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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0047613

Facility Name: Assisi Health Care Center

Address: 829 Carrilon 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: 06/02/2008

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	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 7/1/2017 to 6/30/2018 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 LLLP, 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 Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 N/A

	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	6,964	9,053	11,259	27,276	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,964	9,053	11,259	27,276	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.10%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 06/02/2008

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 11,259

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	1,158,128	91,199	173,323	1,422,650		1,422,650	(780,310)	642,340			1
2	Food Purchase		804,225		804,225		804,225	(426,799)	377,426			2
3	Housekeeping	558,433	55,965	12,761	627,159		627,159	(523,269)	103,890			3
4	Laundry											4
5	Heat and Other Utilities			870,072	870,072		870,072	(680,847)	189,225			5
6	Maintenance	500,040	49,203	611,071	1,160,314		1,160,314	(1,013,203)	147,111			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,216,601	1,000,592	1,667,227	4,884,420		4,884,420	(3,424,428)	1,459,992			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,108,160	213,039	362,758	4,683,957	(3,440)	4,680,517	(640,460)	4,040,057			10
10a	Therapy			1,143,197	1,143,197		1,143,197		1,143,197			10a
11	Activities	284,317	11,752	71,495	367,564		367,564	(152,670)	214,894			11
12	Social Services	236,883		2,260	239,143		239,143		239,143			12
13	CNA Training											13
14	Program Transportation	10,382		258	10,640		10,640	(322)	10,318			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,639,742	224,791	1,579,968	6,444,501	(3,440)	6,441,061	(793,452)	5,647,609			16
	C. General Administration											
17	Administrative	338,649			338,649		338,649	(242,004)	96,645			17
18	Directors Fees											18
19	Professional Services			93,070	93,070		93,070		93,070			19
20	Dues, Fees, Subscriptions & Promotions			73,710	73,710	3,440	77,150		77,150			20
21	Clerical & General Office Expenses	593,667	8,912	633,221	1,235,800		1,235,800	(948,692)	287,108			21
22	Employee Benefits & Payroll Taxes			1,643,493	1,643,493		1,643,493	(619,926)	1,023,567			22
23	Inservice Training & Education											23
24	Travel and Seminar			43,386	43,386		43,386	(20,287)	23,099			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			391,516	391,516		391,516	(326,661)	64,855			26
27	Other (specify):* Marketing	132,860	1,040	333,670	467,570		467,570	(467,570)				27
28	**TOTAL General Administration**	1,065,176	9,952	3,212,066	4,287,194	3,440	4,290,634	(2,625,140)	1,665,494			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,921,519	1,235,335	6,459,261	15,616,115		15,616,115	(6,843,020)	8,773,095			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 #0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,634,622	1,634,622		1,634,622	(1,365,216)	269,406			30
31	Amortization of Pre-Op. & Org.			396,408	396,408		396,408	(330,742)	65,666			31
32	Interest			3,129,988	3,129,988		3,129,988	(2,641,316)	488,672			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			253,336	253,336		253,336	(211,370)	41,966			34
35	Rent-Equipment & Vehicles			1,569	1,569		1,569	(1,309)	260			35
36	Other (specify):*											36
37	**TOTAL Ownership**			5,415,923	5,415,923		5,415,923	(4,549,953)	865,970			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			500,820	500,820		500,820		500,820			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,172	160,172		160,172		160,172			42
43	Other (specify):*	61,372		(2,067)	59,305		59,305	(59,305)				43
44	**TOTAL Special Cost Centers**	61,372		658,925	720,297		720,297	(59,305)	660,992			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,982,891	1,235,335	12,534,109	21,752,335		21,752,335	(11,452,278)	10,300,057			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 # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	(29,145)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(33,723)	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	(2,607,593)	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	(3,636)	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	(150,000)	21		24
25	Fund Raising, Advertising and Promotional	(467,570)	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)**	$ (3,291,667)		$	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))**	$ (3,291,667)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Assisi Health Care Center

ID# 0047613

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable (AL & IL) Dietary	$ (751,165)	1	1
2	Non-Allowable (AL & IL) Food	(424,634)	2	2
3	Non-Allowable (AL & IL) Housekeeping	(523,269)	3	3
4	Non-Allowable (AL & IL) Utilities	(680,847)	5	4
5	Non-Allowable (AL & IL) Maintenance	(968,106)	6	5
6	Non-Allowable (AL & IL) Nursing	(640,460)	10	6
7	Non-Allowable (AL & IL) Administrative	(242,004)	17	7
8	Non-Allowable (AL & IL) Clerical and Office	(775,928)	21	8
9	Non-Allowable (AL & IL) Benefits & Payroll Taxes	(619,926)	22	9
10	Non-Allowable (AL & IL) Property/Liability Insurance	(326,661)	26	10
11	Non-Allowable (AL & IL) Depreciation	(1,365,216)	30	11
12	Non-Allowable (AL & IL) Amortization	(330,742)	31	12
13	Non-Allowable (AL & IL) Expenses	(59,305)	43	13
14	Non-Allowable (AL & IL) Travel and Seminar	(20,287)	24	14
15	Non-Allowable (AL & IL) Trash Removal Expense	(45,097)	6	15
16	Non-Allowable Food	(2,165)	2	16
17	Non-Allowable (AL & IL) Ground Lease Expense	(211,370)	34	17
18	Non-Allowable (AL & IL) Equipment Rental	(1,309)	35	18
19	Guest Accomodations	(9,188)	21	19
20	Misc Revenue	(9,940)	21	20
21	Transportation Revenue	(322)	14	21
22	Non-Allowable (Al & IL) Resident Services	(152,670)	11	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,160,611)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	(780,310)	0	0	0	0	0	0	0	0	0	0	(780,310)	1
2	Food Purchase	(426,799)	0	0	0	0	0	0	0	0	0	0	(426,799)	2
3	Housekeeping	(523,269)	0	0	0	0	0	0	0	0	0	0	(523,269)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(680,847)	0	0	0	0	0	0	0	0	0	0	(680,847)	5
6	Maintenance	(1,013,203)	0	0	0	0	0	0	0	0	0	0	(1,013,203)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,424,428)	0	0	0	0	0	0	0	0	0	0	(3,424,428)	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	(640,460)	0	0	0	0	0	0	0	0	0	0	(640,460)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(152,670)	0	0	0	0	0	0	0	0	0	0	(152,670)	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	(322)	0	0	0	0	0	0	0	0	0	0	(322)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(793,452)	0	0	0	0	0	0	0	0	0	0	(793,452)	16
	C. General Administration													
17	Administrative	(242,004)	0	0	0	0	0	0	0	0	0	0	(242,004)	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	(948,692)	0	0	0	0	0	0	0	0	0	0	(948,692)	21
22	Employee Benefits & Payroll Taxes	(619,926)	0	0	0	0	0	0	0	0	0	0	(619,926)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(20,287)	0	0	0	0	0	0	0	0	0	0	(20,287)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(326,661)	0	0	0	0	0	0	0	0	0	0	(326,661)	26
27	Other (specify):*	(467,570)	0	0	0	0	0	0	0	0	0	0	(467,570)	27
28	TOTAL General Administration	(2,625,140)	0	0	0	0	0	0	0	0	0	0	(2,625,140)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,843,020)	0	0	0	0	0	0	0	0	0	0	(6,843,020)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Assisi Health Care Center # 0047613 **Report Period Beginning:** 7/1/2017 **Ending:** 6/30/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,365,216)	0	0	0	0	0	0	0	0	0	0	(1,365,216)	30
31	Amortization of Pre-Op. & Org.	(330,742)	0	0	0	0	0	0	0	0	0	0	(330,742)	31
32	Interest	(2,641,316)	0	0	0	0	0	0	0	0	0	0	(2,641,316)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(211,370)	0	0	0	0	0	0	0	0	0	0	(211,370)	34
35	Rent-Equipment & Vehicles	(1,309)	0	0	0	0	0	0	0	0	0	0	(1,309)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,549,953)	0	0	0	0	0	0	0	0	0	0	(4,549,953)	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):*	(59,305)	0	0	0	0	0	0	0	0	0	0	(59,305)	43
44	**TOTAL Special Cost Centers**	(59,305)	0	0	0	0	0	0	0	0	0	0	(59,305)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,452,278)	0	0	0	0	0	0	0	0	0	0	(11,452,278)	45

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	34	Ground Lease	$ 253,336	Sisters of St. Joseph	0.00%	$ 253,336	$	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			$ 253,336			$ 253,336	$ *	14

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

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	Therese M. Malm							1
2	Paul Clemens							2
3	Michael D. Hovde, Jr.							3
4	Kathy Meisinger							4
5	Gerrianne M. Hartman							5
6	Maureen Taus							6
7	Valerie Salmons							7
8	Beth Welch							8
9	Jeannene Walker							9
10	Tiffany Barton							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 # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	Therese M. Malm	President	Class A Member						$		1
2	Paul Clemens	Treasurer	Class A Member								2
3	Michael D. Hovde, Jr.	Vice President/Secret	Class A Member								3
4	Kathy Meisinger	Board Member	Class A Member								4
5	Gerrianne M. Hartman	Board Member	Class B Member								5
6	Maureen Taus	Board Member	Class B Member								6
7	Valerie Salmons	Board Member	Class B Member								7
8	Beth Welch	CEO	Non-voting board member								8
9	Jeannene Walker	CFOO	Non-voting board member								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 # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 2012 A Bonds		X	Refinancing		12/1/2012	$ 12,000,000	$ 8,615,000	11/15/2027	7.0000	$ 446,162	1
2	Series 2012 A-3 Bonds		X	Refinancing		12/1/2012	2,000,000		11/15/2017	7.0000	222,163	2
3	Series 2012 B Bonds		X	Refinancing		12/1/2012	39,991,094	39,991,094	11/15/2052	Various	1,599,644	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										769,619	5
	Working Capital											
6	Bond Issuance Costs		X	Issuance costs							92,400	6
7												7
8												8
9	TOTAL Facility Related						$ 89,000,068	$ 83,615,068			$ 3,129,988	9
	B. Non-Facility Related*											
10	Less: Non-allowable portion of above bonds										(2,607,593)	10
11	Less: Interest Income										(33,723)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,641,316)	14
15	TOTALS (line 9+line14)						$ 89,000,068	$ 83,615,068			$ 488,672	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 # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:		
	2013	8
	2014	9
	2015	10
	2016	11
	2017	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Assisi Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047613

CONTACT PERSON REGARDING THIS REPORT Gigi Walker

TELEPHONE 630-483-4730 FAX #:

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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: 5,272,389
2. Number of Years Over Which it is Being Amortized: Marketing-13, Financing-30
3. Current Period Amortization: 396,408
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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	$	$ 10,540,776	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	2010 Fixed Assets			2010	275,239						11
12	2011 Fixed Assets			2011	6,977						12
13	2012 Fixed Assets			2012	283,331						13
14	2013 Fixed Assets			2013	347,626						14
15	2014 Fixed Assets			2014	120,246						15
16	New HVAC system in MPR			2015	335,621						16
17	Addition to emp parking lot, resurfacing of existing emp l			2015	75,683						17
18	Bury existing down spouts on the A building to divert wate			2015	13,000						18
19	Bury down spouts on B,C,D buildings to divert water from			2015	8,700						19
20	Remove, replace, and repair rubber roofing material over m			2015	5,000						20
21	Add railing to exterior walkway			2015	9,899						21
22	New vinyl flooring inthe ATC resident dining room			2015	6,205						22
23	New industrial sized freezer in main kitchen			2015	66,848						23
24	Upgrades and Renovations to Center business offices - new			2015	5,535						24
25	New automatic doors in garages, Commons, MPR, and, AL			2015	20,787						25
26	Painting Refresh for AL and MS hallways			2015	7,203						26
27	Renovation of AL dining room - new vinyl plank flooring and paint			2015	11,772						27
28	Repair 3 sky lights			2016	4,950						28
29	Repair, restore, refinish 3 IL balcony concrete pads			2016	5,782						29
30	Upgrade entry-way pillars at the 825, 827, 829 enntrances			2016	5,760						30
31	Mech HVAC Improvements			2016	5,252						31
32	Bird Guard Project			2016	1,998						32
33	IL 103 Refurb			2016	7,251						33
34	IL 201 Refurb			2016	5,880						34
35	IL 131 Refurb			2016	3,337						35
36	IL 203 Refurb			2016							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 # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	IL 308 Refurb	2016	$ 6,373	$		$	$	$	37
38	IL 404 Refurb	2016	9,208						38
39	IL 408 Refurb	2016	8,820						39
40	IL 413 Refurb	2016	3,110						40
41	IL 415 Refurb	2016	4,518						41
42	IL 426 Refurb	2016	7,926						42
43	IL 433 Refurb	2016	3,804						43
44	IL 436 Refurb	2016	7,304						44
45	IL 422 Refurb	2016	9,380						45
46	ERV#1 Improvement	2016	9,878						46
47	IL Kitchen HVAC AC replacement	2016	8,891						47
48	IL Skylights Improvements	2016							48
49	Site Drainage and Walkway improvements	2016	28,189						49
50	Drainage Improvement	2016	8,500						50
51	Vent Covers	2016	7,500						51
52	Rewire walk in kitchen cooler	2016	4,070						52
53	Concrete walkway/drainage improvements	2016	138,467						53
54	IL	2016	3,014						54
55	IL 102 Refurb	2016	2,778						55
56	IL 112 Refurb	2016	3,659						56
57	IL 121 Refurb	2016	3,960						57
58	IL 331 Refurb	2016	2,718						58
59	IL 412 Refurb	2016	5,847						59
60	WSHP - four units	2016	8,038						60
61	ERV #3 & 6	2016	5,929						61
62	ERV4 Improvements	2016	3,324						62
63	SARA Monitoring System	2016	111,882						63
64	Seal Coating and Striping	2016	37,963						64
65	Pergola - Memory Support	2016	4,431						65
66	Pool Dehumidifier	2016	19,043						66
67	ERV 3 & 4	2016	5,722						67
68	IL COTT 9 REFURB	2016	4,955						68
69	IL 202 Refurb	2016	3,095						69
70	TOTAL (lines 4 thru 69)		$ 30,352,652	$ 876,611		$ 876,611	$	$ 10,540,776	70

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

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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		$ 30,352,652	$ 876,611		$ 876,611	$	$ 10,540,776	1
2	IL 206 Refurb	2016	7,805						2
3	IL 408 Refurb	2016	1,506						3
4	IL 413 Refurb	2016	770						4
5	IL 415 Refurb	2016	2,732						5
6	IL 422 Refurb	2016	1,892						6
7	IL 206 Refurb	2016	3,094						7
8	Balcony and Siding Improvements	2016	5,027						8
9	Drain Tile System installation	2016	8,440						9
10	IL COTT 6 REFURB	2016	14,200						10
11	IL 119 Refurb	2016	3,549						11
12	IL 125 Refurb	2016	6,518						12
13	IL 313 Refurb	2016	6,720						13
14	IL 414 Refurb	2016	3,311						14
15	Swimming Pool Improvements	2016	5,294						15
16	Fence in AL	2016	5,835						16
17	IL Courtyard walkways	2016	2,000						17
18	ERV4 Compressor	2017	9,510						18
19	Unit 413 Updates	2017	1,550						19
20	Unit 132 Updates	2017	2,485						20
21	Unit 102 Updates	2017	3,817						21
22	IL unit #013 refurb	2017	5,559						22
23	IL unit #107 refurb	2017	3,751						23
24	Unit 322 Updates	2017	7,750						24
25	WSHP IL and AL	2017	18,948						25
26	Concrete ramp and curb cut	2017	3,100						26
27	IL Dining Room improvements	2017	52,600						27
28	Fencing repalcement generator and compactor	2017	14,221						28
29	Cottage driveways and curb cut	2017	46,231						29
30	IL unit #132 refurb	2017	1,840						30
31	IL unit #322 refurb	2017	1,405						31
32	IL unit #004 refurb	2017	6,358						32
33	IL unit #111 refurb	2017	7,661						33
34	TOTAL (lines 1 thru 33)		$ 30,618,130	$ 876,611		$ 876,611	$	$ 10,540,776	34

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

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 12B, Carried Forward		$ 30,618,130	$ 876,611		$ 876,611	$	$ 10,540,776	1
2	IL unit #316 refurb	2017	6,807						2
3	IL unit# Cott6	2018	1,549						3
4	IL unit# 102	2018	703						4
5	Emergency Panel Exp	2018	8,705						5
6	Walking Path Improvements	2018	4,460						6
7	ERV1 Compressor Replacement	2018	9,809						7
8	Expanding Security Cameras	2018	3,177						8
9	Main Kitchen Exhaust Fan	2018	4,763						9
10	ERV 4 Stage 1 Compressor	2018	5,573						10
11	ERV2 Main Control Board	2018	2,748						11
12	IL unit# 116	2018	14,547						12
13	Generator Improvement	2018	2,746						13
14	IL unit# 136	2018	14,353						14
15	IL unit# 004	2018	3,303						15
16	IL unit# 206	2018	15,401						16
17	IL unit# 106	2018	12,794						17
18	Pool Dehumidifier	2018	8,487						18
19	WSHP 60HP motor	2018	8,655						19
20	Il unit# 430	2018	8,806						20
21	ERV1/Commons Damper Installation	2018	4,003						21
22	Main Kitchen Air Flow Improvement	2018	6,844						22
23	IL unit# 321	2018	10,638						23
24	IL unit# 333	2018	8,713						24
25	4" Pipe replacement	2018	54,605						25
26	Balcony Repair	2018	7,842						26
27	IL unit# 304	2018	8,721						27
28	IL unit# 320	2018	11,680						28
29	Main Kitchen Heating Expansion	2018	4,140						29
30	WSHP replacement units	2018	43,206						30
31	IL unit# 219	2018	9,851						31
32	IL unit# 129	2018	10,745						32
33	IL unit# 432	2018	9,920						33
34	TOTAL (lines 1 thru 33)		$ 30,946,424	$ 876,611		$ 876,611	$	$ 10,540,776	34

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

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 12C, Carried Forward		$ 30,946,424	$ 876,611		$ 876,611	$	$ 10,540,776	1
2	ERV1 Compressor Replacement	2018	8,092						2
3	IL unit# 316	2018	605						3
4	IL unit 324	2018	2,434						4
5	IL unit#011	2018	9,308						5
6	Il unit#111	2018	2,205						6
7	ERV1 Compressor Replacement	2018	8,589						7
8	IL unit# 320	2018	260						8
9	IL unit#335	2018	11,177						9
10	Cottage #9	2018	7,568						10
11	801 Roof Repair	2018	16,770						11
12	ERV1 Controller Replacement	2018	19,750						12
13	IL unit# 210	2018	3,508						13
14	IL unit# 008	2018	9,342						14
15									15
16									16
17	Financial Statement Depreciation			395,144		395,144		2,015,206	17
18	Less: AL/IL		(25,908,794)	(1,059,495)		(1,059,495)		(10,385,367)	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,137,237	$ 212,260		$ 212,260	$	$ 2,170,615	34

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

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	$ 3,122,781	$ 337,486	$ 337,486	$		$ 2,716,305	71
72	Current Year Purchases	68,019	4,906	4,906			4,906	72
73	Fully Depreciated Assets	1,494,192					1,494,192	73
74	Less AL/IL	(3,903,051)	(285,246)	(285,246)			(3,511,838)	74
75	TOTALS	$ 781,941	$ 57,146	$ 57,146	$		$ 703,565	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	$	$	$		$ 69,631	76
77										77
78										78
79										79
80	TOTALS			$ 69,631	$	$	$		$ 69,631	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)	$ 5,988,809	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 269,406	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 269,406	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,943,811	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	$ 25,908,794	$ 1,059,495	$ 10,385,367	86
87	Non-Allowable (AL & IL) Equipment	3,903,051	285,246	3,511,838	87
88	Non-Allowable (AL & IL) Vehicles	187,631	20,475	60,611	88
89					89
90					90
91	TOTALS	$ 29,999,476	$ 1,365,216	$ 13,957,816	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 Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 1,569 Description: Portable Oxygen tanks, Beds, Bi-pap, C-pap, Mattresses, 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 Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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.

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	$	26,566	$ 433,909	$	26,566	$ 433,909	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		5,092	209,488		5,092	209,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		31,146	499,800		31,146	499,800	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			435,461			435,461	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-3				65,359			65,359	12
13	Other (specify):									13
14	TOTAL			$	62,804	$ 1,644,017	$	62,804	$ 1,644,017	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 Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2018 (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	$ 2,522,891	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 323,488)	2,019,737		3
4	Supply Inventory (priced at)	48,059		4
5	Short-Term Investments			5
6	Prepaid Insurance	164,700		6
7	Other Prepaid Expenses	1,349,231		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,104,618	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	31,099,389		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,942,254		16
17	Accumulated Depreciation (book methods)	(18,797,858)		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 (spe **Deferred Rent Asset**	440,000		22
23	Other(specify): See supplemental schedule	8,141,029		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,824,814	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 31,929,432	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 461,290	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,493		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	281,331		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current Portion of Bonds Payable	670,000		36
37	Other Accrued Expenses	330,092		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,971,206	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	84,908,876		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	45,298,492		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 130,207,368	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 132,178,574	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (100,249,142)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 31,929,432	$	48

***(See instructions.)**

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (97,135,114)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (97,135,114)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,115,733)	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) **Re-class of net assets from audit**	1,705	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (3,114,028)	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)**	$ (100,249,142)	24 *

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

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	$ 8,802,346	1
2	Discounts and Allowances for all Levels	(2,889,608)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,912,738	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,869,212	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,869,212	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	7,940	13
14	Non-Patient Meals	29,146	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	423,885	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,206	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 487,177	23
	D. Non-Operating Revenue		
24	Contributions	7,283	24
25	Interest and Other Investment Income***	33,723	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,006	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**IL Revenue**	8,278,780	28
28a	**Other Revenue**	47,689	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,326,469	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,636,602	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,884,420	31
32	Health Care	6,444,501	32
33	General Administration	4,287,194	33
	B. Capital Expense		
34	Ownership	5,415,923	34
	C. Ancillary Expense		
35	Special Cost Centers	560,125	35
36	Provider Participation Fee	160,172	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,752,335	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,115,733)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,115,733)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,103,080	44
45	Private Pay - Net Inpatient Revenue	3,074,611	45
46	Medicare - Net Inpatient Revenue	1,619,789	46
47	Other-(specify) **Managed Care**	115,258	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,912,738	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	2,072	2,072	$ 104,113	$ 50.25	1
2	Assistant Director of Nursing	1,992	1,992	72,524	36.41	2
3	Registered Nurses	30,033	30,033	1,041,187	34.67	3
4	Licensed Practical Nurses	33,161	33,161	969,684	29.24	4
5	CNAs & Orderlies	100,338	100,338	1,466,486	14.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,154	2,154	47,673	22.13	9
10	Activity Assistants	17,138	17,138	312,428	18.23	10
11	Social Service Workers	4,198	4,198	108,731	25.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	71,307	71,307	1,059,204	14.85	15
16	Dishwashers	10,082	10,082	110,598	10.97	16
17	Maintenance Workers	22,367	22,367	451,826	20.20	17
18	Housekeepers	42,172	42,172	527,181	12.50	18
19	Laundry	2,107	2,107	25,260	11.99	19
20	Administrator	2,080	2,080	118,500	56.97	20
21	Assistant Administrator					21
22	Other Administrative	15,817	15,817	819,878	51.84	22
23	Office Manager					23
24	Clerical	29,668	29,668	602,255	20.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,796	1,796	43,151	24.03	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,639	5,639	102,212	18.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	394,121	394,121	$ 7,982,891 *	$ 20.25	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	151	34,000	10-3	36
37	Medical Records Consultant	19	1,235	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	106	6,891	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	16	1,040	10-3	44
45	Social Service Consultant	18	1,260	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	310	$ 44,426		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	71	$ 4,024	10-3	50
51	Licensed Practical Nurses	115	6,736	10-3	51
52	Certified Nurse Assistants/Aides	621	16,764	10-3	52
53	TOTAL (lines 50 - 52)	807	$ 27,524		53

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tiffany Barton	Administrator		$ 119,876
Elizabeth Welch	Executive Director		218,773
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 338,649

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
CLA	Accounting	$ 40,812
Polsinelli	Legal	50,770
Neal, Gerber & Eisenberg	Legal	1,488
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 93,070

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 261,660
Unemployment Compensation Insurance	40,273
FICA Taxes	576,394
Employee Health Insurance	698,342
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	57,736
Employee Retention	9,088
Less: Non-Allowable Benefits	(619,926)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,023,567

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	32,318
Health Care Worker Background Check	
(Indicate # of checks performed 95)	9,298
Patient Background Checks 344	3,440
IDPH License Fee (AL)	2,660
Dues and Subscriptions	29,434
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 77,150

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,099
Meals	14,825
Seminar Expense	23,462
Less: Non-Allowable Travel	(20,287)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,099

**See instructions.

Vendor Code	Vendor Name	State	Invoice Number	Invoice Date	Posting Period	Invoice Amount	Description
996	Polsinelli PC, File No. 062012-	IL	1423494	7/12/2017	7/31/2017	440	Employment legal matters
996	Polsinelli PC, File No. 062012-	IL	1432214	8/3/2017	8/31/2017	3,651	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1435854	8/10/2017	8/31/2017	3,188	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1435855	8/10/2017	8/31/2017	7,315	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1444994	9/8/2017	9/30/2017	866	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1445297	9/9/2017	9/30/2017	2,185	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1445298	9/9/2017	9/30/2017	638	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1468534	11/17/2017	11/30/2017	220	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1468535	11/17/2017	11/30/2017	727	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1469353	11/21/2017	11/30/2017	3,975	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1474918	12/11/2017	12/31/2017	264	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1474919	12/11/2017	12/31/2017	599	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1474920	12/11/2017	12/31/2017	252	Employment legal matters
996	Polsinelli PC, File No. 062012-	IL	1474918	12/11/2017	12/31/2017	83	SNF legal matters
996	Polsinelli PC, File No. 062012-	IL	1474919	12/11/2017	12/31/2017	220	SNF legal matters
996	Polsinelli PC, File No. 062012-	IL	1488321	1/19/2018	1/31/2018	55	SNF legal matters
996	Polsinelli PC, File No. 062012-	IL	1478478	12/18/2017	2/28/2018	1,805	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1478479	12/18/2017	2/28/2018	6,300	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1494811	2/13/2018	2/28/2018	1,344	Employment legal matters
996	Polsinelli PC, File No. 062012-	IL	1504964	3/12/2018	4/30/2018	210	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1514646	4/10/2018	4/30/2018	605	Employment legal matters
996	Polsinelli PC, File No. 062012-	IL	1504963	3/12/2018	4/30/2018	825	SNF legal matters
996	Polsinelli PC, File No. 062012-	IL	1514645	4/10/2018	4/30/2018	2,157	SNF legal matters
996	Polsinelli PC, File No. 062012-	IL	1523231	5/8/2018	5/31/2018	2,043	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1523232	5/8/2018	5/31/2018	2,738	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1524826	5/9/2018	5/31/2018	1,416	SNF legal matters
3401	Neal, Gerber & Eisenberg LLP,	IL	360434	6/22/2018	6/30/2018	1,488	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1539643	6/19/2018	6/30/2018	4,035	SNF legal matters
996	Polsinelli PC, File No. 062012-	IL	1535717	6/12/2018	6/30/2018	1,575	General professional matters
996	Polsinelli PC, File No. 062012-	IL	1535718	6/12/2018	6/30/2018	1,045	General professional matters
						52,258	

Facility Name & ID Number Assisi Health Care Center # 0047613 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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. **Leading Age - $19,618**

(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. $ **49,930** 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. $ **160,172**
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. $ **29,145**

(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? **No**
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 LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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