Ground Lease Expense	40,000	Sisters of St. Joseph	0.00%	40,000		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				$ 195,000			$ 195,000	$ *	14

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

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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	See attached listing of board of directors.								$		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 Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
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	TOTALS					$	$		$	25

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	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	Series 2006 Bonds		X	Construction & Equipment		7/19/2006	$ 109,125,000	$ 98,265,231	Varies	Varies	$ 5,143,152	1
2	LOC and Bank Fees		X								795,829	2
3												3
4	Note Payable	X		Development & Construction		7/1/2006	3,100,000	3,100,000	6/30/2021	5.0000	155,000	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 112,225,000	$ 101,365,231			$ 6,093,981	9
	B. Non-Facility Related*											
10	Less: Non-allowable portion of above bonds										(5,084,502)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,084,502)	14
15	TOTALS (line 9+line14)						$ 112,225,000	$ 101,365,231			$ 1,009,479	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 Assisi Health Care Centerat Clare Oaks **#** 0047613 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:			
	2005		**8**
	2006		**9**
	2007		**10**
	2008		**11**
	2009		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Assisi Health Care Centerat Clare Oaks COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047613

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,088 B. General Construction Type: Exterior Brick and Composite C Frame Steel and Concrete Number of Stories 5

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).

Clare Oaks, Independent Living Facility (154 Apartments; 10 Cottages)
Clare Oaks, Assisted Living Facility (17 Units)
Clare Oaks, Memory Support (16 Units)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 10,716,763
2. Number of Years Over Which it is Being Amortized: Marketing - 13; Financing - 33
3. Current Period Amortization: 925,070
4. Dates Incurred: 2/1/2008

Nature of Costs: deferred marketing costs and deferred financing 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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	120		2008	2008	$ 8,529,283	$ 213,232	40	$ 213,232	$	$ 426,464	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fall Prevention Gate Locks			2008	7,270	484	15	484		929	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											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											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 Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,536,553	$ 213,716		$ 213,716	$	$ 427,393	70

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

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,322,109	$ 131,977	$ 131,977	$	5/10 Years	$ 363,958	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,322,109	$ 131,977	$ 131,977	$		$ 363,958	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transportation of Residents	2008 Chevrolet Starcraft Van	2008	$ 69,631	$ 13,926	$ 13,926	$	5	$ 25,280	76
77										77
78										78
79										79
80	TOTALS			$ 69,631	$ 13,926	$ 13,926	$		$ 25,280	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)	$ 9,928,293	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 359,619	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 359,619	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)	$ 816,631	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	Non-Allowable (AL & IL) Building	$ 84,261,613	$ 3,056,420	$ 5,671,818	86
87	Non-Allowable (AL & IL) Equipment	2,006,819	433,230	866,460	87
88	Non-Allowable (AL & IL) Vehicles	33,780	6,175	12,350	88
89					89
90					90
91	TOTALS	$ 86,302,212	$ 3,495,825	$ 6,550,628	91

G. Construction-in-Progress

	Description	Cost	
92	GMP Construction Contract	$ 798,573	92
93	Contingency Amount	272,871	93
94			94
95		$ 1,071,444	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 Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ Description:
(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 Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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
   - [X] 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 [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - 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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	10A-3	hrs	$	11,785	$ 399,783	$	11,785	$ 399,783	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,393	115,101		3,393	115,101	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		22,160	751,734		22,160	751,734	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			$	37,338	$ 1,266,618	$	37,338	$ 1,266,618	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 Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2010 (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	$ 1,069,692	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	3,520,464		3
4	Supply Inventory (priced at)	20,357		4
5	Short-Term Investments			5
6	Prepaid Insurance	170,915		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,781,428	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	598,175		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	92,798,166		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,432,339		16
17	Accumulated Depreciation (book methods)	(7,367,259)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	779,198		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attachment	19,360,575		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 109,601,194	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 114,382,622	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,222,889	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	239,602		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,186,502		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Paid Time Off	92,025		36
37	Accrued Ground Lease			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,741,018	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	101,365,231		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attachment	37,134,342		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 138,499,573	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 142,240,591	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (27,857,969)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 114,382,622	$	48

***(See instructions.)**

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks **#** 0047613 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (15,755,536)	1
2	Restatements (describe):		2
3	**2009 Audit Adjustments**	(1,656,608)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (17,412,144)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(10,445,825)	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)**	$ (10,445,825)	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)**	$ (27,857,969)	24 *

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

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,351,915	1
2	Discounts and Allowances for all Levels	(2,050,472)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,301,443	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,280,574	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,280,574	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,950	13
14	Non-Patient Meals	3,280	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	7,965	20
21	Other Medical Services	40	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,235	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	233,140	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 233,140	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attachment	6,377,207	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,377,207	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,206,599	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,789,083	31
32	Health Care	7,071,668	32
33	General Administration	3,905,963	33
	B. Capital Expense		
34	Ownership	10,964,013	34
	C. Ancillary Expense		
35	Special Cost Centers	921,697	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 26,652,424	40
41	**Income before Income Taxes (line 30 minus line 40)****	(10,445,825)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (10,445,825)	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.**

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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	1,185	1,348	$ 52,861	$ 39.21	1
2	Assistant Director of Nursing	11,179	11,763	330,150	28.07	2
3	Registered Nurses	27,463	28,979	1,054,905	36.40	3
4	Licensed Practical Nurses	16,976	17,538	517,441	29.50	4
5	CNAs & Orderlies	89,742	95,082	1,498,182	15.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	52,677	25.33	9
10	Activity Assistants	9,930	10,701	159,849	14.94	10
11	Social Service Workers	2,400	2,564	66,314	25.86	11
12	Dietician	2,120	2,168	66,462	30.66	12
13	Food Service Supervisor	4,857	5,232	107,362	20.52	13
14	Head Cook	16,041	17,300	325,318	18.80	14
15	Cook Helpers/Assistants	27,806	29,815	507,432	17.02	15
16	Dishwashers	10,594	11,327	104,898	9.26	16
17	Maintenance Workers	12,027	13,103	237,322	18.11	17
18	Housekeepers	23,002	25,713	418,081	16.26	18
19	Laundry					19
20	Administrator	1,817	1,865	76,155	40.83	20
21	Assistant Administrator					21
22	Other Administrative	23,783	24,622	622,470	25.28	22
23	Office Manager	2,080	2,258	43,936	19.46	23
24	Clerical	7,666	7,968	56,105	7.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	5,320	5,604	144,649	25.81	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,224	44,975	20.22	31
32	Other Health Care(specify)	9,334	9,579	375,180	39.17	32
33	Other(specify) Security	5,884	6,435	104,375	16.22	33
34	TOTAL (lines 1 - 33)	315,366	335,268	$ 6,967,099 *	$ 20.78	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	206	$ 9,684	1-3	35
36	Medical Director	120	24,000	10-1	36
37	Medical Records Consultant	19	1,110	10-3	37
38	Nurse Consultant	10	2,500	10-3	38
39	Pharmacist Consultant	104	4,954	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,200	11-3	44
45	Social Service Consultant				45
46	Other(specify) See Attached	2,323	174,806		46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,802	$ 218,254		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,570	$ 188,098	10-3	50
51	Licensed Practical Nurses	489	19,593	10-3	51
52	Certified Nurse Assistants/Aides	1,418	31,035	10-3	52
53	TOTAL (lines 50 - 52)	5,477	$ 238,726		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paula Bartolozzi	Executive Director	0	$ 165,083
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 165,083

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
DLA Piper	Legal	$ 33,618
On Target Staff	Agency Staffing	4,620
LarsonAllen	Accounting	61,675
Polsinelli & Shughart	Legal	4,675
Quarles & Brady	Legal	5,296
Ungaretti & Harris	Legal	15,831
Laurie & Brennan	Legal	11,325
Anwyll & Company	Marketing	9,211
CRSA	Mgmt	792
Morrisroe & Associates	Legal	300
Illinois Charity Bureau Fund	Filing Fee	115
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 147,458

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 213,977
Unemployment Compensation Insurance	118,223
FICA Taxes	542,183
Employee Health Insurance	315,521
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Misc Other Employee Benefits	85,158
Less: Non-Allowable Benefits	(446,527)
TOTAL (agree to Schedule V, line 22, col.8)	$ 828,535

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	1,480
(Indicate # of checks performed 148)	
Patient Background Checks	
Dues and	1,336
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,816

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,666
Seminar Expense	14,779
Entertainment Expense	27,519
TOTAL (agree to Sch. V, line 24, col. 8)	$ 54,964

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Assisi Health Care Centerat Clare Oaks # 0047613 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 Assisi Health Care Centerat Clare Oaks **#** 0047613 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $800.00**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,291** 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?
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. $ **66,528**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.