FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0047613

Facility Name: Assisi Health Care Center at 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
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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 7/1/11 to 6/30/12 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) Gigi Walker
(Title) Finance Director

Paid Preparer

(Signed) (Date)
(Print Name and Title) Allan B. Larson, CPA, Partner
(Firm Name & Address) CliftonLarsonAllen 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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	43,920	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	43,920	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	8,328	9,509	16,290	34,127	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,328	9,509	16,290	34,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.70%

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

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

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 14,617

Medicare Intermediary National Government Serivces Inc

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/12 Fiscal Year: 6/30/12

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

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	1,080,055	57,849	187,675	1,325,579		1,325,579	(685,497)	640,082			1
2	Food Purchase		776,574		776,574		776,574	(410,487)	366,087			2
3	Housekeeping	433,438	50,997	148,155	632,590		632,590	(542,149)	90,441			3
4	Laundry											4
5	Heat and Other Utilities			776,277	776,277		776,277	(695,521)	80,756			5
6	Maintenance	322,800	34,210	505,540	862,550		862,550	(719,675)	142,875			6
7	Other (specify):*							(28,168)	(28,168)			7
8	**TOTAL General Services**	1,836,293	919,630	1,617,647	4,373,570		4,373,570	(3,081,497)	1,292,073			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,006,756	256,112	364,091	4,626,959		4,626,959	(456,551)	4,170,408			10
10a	Therapy			1,685,032	1,685,032		1,685,032		1,685,032			10a
11	Activities	372,830	21,145	51,292	445,267		445,267	(5)	445,262			11
12	Social Services	97,988		1,285	99,273		99,273		99,273			12
13	CNA Training											13
14	Program Transportation	10,909		68,697	79,606		79,606	(120)	79,486			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,488,483	277,257	2,170,397	6,936,137		6,936,137	(456,676)	6,479,461			16
	C. General Administration											
17	Administrative	261,047			261,047		261,047	(186,707)	74,340			17
18	Directors Fees											18
19	Professional Services			294,962	294,962		294,962		294,962			19
20	Dues, Fees, Subscriptions & Promotions			10,423	10,423		10,423		10,423			20
21	Clerical & General Office Expenses	407,911	9,806	4,852,853	5,270,570		5,270,570	(3,783,512)	1,487,058			21
22	Employee Benefits & Payroll Taxes			1,285,409	1,285,409		1,285,409	(450,150)	835,259			22
23	Inservice Training & Education											23
24	Travel and Seminar			43,558	43,558		43,558	(8,093)	35,465			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			5,653	5,653		5,653	(4,717)	936			26
27	Other (specify):* **Marketing**	177,272	3,920	302,456	483,648		483,648	(483,648)				27
28	**TOTAL General Administration**	846,230	13,726	6,795,314	7,655,270		7,655,270	(4,916,827)	2,738,443			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,171,006	1,210,613	10,583,358	18,964,977		18,964,977	(8,455,000)	10,509,977			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 Center at Clare Oaks #0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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			3,466,361	3,466,361		3,466,361	(2,892,152)	574,209			30
31	Amortization of Pre-Op. & Org.			558,468	558,468		558,468	(465,957)	92,511			31
32	Interest			4,983,649	4,983,649		4,983,649	(4,286,757)	696,892			32
33	Real Estate Taxes			40,000	40,000		40,000		40,000			33
34	Rent-Facility & Grounds							(33,374)	(33,374)			34
35	Rent-Equipment & Vehicles			23,489	23,489		23,489	(19,598)	3,891			35
36	Other (specify):*											36
37	**TOTAL Ownership**			9,071,967	9,071,967		9,071,967	(7,697,838)	1,374,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			796,897	796,897		796,897		796,897			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			184,324	184,324		184,324		184,324			42
43	Other (specify):* **AL/IL School**	185,039		2,040	187,079		187,079	(187,079)				43
44	**TOTAL Special Cost Centers**	185,039		983,261	1,168,300		1,168,300	(187,079)	981,221			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,356,045	1,210,613	20,638,586	29,205,244		29,205,244	(16,339,917)	12,865,327			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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	(4,597)	1		4
5	Telephone, TV & Radio in Resident Rooms	(76,003)	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	(128,658)	32		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	(100)	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				24
25	Fund Raising, Advertising and Promotional	(483,648)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (693,006)		$	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))**	$ (693,006)		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

STATE OF ILLINOIS **Page 5A**

Assisi Health Care Center at Clare Oaks

ID# 0047613

Report Period Beginning: 7/1/11

Ending: 6/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable (AL & IL) Dietary	$ (680,900)	1	1
2	Non-Allowable (AL & IL) Food	(402,412)	2	2
3	Non-Allowable (AL & IL) Housekeeping	(527,800)	3	3
4	Non-Allowable (AL & IL) Utilities	(619,518)	5	4
5	Non-Allowable (AL & IL) Maintenance	(719,667)	6	5
6	Non-Allowable (AL & IL) Nursing	(456,551)	10	6
7	Non-Allowable (AL & IL) Administrative	(186,707)	17	7
8	Non-Allowable (AL & IL) Clerical and Office	(3,769,638)	21	8
9	Non-Allowable (AL & IL) Benefits & Payroll Taxes	(450,150)	22	9
10	Non-Allowable (AL & IL) Property/Liability Insurance	(4,717)	26	10
11	Non-Allowable (AL & IL) Depreciation	(2,892,152)	30	11
12	Non-Allowable (AL & IL) Amortization	(465,957)	31	12
13	Non-Allowable (AL & IL) Interest	(4,158,099)	32	13
14	Non-Allowable (AL & IL) Expenses	(187,079)	43	14
15	Non-Allowable (AL & IL) Travel and Seminar	(8,093)	24	15
16	Non-Allowable (AL & IL) Trash Removal Expense	(28,168)	7	16
17	Non-Allowable Food	(8,075)	2	17
18	Non-Allowable (AL & IL) Ground Lease Expense	(33,374)	34	18
19	Non-Allowable (AL & IL) Equipment Rental	(19,598)	35	19
20	Transportation Revenue	(120)	14	20
21	Resident Activities	0	12	21
22	Housekeeping	(11,566)	3	22
23	Guest Accomodations	(9,805)	21	23
24	Wellness Services	(5)	11	24
25	Laundry Service	(2,783)	3	25
26	Maintenance Income	(8)	6	26
27	Misc Revenue	(3,969)	21	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**	(15,646,911)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Assisi Health Care Center at Clare Oaks **#** 0047613 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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	(685,497)	0	0	0	0	0	0	0	0	0	0	(685,497)	1
2	Food Purchase	(410,487)	0	0	0	0	0	0	0	0	0	0	(410,487)	2
3	Housekeeping	(542,149)	0	0	0	0	0	0	0	0	0	0	(542,149)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(695,521)	0	0	0	0	0	0	0	0	0	0	(695,521)	5
6	Maintenance	(719,675)	0	0	0	0	0	0	0	0	0	0	(719,675)	6
7	Other (specify):*	(28,168)	0	0	0	0	0	0	0	0	0	0	(28,168)	7
8	**TOTAL General Services**	(3,081,497)	0	0	0	0	0	0	0	0	0	0	(3,081,497)	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	(456,551)	0	0	0	0	0	0	0	0	0	0	(456,551)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	(120)	0	0	0	0	0	0	0	0	0	0	(120)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(456,676)	0	0	0	0	0	0	0	0	0	0	(456,676)	16
	C. General Administration													
17	Administrative	(186,707)	0	0	0	0	0	0	0	0	0	0	(186,707)	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	(3,783,512)	0	0	0	0	0	0	0	0	0	0	(3,783,512)	21
22	Employee Benefits & Payroll Taxes	(450,150)	0	0	0	0	0	0	0	0	0	0	(450,150)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,093)	0	0	0	0	0	0	0	0	0	0	(8,093)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(4,717)	0	0	0	0	0	0	0	0	0	0	(4,717)	26
27	Other (specify):*	(483,648)	0	0	0	0	0	0	0	0	0	0	(483,648)	27
28	**TOTAL General Administration**	(4,916,827)	0	0	0	0	0	0	0	0	0	0	(4,916,827)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,455,000)	0	0	0	0	0	0	0	0	0	0	(8,455,000)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Assisi Health Care Center at Clare Oaks **#** 0047613 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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	(2,892,152)	0	0	0	0	0	0	0	0	0	0	(2,892,152)	30
31	Amortization of Pre-Op. & Org.	(465,957)	0	0	0	0	0	0	0	0	0	0	(465,957)	31
32	Interest	(4,286,757)	0	0	0	0	0	0	0	0	0	0	(4,286,757)	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	(19,598)	0	0	0	0	0	0	0	0	0	0	(19,598)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,697,838)	0	0	0	0	0	0	0	0	0	0	(7,697,838)	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):*	(187,079)	0	0	0	0	0	0	0	0	0	0	(187,079)	43
44	TOTAL Special Cost Centers	(187,079)	0	0	0	0	0	0	0	0	0	0	(187,079)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(16,339,917)	0	0	0	0	0	0	0	0	0	0	(16,339,917)	45

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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
				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	34	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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	$ 106,125,000	$ 96,282,855	Varies	Varies	$ 4,342,955	1
2	LOC and Bank Fees		X								418,626	2
3												3
4	Notes Payable	X		Development & Construction		7/1/2006	3,100,000	3,100,000	6/30/21	5.0000	155,000	4
5												5
	Working Capital											
6	Life Care Services	X		Operations		11/12/2010	200,000	200,000	12/31/2012	5.0000	33,534	6
7	Sisters of St. Joseph	X		Operations		11/12/2010	200,000	200,000	12/31/2012	5.0000	33,534	7
8												8
9	TOTAL Facility Related						$ 109,625,000	$ 99,782,855			$ 4,983,649	9
	B. Non-Facility Related*											
10	Less: Non-allowable portion of above bonds										(4,157,335)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,157,335)	14
15	TOTALS (line 9+line14)						$ 109,625,000	$ 99,782,855			$ 826,314	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 Center at Clare Oaks **#** 0047613 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Assisi Health Care Center at 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	NA		$	$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,088 B. General Construction Type: Exterior Brick and Composite 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: 10,593,318
2. Number of Years Over Which it is Being Amortized: Marketing 13 years/Financing 3
3. Current Period Amortization: 558,468
4. Dates Incurred: 2/1/2008

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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	120		2008	2008	$ 8,529,283	$ 213,232	40	$ 213,232	$	$ 852,928	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fall Prevention Gate Locks			2008	7,270	485	15	485		1,899	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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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			$	$		$	$	$	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	$ 213,717		$ 213,717	$	$ 854,827	70

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

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	$ 1,325,339	$ 332,381	$ 332,381	$	Various	$ 734,925	71
72	Current Year Purchases	299,336	14,185	14,185	0	Various	14,185	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,624,675	$ 346,566	$ 346,566	$ 0		$ 749,110	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	Transportation of Residents	2008 Chevrolet Starcraft Van	2008	$ 69,631	$ 13,926	$ 13,926	$	5	$ 53,132	76
77										77
78										78
79										79
80	TOTALS			$ 69,631	$ 13,926	$ 13,926	$		$ 53,132	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)	$ 10,230,859	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 574,209	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 574,209	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,657,069	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	$ 85,157,279	$ 2,818,190	$ 11,539,446	86
87	Non-Allowable (AL & IL) Equipment	2,026,730	67,206	1,448,543	87
88	Non-Allowable (AL & IL) Vehicles	33,780	6,756	26,442	88
89					89
90					90
91	TOTALS	$ 87,217,789	$ 2,892,152	$ 13,014,431	91

G. Construction-in-Progress

	Description	Cost	
92	GMP Construction Contract	$ 252,615	92
93			93
94			94
95		$ 252,615	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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
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.	/2013	$
13.	/2014	$
14.	/2015	$

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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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.

   Clare Oaks only hires certified CNA's.

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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	9,615	$ 650,300	$	9,615	$ 650,300	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,157	224,801		3,157	224,801	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		11,613	809,931		11,613	809,931	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			$	24,385	$ 1,685,032	$	24,385	$ 1,685,032	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 Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/12 (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	$ 2,054,480	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 116,050)	2,598,768		3
4	Supply Inventory (priced at)	25,237		4
5	Short-Term Investments			5
6	Prepaid Insurance	54,294		6
7	Other Prepaid Expenses	190,770		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,923,549	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	94,801,673		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,745,104		16
17	Accumulated Depreciation (book methods)	(14,671,715)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,316,634		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	11,088,833		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 97,280,529	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 102,204,078	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,437,188	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,010		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,673,250		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	295,671		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,552,119	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	99,782,855		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	35,765,013		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 135,547,868	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 141,099,987	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (38,895,909)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 102,204,078	$	48

***(See instructions.)**

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 **Report Period**] 7/1/11 **Ending:** 6/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/12 **(last day of reporting year)**

Line 23 - Other Assets

Accum Amort - Bond Issue Costs	(715,765)
Financing Costs	84,921
Cost of Bond Issuance	5,236,008
2006 A/B Extras Debt Service Reserv	1,144,778
2006 A/B Extras Project Fund	43,351
2006 A/B Project Fund - Equity Sub	47,440
Contingency Reserve Fund	100,006
2006C Reserve Acct - Debt Service R	491,051
2006D Reserve Acct - Debt Service R	321,658
2006 C/D Project Fund	142,341
2006 D Interest Acct - Interest Fun	14,728
2006 C/D Purchase Fund	350,149
2006 C/D Project Fund - Equity Sub	31,148
Entrance Fee Fund	34,905
Accumulated Amort. - Marketing Cost	(1,762,890)
Capitalized Marketing Costs	5,272,389
GMP Construction Contract	252,615
	11,088,833

Line 36 - Other Accurals

Accrued Provider Tax	93,132
Accrued PTO	192,489
Benevolent Fund	5,051
Accrued Ground Lease	4,999
	295,671

Line 43 - Other Liabilities

Payable to Freeman White	(132,500)
Entrance Fee Spend Down	85,000
EF- Refunds Payable	(2,048,260)
EF - 90% Refundable Plan	(40,422,973)
EF Refunds	5,606,069
Current Deferred Entrance Fees	0
Deferred Revenue From EF	0
Refundable- 90% Accumulated Amortizatio	0
Refundable- 10% Accumulated Amortiz	1,555,546
AL/HC EF Refund Loans	0
Traditional Plan Accumulated Amorti	345,476
Deferred Development Fee	(333,332)
10 % Deposits	(21,389)
Parking Garage Deposits	(398,500)
Processing Fee Deposits	(150)
	(35,765,013)

Facility Name & ID Number Assisi Health Care Center at Clare Oaks **#** 0047613 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (29,813,573)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (29,813,573)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(9,082,336)	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)**	$ (9,082,336)	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)**	$ (38,895,909)	24	*

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

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,622,992	1
2	Discounts and Allowances for all Levels	(2,875,475)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,747,517	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,998,145	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,998,145	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	9,042	13
14	Non-Patient Meals	10,652	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	94,476	19
20	Radiology and X-Ray		20
21	Other Medical Services	12	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 114,182	23
	D. Non-Operating Revenue		
24	Contributions	145	24
25	Interest and Other Investment Income***	966,436	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 966,581	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,084,655	28
28a	See Supplemental Schedule	211,828	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,296,483	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,122,908	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,373,570	31
32	Health Care	6,936,137	32
33	General Administration	7,171,622	33
	B. Capital Expense		
34	Ownership	9,071,967	34
	C. Ancillary Expense		
35	Special Cost Centers	796,897	35
36	Provider Participation Fee	184,324	36
	D. Other Expenses (specify):		
37	Marketing	670,727	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 29,205,244	40
41	**Income before Income Taxes (line 30 minus line 40)****	(9,082,336)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (9,082,336)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,352,880	44
45	Private Pay - Net Inpatient Revenue	2,619,131	45
46	Medicare - Net Inpatient Revenue	(485,774)	46
47	Other-(specify) Managed Care	184,970	47
48	Other-(specify) Hospice	76,310	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,747,517	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.**

Line 28 - IL Revenue

Monthly Services Fee - IL	3,726,446
Monthly Services Fee - AL	1,151,374
Monthly Services Fee - MS	1,313,951
Monthly Service Fee - IL 2nd Person	366,081
MSF - AL Transfer Discount	(95,408)
MSF - MS Transfer Discount	(114,244)
Monthly Service Fee - Charity	(40,451)
IL Additional Meals	9,976
IL Resident Guest Meals	2,174
Transportation - IL	230
Resident Activities - IL	4,206
Store Revenue - IL	2,449
IL Eng and Maint	(1,149)
Garage Rental	34,100
Application Fee Revenue	2,250
Memorial Contribution - IL	115
Earned Entrance Fees	722,555
	7,084,655

Line 28a - Other Revenue

Marketing Incentives	(1,445)
Rent Incentives	(9,644)
Meal Credit - Unbundle Services	(3,360)
Catering	10,273
IL Liquor	2,821
Transportation	44
Transportation - HC - PP	31
Resident Billable Maintenance	37,619
Housekeeping	11,566
Beauty Shop - HC	(1,177)
Guest Accommodations	9,805
SSJ The Center Monthly Fees	2,520
SSJ Reimburse Major Rpairs	37,528
BLC Housekeeping Reimbursement	2,871
BLC Utilities Reimbursement	76,865
BLC Maint Reimbursement	26,994
Concierge Services & Greeting Cards	600

Misc Revenue	3,969
Wellness Services	5
Transportation	45
Concierge Services	5
Resident Activities	42
HC Maintenance and Supply Charge	8
Laundry Service	2,783
HC Liquor Charge	144
Interest Earned	916
	211,828

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	2,080	1,580	$ 68,075	$ 43.09	1
2	Assistant Director of Nursing	2,080	3,220	117,231	36.41	2
3	Registered Nurses	34,178	30,178	975,126	32.31	3
4	Licensed Practical Nurses	38,010	33,931	884,396	26.06	4
5	CNAs & Orderlies	126,969	107,050	1,368,725	12.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,994	2,978	39,750	13.35	9
10	Activity Assistants	17,995	17,306	293,049	16.93	10
11	Social Service Workers	4,306	4,248	100,711	23.71	11
12	Dietician	2,330	2,310	63,293	27.40	12
13	Food Service Supervisor	54,634	50,834	549,919	10.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,334	30,448	455,531	14.96	15
16	Dishwashers					16
17	Maintenance Workers	17,849	17,080	331,139	19.39	17
18	Housekeepers	43,088	40,640	443,084	10.90	18
19	Laundry					19
20	Administrator	2,080	2,120	112,711	53.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	31,923	29,293	660,542	22.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,141	2,132	31,256	14.66	31
32	Other Health Care(specify)	26,323	24,099	678,984	28.17	32
33	Other(specify) Marketing	5,792	5,652	182,523	32.29	33
34	TOTAL (lines 1 - 33)	447,106	405,099	$ 7,356,045 *	$ 18.16	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		$		35
36	Medical Director	192	66,000	10-3	36
37	Medical Records Consultant	18	1,170	10-3	37
38	Nurse Consultant	20	1,743	10-3	38
39	Pharmacist Consultant	240	7,020	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	470	$ 75,933		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	240	$ 12,036	10-3	50
51	Licensed Practical Nurses	605	24,820	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	845	$ 36,856		53

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Hart-Carlson	Administrator	0	$ 109,627
Paula Bartolozzi	Executive Director	0	151,420
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 261,047

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
Various	Legal	$ 198,735
CliftonLarsonAllen	Accounting	96,227
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 294,962

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 195,341
Unemployment Compensation Insurance	
FICA Taxes	551,918
Employee Health Insurance	251,454
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
FUTA/SUI Expense	165,784
Employee PTO	43,554
Employee Vaccinations/Hiring Expense	1,608
Employee Recruitment	39,897
Drug/Background Checks	27,927
Employee Retention	7,926
Less: Non-Allowable Benefits	(450,150)
TOTAL (agree to Schedule V, line 22, col.8)	$ 835,259

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	10,423
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,423

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,196
Meals	10,012
Seminar Expense	21,350
Less: Non-Allowable Travel	(8,093)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 35,465

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Assisi Health Care Center at Clare Oaks # 0047613 Report Period Beginning: 7/1/11 Ending: 6/30/12

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		$		$	$	$	$	$	$	$	$	$

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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. **LSN - $7,474**

(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. $ **47,440** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **184,324**
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? **Yes** Indicate the amount. $ **4,597**

(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. $ **NA**

(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.