		FOR BHF USE				

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 Hlth CC 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: 6/02/2008

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[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 7/1/2014 to 6/30/2015 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)	Tiffany Barton
	(Title)	Administrator
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Deb Freeland Principal
	(Firm Name & Address)	CliftonLarsonAllen LLP 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
	(Telephone)	317-569-6230 Fax # 317-574-9707

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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	6,869	14,492	11,362	32,723	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,869	14,492	11,362	32,723	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.71%

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 6/02/2008

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 11,362

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: 6/30/2015 Fiscal Year: 6/30/2015

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

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,175,477	71,448	193,253	1,440,178		1,440,178	(705,035)	735,143			1
2	Food Purchase		761,870		761,870		761,870	(365,374)	396,496			2
3	Housekeeping	551,294	54,819	3,326	609,439		609,439	(508,613)	100,826			3
4	Laundry											4
5	Heat and Other Utilities			880,307	880,307		880,307	(695,725)	184,582			5
6	Maintenance	420,067	54,300	572,763	1,047,130		1,047,130	(912,578)	134,552			6
7	Other (specify):*											7
8	TOTAL General Services	2,146,838	942,437	1,649,649	4,738,924		4,738,924	(3,187,325)	1,551,599			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,418,622	233,299	615,413	5,267,334		5,267,334	(582,761)	4,684,573			10
10a	Therapy			1,525,526	1,525,526		1,525,526		1,525,526			10a
11	Activities	183,757	12,310	65,624	261,691		261,691		261,691			11
12	Social Services	213,519		1,940	215,459		215,459		215,459			12
13	CNA Training											13
14	Program Transportation	33,984		5,498	39,482		39,482	(4,270)	35,212			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,849,882	245,609	2,214,001	7,309,492		7,309,492	(587,031)	6,722,461			16
	C. General Administration											
17	Administrative	303,419			303,419		303,419	(202,446)	100,973			17
18	Directors Fees											18
19	Professional Services			76,781	76,781		76,781		76,781			19
20	Dues, Fees, Subscriptions & Promotions			21,236	21,236		21,236		21,236			20
21	Clerical & General Office Expenses	596,822	9,696	591,555	1,198,073		1,198,073	(420,010)	778,063			21
22	Employee Benefits & Payroll Taxes			1,663,711	1,663,711		1,663,711	(594,111)	1,069,600			22
23	Inservice Training & Education											23
24	Travel and Seminar			46,141	46,141		46,141	(4,678)	41,463			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			330,475	330,475		330,475		330,475			26
27	Other (specify):* Marketing	199,636	7,122	521,514	728,272		728,272	(728,272)				27
28	TOTAL General Administration	1,099,877	16,818	3,251,413	4,368,108		4,368,108	(1,949,517)	2,418,591			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,096,597	1,204,864	7,115,063	16,416,524		16,416,524	(5,723,873)	10,692,651			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,462,510	1,462,510		1,462,510	(1,217,369)	245,141			30
31	Amortization of Pre-Op. & Org.			488,808	488,808		488,808	(407,836)	80,972			31
32	Interest			3,252,301	3,252,301		3,252,301	(2,710,395)	541,906			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			333,336	333,336		333,336	(278,118)	55,218			34
35	Rent-Equipment & Vehicles			2,583	2,583		2,583	(2,115)	468			35
36	Other (specify):*											36
37	**TOTAL Ownership**			5,539,538	5,539,538		5,539,538	(4,615,833)	923,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			801,951	801,951		801,951		801,951			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			190,445	190,445		190,445		190,445			42
43	Other (specify):* AL/IL School	189,964		2,432	192,396		192,396	(192,396)				43
44	**TOTAL Special Cost Centers**	189,964		994,828	1,184,792		1,184,792	(192,396)	992,396			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,286,561	1,204,864	13,649,429	23,140,854		23,140,854	(10,532,102)	12,608,752			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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	(22,456)	1		4
5	Telephone, TV & Radio in Resident Rooms	(150)	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	(903)	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	(2,709,492)	32		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	(4,230)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(728,272)	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)**	$ (3,465,503)		$	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))**	$ (3,465,503)		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 Hlth CC at Clare Oaks

ID# 0047613

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable (AL & IL) Dietary	$ (682,579)	1	1
2	Non-Allowable (AL & IL) Food	(361,092)	2	2
3	Non-Allowable (AL & IL) Housekeeping	(508,484)	3	3
4	Non-Allowable (AL & IL) Utilities	(695,575)	5	4
5	Non-Allowable (AL & IL) Maintenance	(873,671)	6	5
6	Non-Allowable (AL & IL) Nursing	(582,761)	10	6
7	Non-Allowable (AL & IL) Administrative	(202,446)	17	7
8	Non-Allowable (AL & IL) Clerical and Office	(401,111)	21	8
9	Non-Allowable (AL & IL) Benefits & Payroll Taxes	(594,111)	22	9
10	Non-Allowable (AL & IL) Property/Liability Insurance	0	26	10
11	Non-Allowable (AL & IL) Depreciation	(1,217,369)	30	11
12	Non-Allowable (AL & IL) Amortization	(407,836)	31	12
13	Non-Allowable (AL & IL) Expenses	(192,396)	43	13
14	Non-Allowable (AL & IL) Travel and Seminar	(4,678)	24	14
15	Non-Allowable (AL & IL) Trash Removal Expense	(38,907)	6	15
16	Non-Allowable Food	(4,282)	2	16
17	Non-Allowable (AL & IL) Ground Lease Expense	(278,118)	34	17
18	Non-Allowable (AL & IL) Equipment Rental	(2,115)	35	18
19	Guest Accomodations	(13,579)	21	19
20	Laundry Services	(129)	3	20
21	Misc Revenue	(1,090)	21	21
22	Transporation Revenue	(4,270)	14	22
23	Non-Allowable Travel & Seminar Expense		24	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**	(7,066,599)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	(705,035)	0	0	0	0	0	0	0	0	0	0	(705,035)	1
2	Food Purchase	(365,374)	0	0	0	0	0	0	0	0	0	0	(365,374)	2
3	Housekeeping	(508,613)	0	0	0	0	0	0	0	0	0	0	(508,613)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(695,725)	0	0	0	0	0	0	0	0	0	0	(695,725)	5
6	Maintenance	(912,578)	0	0	0	0	0	0	0	0	0	0	(912,578)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,187,325)	0	0	0	0	0	0	0	0	0	0	(3,187,325)	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	(582,761)	0	0	0	0	0	0	0	0	0	0	(582,761)	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	(4,270)	0	0	0	0	0	0	0	0	0	0	(4,270)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(587,031)	0	0	0	0	0	0	0	0	0	0	(587,031)	16
	C. General Administration													
17	Administrative	(202,446)	0	0	0	0	0	0	0	0	0	0	(202,446)	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	(420,010)	0	0	0	0	0	0	0	0	0	0	(420,010)	21
22	Employee Benefits & Payroll Taxes	(594,111)	0	0	0	0	0	0	0	0	0	0	(594,111)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,678)	0	0	0	0	0	0	0	0	0	0	(4,678)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(728,272)	0	0	0	0	0	0	0	0	0	0	(728,272)	27
28	**TOTAL General Administration**	(1,949,517)	0	0	0	0	0	0	0	0	0	0	(1,949,517)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,723,873)	0	0	0	0	0	0	0	0	0	0	(5,723,873)	29

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	(1,217,369)	0	0	0	0	0	0	0	0	0	0	(1,217,369)	30
31	Amortization of Pre-Op. & Org.	(407,836)	0	0	0	0	0	0	0	0	0	0	(407,836)	31
32	Interest	(2,710,395)	0	0	0	0	0	0	0	0	0	0	(2,710,395)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(278,118)	0	0	0	0	0	0	0	0	0	0	(278,118)	34
35	Rent-Equipment & Vehicles	(2,115)	0	0	0	0	0	0	0	0	0	0	(2,115)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,615,833)	0	0	0	0	0	0	0	0	0	0	(4,615,833)	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):*	(192,396)	0	0	0	0	0	0	0	0	0	0	(192,396)	43
44	**TOTAL Special Cost Centers**	(192,396)	0	0	0	0	0	0	0	0	0	0	(192,396)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,532,102)	0	0	0	0	0	0	0	0	0	0	(10,532,102)	45

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Ground Lease	$ 333,336	Sisters of St. Joseph	0.00%	$ 333,336	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 333,336			$ 333,336	$ *	14

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

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Series 2012 A Bonds		X	Refinancing		12/1/2012	$ 12,000,000	$ 11,050,000	11/15/2027	7.0000	$ 786,888	1
2	Series 2012 A-3 Bonds		X	Refinancing		12/1/2012	2,000,000	2,000,000	11/15/2017	7.0000	140,000	2
3	Series 2012 B Bonds		X	Refinancing		12/1/2012	39,991,094	39,991,094	11/15/2052	Various	1,598,156	3
4	Series 2012 C Bonds		X	Refinancing		12/1/2012	35,008,974	35,008,974	11/15/2052	2.0000		4
5	Interest Accretion Series 2012										727,257	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 89,000,068	$ 88,050,068			$ 3,252,301	9
	B. Non-Facility Related*											
10	Less: Non-allowable portion of above bonds										(2,709,492)	10
11	Less: Interest Income										(903)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,710,395)	14
15	TOTALS (line 9+line14)						$ 89,000,068	$ 88,050,068			$ 541,906	15

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

* 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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2014 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Assisi Hlth CC 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 2014 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 2014.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	N/A		$	$
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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,537,561
2. Number of Years Over Which it is Being Amortized: Marketing 13-Financing 30
3. Current Period Amortization: 488,808
4. Dates Incurred: 2/1/2008 and 12/1/2012

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 26,298,344	$ 876,611	30	$ 876,611	$	$ 7,910,942	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2008 Fixed Assets			2008	1,866,356						9
10	2009 Fixed Assets			2009	55,774						10
11	Maple Sugar #006 apt conversion			2010	1,754						11
12	Asbestos removal			2010	1,135						12
13	Requisition #35 pd 11/19/2010			2010	261,606						13
14	Asphalt repairs school parking lot			2010	2,000						14
15	drainage repair Cornerstone Partners 11/20/10			2010	5,764						15
16	drainage repairs Cornerstone Partners 11/23/10			2010	2,602						16
17	drainage repairs Cornerstone Partners 11/29/10			2010	378						17
18	Convert unit from Handicap to Std			2011	1,517						18
19	Labor for HVAC Repair			2011	1,600						19
20	New concrete sidewalks			2011	3,860						20
21	Gutters			2012	2,451						21
22	Drainage system improvement			2012	2,150						22
23	Boiler - De-aertor equipment - 1st draw			2012	28,000						23
24	New granite counter tops and sinks			2012	12,850						24
25	Refriderant supply lines improvements			2012	8,564						25
26	Apartment/Cottage upgrades - faucets, lighting			2012	1,667						26
27	WSHP water load system			2012	2,800						27
28	New appliances for cottage upgrade			2012	3,983						28
29	New pendant system			2012	73,164						29
30	New security camera system			2012	25,490						30
31	New grease trap for main kitchen			2012	24,500						31
32	Boiler - De-aertor equipment - 2nd draw			2012	52,135						32
33	Boiler - Steam boiler treatment and control system			2012	21,855						33
34	WSHP Replacement units			2012	20,580						34
35	4 compressors for WSHP units			2012	3,142						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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	Boiler - Installation	2013	$ 48,860	$		$	$	$	37
38	Apartment/Cottage upgrades - labor	2013	2,366						38
39	HVAC unit install	2013	1,094						39
40	Soft start drive controls for cooling tower	2013	4,795						40
41	Replacement interior doors in HC	2013	3,302						41
42	Replace compressor in unit 219	2013	3,083						42
43	Electrical line - new pendent	2013	1,018						43
44	Apartment/Cottage upgrades - Painting	2013	7,107						44
45	Apartment/Cottage upgrades - Additional lighting fixt.	2013	689						45
46	Refurbish unit 232	2013	1,548						46
47	Flooring upgrade - IL305	2013	1,952						47
48	Boiler - De-aertor equipment - 4th draw	2013	13,400						48
49	Boiler - De-aertor equipment - 3rd draw	2013	16,600						49
50	New laminate countertops for IL 232 & 131	2013	2,164						50
51	Boiler - De-aertor equipment - 5th and Final draw	2013	27,165						51
52	Upgrades to IL 310	2013	1,586						52
53	New push button systems for main entrance doors	2013	2,549						53
54	Boiler - RO system	2013	9,018						54
55	Fire safety doors for Clare Woods Academy	2013	21,791						55
56	Additon of a walkway to access pond	2013	3,850						56
57	Parking lot - sealcoating, restriping, repair cracks	2013	24,000						57
58	Asphalt sealing for bike path	2013	2,380						58
59	Speed bumps	2013	2,400						59
60	Sewer cover repair & assembly	2013	1,708						60
61	Outlets for generator in main phone room	2013	1,184						61
62	Amer. Elm Cottage/Furniture/Décor/Light Fixtures/Cabinet	2013	72,035						62
63	Boiler Project - Deareator insulation	2013	1,050						63
64	Model Upgrades - New Appliances	2013	3,541						64
65	Model Upgrades - New Countertops	2013	3,150						65
66	Boiler - completion of chemical feed	2013	7,700						66
67	Replace unit disconnect	2013	3,565						67
68	Discovery Room Upgrade Chairs/table Marketing	2013	4,247						68
69	Breakroom Upgrade bar stools/chairs	2013	11,583						69
70	TOTAL (lines 4 thru 69)		$ 29,098,500	$ 876,611		$ 876,611	$	$ 7,910,942	70

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

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 29,098,500	$ 876,611		$ 876,611	$	$ 7,910,942	1
2	Painting and Flooring for Apts 310,312,Cottage 1&10	2013	16,496						2
3	IL Hallway Project Prep/Paint/drywall building 827	2013	18,650						3
4	ED office renovation (Demolition, Doors, Drywall, Electrical, Carp	2014	5,260						4
5	Painting Project - New office area	2014	5,200						5
6	Painting 2nd/3rd Floor Hallways, Libraries, Offices (DRs, MDS, C	2014	30,042						6
7	New sprinkler and fire alarm system in new office area	2014	16,785						7
8	New flooring and wall repair in AL Spa	2014	5,446						8
9	Apply ceiling insulation in the Commons attic	2014	20,680						9
10	General Electrical Work Rooms 2R and G-53	2014	1,020						10
11	New Laminate Flooring Rooms 2R and G-53	2014	2,646						11
12	Painting (labor and supplies) room G-53	2014	390						12
13	Paint 2 coats, walls and trim, plus repair cracks in room 2R	2014	300						13
14	New door handles (11), light bulbs (3 pk) and blinds	2014	799						14
15	New Hardwood Flooring for Pub & IL Private Dining Rm	2014	19,400						15
16	Landscaping Project, improvment of grounds	2014	10,578						16
17	Extend drain curtain in parking lot	2014	1,700						17
18	New HVAC system in MPR	2015	335,621						18
19	Addition to emp parking lot, resurfacing of existing emp l	2015	75,683						19
20	Bury existing down spouts on the A building to divert wate	2015	13,000						20
21	Bury down spouts on B,C,D buildings to divert water from	2015	8,700						21
22	Remove, replace, and repair rubber roofing material over m	2015	5,000						22
23	Add railing to exterior walkway	2015	9,899						23
24	New vinyl flooring inthe ATC resident dining room	2015	6,205						24
25	New industrial sized freezer in main kitchen	2015	66,848						25
26	Upgrades and Renovations to Center business offices - new	2015	5,535						26
27	New automatic doors in garages, Commons, MPR, and, AL	2015	20,787						27
28	Painting Refresh for AL and MS hallways	2015	11,772						28
29	Renovation of AL dining room - new vinyl plank flooring and paint	2015	7,203						29
30									30
31	Financial Statement Depreciation			197,150		197,150		2,997,799	31
32	AL/IL Depreciation			(894,547)		(894,547)		(7,522,363)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 29,820,145	$ 179,214		$ 179,214	$	$ 3,386,378	34

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

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 3,053,549	$ 367,509	$ 367,509	$	VAR	$ 1,844,071	71
72	Current Year Purchases	273,366	17,256	17,256		VAR	17,256	72
73	Fully Depreciated Assets	1,230,573				VAR	1,230,573	73
74	Less AL/IL		(319,527)	(319,527)			(2,575,851)	74
75	TOTALS	$ 4,557,488	$ 65,238	$ 65,238	$		$ 516,049	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	$	$	$	5	$ 69,631	76
77	Transportation of Residents	Bus Lease Buyout	2014	6,888	689	689		5	1,033	77
78										78
79										79
80	TOTALS			$ 76,519	$ 689	$ 689	$		$ 70,664	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)	$ 34,454,152	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 245,141	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 245,141	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)	$ 3,973,091	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	$ 24,843,060	$ 894,547	$ 7,522,363	86
87	Non-Allowable (AL & IL) Equipment	3,796,828	319,527	2,575,851	87
88	Non-Allowable (AL & IL) Vehicles	66,734	3,295	40,371	88
89					89
90					90
91	TOTALS	$ 28,706,622	$ 1,217,369	$ 10,138,585	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 2,298 Description: Portable Oxygen tanks, Beds, Bi-pap, C-pap, Matresses, Rails, Leg Pump, Wound Vac
    (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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	12,820	$ 533,171	$	12,820	$ 533,171	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,355	139,531		3,355	139,531	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		20,506	852,824		20,506	852,824	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			$	36,681	$ 1,525,526	$	36,681	$ 1,525,526	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2015 (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	$ 2,133,558	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 504,298)	2,430,063		3
4	Supply Inventory (priced at)	36,313		4
5	Short-Term Investments			5
6	Prepaid Insurance	171,209		6
7	Other Prepaid Expenses	1,463,313		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,234,456	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	29,820,145		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,700,741		16
17	Accumulated Depreciation (book methods)	(14,116,194)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	13,652,906		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 34,057,598	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 40,292,054	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 667,102	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	260,155		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	313,939		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	685,644		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,926,840	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	89,836,448		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	39,780,660		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 129,617,108	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 131,543,948	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (91,251,894)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 40,292,054	$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (87,605,222)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (87,605,222)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,646,672)	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)**	$ (3,646,672)	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)**	$ (91,251,894)	24 *

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

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 10,989,555	1
2	Discounts and Allowances for all Levels	(4,156,357)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,833,198	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,075,954	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,075,954	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	5,875	13
14	Non-Patient Meals	22,462	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	38,309	19
20	Radiology and X-Ray	2,581	20
21	Other Medical Services	10	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 69,237	23
	D. Non-Operating Revenue		
24	Contributions	70,353	24
25	Interest and Other Investment Income***	903	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 71,256	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	IL Revenue	7,384,376	28
28a	Other Revenue	60,163	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,444,539	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,494,184	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,738,924	31
32	Health Care	7,309,492	32
33	General Administration	4,368,108	33
	B. Capital Expense		
34	Ownership	5,539,538	34
	C. Ancillary Expense		
35	Special Cost Centers	1,184,792	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)***	$ 23,140,854	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,646,670)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,646,670)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,101,887	44
45	Private Pay - Net Inpatient Revenue	3,293,134	45
46	Medicare - Net Inpatient Revenue	2,203,666	46
47	Other-(specify) Managed Care	107,363	47
48	Other-(specify) Hospice	127,148	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,833,198	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.

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,126	$ 96,056	$ 45.18	1
2	Assistant Director of Nursing	2,080	2,123	89,771	42.28	2
3	Registered Nurses	45,181	45,311	1,490,262	32.89	3
4	Licensed Practical Nurses	30,697	30,777	782,271	25.42	4
5	CNAs & Orderlies	110,127	110,196	1,471,561	13.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,217	2,235	38,658	17.30	9
10	Activity Assistants	16,432	16,505	284,345	17.23	10
11	Social Service Workers	4,710	4,733	104,668	22.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	80,225	80,434	1,067,648	13.27	15
16	Dishwashers	12,210	12,221	128,608	10.52	16
17	Maintenance Workers	21,571	21,691	418,495	19.29	17
18	Housekeepers	43,907	43,979	523,604	11.91	18
19	Laundry	2,222	2,233	25,628	11.48	19
20	Administrator	1,919	1,973	102,417	51.91	20
21	Assistant Administrator					21
22	Other Administrative	21,867	22,278	852,700	38.28	22
23	Office Manager					23
24	Clerical	32,754	32,931	634,698	19.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,072	2,107	71,587	33.98	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,214	6,231	103,584	16.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	438,485	440,084	$ 8,286,561 *	$ 18.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	271	$ 12,475	01-3	35
36	Medical Director	144	54,000	10-3	36
37	Medical Records Consultant	13	813	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	88	5,699	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	53	3,429	10-3	44
45	Social Service Consultant	24	1,940	12-3	45
46	Other(specify) Social Work PRN	207	8,266	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	799	$ 86,622		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	233	$ 12,446	10-3	50
51	Licensed Practical Nurses	1,030	27,951	10-3	51
52	Certified Nurse Assistants/Aides	905	20,505	10-3	52
53	TOTAL (lines 50 - 52)	2,168	$ 60,901		53

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tiffany Barton	Administrator		$ 102,802
Elizabeth Welch	Executive Director		200,617
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 303,419

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
CliftonLarsonAllen	Accounting	$ 43,131
Ungaretti & Jarris/Nixon Peabody	Legal	11,889
Polsinelli	Legal	21,761
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 76,781

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 283,466
Unemployment Compensation Insurance	27,685
FICA Taxes	623,677
Employee Health Insurance	588,861
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
FUTA/SUI Expense	
Employee PTO	47,946
401K	32,198
Employee Recruitment	15,640
Drug/Background Checks	33,726
Employee Retention	10,512
Less: Non-Allowable Benefits	(594,111)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,069,600

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and subscriptions	21,236
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,236

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 9,416
Seminars	21,318
In-State Travel	428
Seminars - In State	6,213
Seminar Expense	8,766
Less: Non-Allowable Travel	(4,678)
Less: Reclassification	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 41,463

**See instructions.

Facility Name & ID Number Assisi Hlth CC at Clare Oaks # 0047613 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

Facility Name & ID Number **Assisi Hlth CC at Clare Oaks** **#** **0047613** **Report Period Beginning:** **7/1/2014** **Ending:** **6/30/2015**

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. **$14,690 (LeadingAge)**

(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? **N/A**

(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? **N/A**

(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. $ **51,284** Line **10-2**

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

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

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **190,445**
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. $ ____

(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. $ **N/A**
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?
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? **Yes**
Firm Name: **CliftonLarsonAllen**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.