		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0047613

Facility Name: Assisi Health CC Clare Oaks

Address: 829 Carillon Dr (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
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: Agnes Ulanicki **Telephone Number:** 630-483-5593
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 07/01/2019 to 06/30/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Gigi Walker
(Title) CEO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Deb Emerson, 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 Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,221	10,306	11,310	24,837	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,221	10,306	11,310	24,837	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.55%

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)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

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 06/02/2008 NO [ ]

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 11,310

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2020 Fiscal Year: 06/30/2020

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

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	1,138,535	76,532	89,805	1,304,872		1,304,872	(726,412)	578,460			1
2	Food Purchase		670,172		670,172		670,172	(368,744)	301,428			2
3	Housekeeping	535,394	53,326	11,985	600,705		600,705	(501,197)	99,508			3
4	Laundry											4
5	Heat and Other Utilities			880,641	880,641		880,641	(680,566)	200,075			5
6	Maintenance	458,727	43,852	518,360	1,020,939		1,020,939	(906,014)	114,925			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,132,656	843,882	1,500,791	4,477,329		4,477,329	(3,182,933)	1,294,396			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,948,922	206,157	741,292	4,896,371		4,896,371	(615,424)	4,280,947			10
10a	Therapy			1,190,894	1,190,894		1,190,894		1,190,894			10a
11	Activities	276,533	8,562	56,259	341,354		341,354	(160,985)	180,369			11
12	Social Services	253,818		11,830	265,648		265,648		265,648			12
13	CNA Training											13
14	Program Transportation	671		495	1,166		1,166		1,166			14
15	Other (specify):* COVID-19 Costs			150,158	150,158		150,158		150,158			15
16	**TOTAL Health Care and Programs**	4,479,944	214,719	2,150,928	6,845,591		6,845,591	(776,409)	6,069,182			16
	C. General Administration											
17	Administrative	107,083			107,083		107,083	(78,526)	28,557			17
18	Directors Fees											18
19	Professional Services			2,666,940	2,666,940		2,666,940		2,666,940			19
20	Dues, Fees, Subscriptions & Promotions			94,350	94,350		94,350		94,350			20
21	Clerical & General Office Expenses	775,068	7,496	983,984	1,766,548		1,766,548	(1,766,548)				21
22	Employee Benefits & Payroll Taxes			1,423,740	1,423,740		1,423,740	(549,564)	874,176			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,739	15,739		15,739	(8,800)	6,939			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			706,575	706,575		706,575	(589,530)	117,045			26
27	Other (specify):* Marketing	162,619	263	305,335	468,217		468,217	(468,217)				27
28	**TOTAL General Administration**	1,044,770	7,759	6,196,663	7,249,192		7,249,192	(3,461,185)	3,788,007			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,657,370	1,066,360	9,848,382	18,572,112		18,572,112	(7,420,527)	11,151,585			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 CC Clare Oaks #0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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			1,411,382	1,411,382		1,411,382	(1,173,979)	237,403			30
31	Amortization of Pre-Op. & Org.			396,408	396,408		396,408	(330,742)	65,666			31
32	Interest			3,095,963	3,095,963		3,095,963	(2,582,962)	513,001			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			57,343	57,343		57,343	(47,844)	9,499			35
36	Other (specify):*											36
37	**TOTAL Ownership**			5,214,432	5,214,432		5,214,432	(4,346,897)	867,535			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			501,768	501,768		501,768		501,768			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			144,488	144,488		144,488		144,488			42
43	Other (specify):* **Retirement Center**	65,091		(2,590)	62,501		62,501	(62,501)				43
44	**TOTAL Special Cost Centers**	65,091		643,666	708,757		708,757	(62,501)	646,256			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,722,461	1,066,360	15,706,480	24,495,301		24,495,301	(11,829,925)	12,665,376			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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	(10,525)	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				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	(2,582,962)	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	(2,154)	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	(468,217)	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 PG5A	(8,766,067)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,829,925)		$	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))**	$ (11,829,925)		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 CC Clare Oaks

ID# 0047613

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable (AL & IL) Dietary	$ (715,887)	1	1
2	Non-Allowable (AL & IL) Food	(367,674)	2	2
3	Non-Allowable (AL & IL) Housekeeping	(501,197)	3	3
4	Non-Allowable (AL & IL) Utilities	(680,566)	5	4
5	Non-Allowable (AL & IL) Maintenance	(851,819)	6	5
6	Non-Allowable (AL & IL) Nursing	(615,424)	10	6
7	Non-Allowable (AL & IL) Administrative	(78,526)	17	7
8	Non-Allowable (AL & IL) Clerical and Office	(1,295,445)	21	8
9	Non-Allowable (AL & IL) Benefits & Payroll Taxes	(549,564)	22	9
10	Non-Allowable (AL & IL) Property/Liability Insurance	(589,530)	26	10
11	Non-Allowable (AL & IL) Depreciation	(1,173,979)	30	11
12	Non-Allowable (AL & IL) Amortization	(330,742)	31	12
13	Non-Allowable (AL & IL) Expenses	(62,501)	43	13
14	Non-Allowable (AL & IL) Travel and Seminar	(8,800)	24	14
15	Non-Allowable (AL & IL) Trash Removal Expense	(54,195)	6	15
16	Non-Allowable Food	(1,070)	2	16
17	Non-Allowable (AL & IL) Ground Lease Expense	(211,370)	34	17
18	Non-Allowable (AL & IL) Equipment Rental	(47,844)	35	18
19	Guest Accomodations	(6,448)	21	19
20	Misc Revenue	(462,501)	21	20
21	Transportation Revenue	0	14	21
22	Non-Allowable (Al & IL) Resident Services	(160,985)	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**	(8,766,067)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	(726,412)	0	0	0	0	0	0	0	0	0	0	(726,412)	1
2	Food Purchase	(368,744)	0	0	0	0	0	0	0	0	0	0	(368,744)	2
3	Housekeeping	(501,197)	0	0	0	0	0	0	0	0	0	0	(501,197)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(680,566)	0	0	0	0	0	0	0	0	0	0	(680,566)	5
6	Maintenance	(906,014)	0	0	0	0	0	0	0	0	0	0	(906,014)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,182,933)	0	0	0	0	0	0	0	0	0	0	(3,182,933)	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	(615,424)	0	0	0	0	0	0	0	0	0	0	(615,424)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(160,985)	0	0	0	0	0	0	0	0	0	0	(160,985)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(776,409)	0	0	0	0	0	0	0	0	0	0	(776,409)	16
	C. General Administration													
17	Administrative	(78,526)	0	0	0	0	0	0	0	0	0	0	(78,526)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,766,548)	0	0	0	0	0	0	0	0	0	0	(1,766,548)	21
22	Employee Benefits & Payroll Taxes	(549,564)	0	0	0	0	0	0	0	0	0	0	(549,564)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,800)	0	0	0	0	0	0	0	0	0	0	(8,800)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(589,530)	0	0	0	0	0	0	0	0	0	0	(589,530)	26
27	Other (specify):*	(468,217)	0	0	0	0	0	0	0	0	0	0	(468,217)	27
28	TOTAL General Administration	(3,461,185)	0	0	0	0	0	0	0	0	0	0	(3,461,185)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,420,527)	0	0	0	0	0	0	0	0	0	0	(7,420,527)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Assisi Health CC Clare Oaks **#** 0047613 **Report Period Beginning:** 07/01/2019 **Ending:** 06/30/2020

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	(1,173,979)	0	0	0	0	0	0	0	0	0	0	(1,173,979)	30
31	Amortization of Pre-Op. & Org.	(330,742)	0	0	0	0	0	0	0	0	0	0	(330,742)	31
32	Interest	(2,582,962)	0	0	0	0	0	0	0	0	0	0	(2,582,962)	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	(47,844)	0	0	0	0	0	0	0	0	0	0	(47,844)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,346,897)	0	0	0	0	0	0	0	0	0	0	(4,346,897)	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):*	(62,501)	0	0	0	0	0	0	0	0	0	0	(62,501)	43
44	**TOTAL Special Cost Centers**	(62,501)	0	0	0	0	0	0	0	0	0	0	(62,501)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,829,925)	0	0	0	0	0	0	0	0	0	0	(11,829,925)	45

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	BOD						1
2	Paul Clemens	BOD						2
3	Michael D. Hovde, Jr.	BOD						3
4	Aaron H. Reinke	BOD						4
5	Kathy Meisinger	BOD						5
6	Gerrianne M. Hartmann	BOD						6
7	Maureen Taus	BOD						7
8	Valerie Salmons	BOD						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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.	VP/Secretary	Class A Member								3
4	Aaron H. Reinke	Board Member	Class A Member								4
5	Kathy Meisinger	Board Member	Class A Member								5
6	Gerrianne M. Hartmann	Board Member	Class B Member								6
7	Maureen Taus	Board Member	Class B Member								7
8	Valerie Salmons	Board Member	Class B Member								8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 6/30/2020

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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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 2012A Bonds		X	Refinancing		12/1/2012	$ 12,000,000	$ 8,615,000	11/15/2027		$ 2,202,694	1
2												2
3	Series 2012B Bonds		X	Refinancing		12/1/2012	39,991,094	39,991,094	11/15/2052			3
4	Series 2012C Bonds		X	Refinancing		12/1/2012	35,008,974	35,008,974	11/15/2052			4
5	Interest Accretion Series 2012										800,869	5
	Working Capital											
6	Bond Issuance Costs		X	Issuance Costs							92,400	6
7												7
8												8
9	TOTAL Facility Related						$ 87,000,068	$ 83,615,068			$ 3,095,963	9
	B. Non-Facility Related*											
10	Less: Non-allowable portion of above bonds										(2,582,962)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,582,962)	14
15	TOTALS (line 9+line14)						$ 87,000,068	$ 83,615,068			$ 513,001	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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Assisi Health CC 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 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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: 2/1/08 and 12/1/12

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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	$ 4,389,194	$	30	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2008 Fixed Assets			2008	311,495						9
10	2009 Fixed Assets			2009	9,309						10
11	2010 Fixed Assets			2010	45,645						11
12	2011 Fixed Assets			2011	4,394						12
13	2012 Fixed Assets			2012	79,793						13
14	2013 Fixed Assets			2013	6,944						14
15	2014 Fixed Assets			2014	83,948						15
16	2015 Fixed Assets			2015	20,005						16
17	Mech HVAC Improvements ($5,252)			2016	877						17
18	ERV#1 Improvement ($9,878)			2016	1,649						18
19	Site Drainage and Walkway improvements ($28,189)			2016	4,705						19
20	Drainage Improvement ($8,500)			2016	1,419						20
21	Rewire walk in kitchen cooler ($4,070)			2016	679						21
22	Concrete walkway/drainage improvements ($138,467)			2016	23,110						22
23	ERV #3 & 6 ($5,930)			2016	990						23
24	ERV4 Improvements ($3,324)			2016	555						24
25	SARA Monitoring System ($111,882)			2016	18,673						25
26	Pool Dehumidifier ($19,043)			2016	3,178						26
27	ERV 3 & 4 ($5,721)			2016	955						27
28	Balcony and Siding Improvements ($5,027)			2016	839						28
29	Drain Tile System installation ($8,440)			2016	1,409						29
30	Swimming Pool Improvements ($5,294)			2016	884						30
31	ERV4 Compressor ($9,510)			2017	1,587						31
32	Fencing repalcement generator and compactor ($14,221)			2017	2,373						32
33	Seal Coating and Striping ($37,963)			2016	6,336						33
34	Concrete ramp and curb cut ($3100)			2017	517						34
35	Walking Path Improvements ($4,460)			2017	744						35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	Emergency Panel Exp ($8,705)	2018	$ 1,453	$		$	$	$	37
38	ERV1 Compressor Replacement ($9,809)	2018	1,637						38
39	Expanding Security Cameras ($3,177)	2018	530						39
40	Main Kitchen Exhaust Fan ($4,763)	2018	795						40
41	ERV 4 Stage 1 Compressor ($5,573)	2018	930						41
42	ERV2 Main Control Board ($2,748)	2018	459						42
43	Generator Improvement ($2,746)	2018	458						43
44	Pool Dehumidifier ($8,487)	2018	1,416						44
45	WSHP 60HP motor ($8,655)	2018	1,445						45
46	ERV1/Commons Damper Installation ($4,003)	2018	668						46
47	Main Kitchen Air Flow Improvement ($6,844)	2018	1,142						47
48	4" Pipe replacement ($54,605)	2018	9,114						48
49	Balcony Repair ($7,842)	2018	1,309						49
50	Main Kitchen Heating Expansion ($4,140)	2018	691						50
51	WSHP replacement units ($43,206)	2018	7,211						51
52	ERV1 Compressor Replacement ($8,092)	2018	1,351						52
53	ERV1 Compressor Replacement ($8,589)	2018	1,434						53
54	ERV1 Controller Replacement ($19,750)	2018	3,296						54
55	ERV 3 Evaporator Coil Replacement ($8,360)	2019	1,395						55
56	WSHP Loop Filtration System ($22,847)	2019	3,813						56
57	HVAC systems - additional heat pressure whole building ($91,809	2019	15,323						57
58	HC Renovation - 2nd & 3rd Floor Rooms/Hallways Paint/Repairs	2019	36,080						58
59	WSHP Replacement Unit Purchase - 13 heat pumps ($18,015)	2019	3,007						59
60	ERV 3 Controller/Exhaust Fan Motor in HC	2019	19,331						60
61	Fire Pump Controller Panel Replace ($8,152)	2019	1,361						61
62	HC Flooring Replacement - 2nd & 3rd floors	2019	243,990						62
63	ERV1 Compressor Replacement ($9,313)	2019	1,554						63
64	Major Plumbing & Mechanical System ($1,531,319)	2019	255,577						64
65	ERV5 Compressor Replacement	2020	5,541						65
66	Cooling Tower Pump Valves #2 & #3 ($11,894)	2020	1,985						66
67	Campus Brick Replacement ($32,987)	2020	5,506						67
68	Automatic Transfer Switch ($20,945))	2020	3,496						68
69	Domestic Water Pump For Campus ($5,988)	2020	999						69
70	TOTAL (lines 4 thru 69)		$ 5,656,502	$		$	$	$	70

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

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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		$ 5,656,502	$		$	$	$	1
2	New Server Sara System - full building ($12,177)	2020	2,032						2
3	Major Mechanical Systems Building Heat Work ($15,561)	2020	2,597						3
4	Heat Pumps Replacement HC/IL ($17,551)	2020	2,929						4
5	WSHP replacement units HC/IL ($8,898)	2020	1,485						5
6	Generator Improvements ($13,223)	2020	2,207						6
7	Cooling Tower Improvements ($11,779)	2020	1,966						7
8	Electrical Improvements/Upgrades - full building ($4,753)	2020	793						8
9	Hot Water Heating Project - full building ($766,451)	2020	127,921						9
10									10
11									11
12	Financial Statement Depreciation			221,581		221,581		2,462,420	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,798,432	$ 221,581		$ 221,581	$	$ 2,462,420	34

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

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	$ 711,089	$ 73,354	$ 73,354	$	various	$ 430,687	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	3,990,726					3,990,726	73
74		(3,917,082)	(61,111)	(61,111)			(3,683,479)	74
75	TOTALS	$ 784,733	$ 12,243	$ 12,243	$		$ 737,934	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	Dodge Grand Caravan	2016	$ 35,793	$ 3,579	$ 3,579	$	10	$ 15,809	76
77										77
78										78
79										79
80	TOTALS			$ 35,793	$ 3,579	$ 3,579	$		$ 15,809	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)	$ 6,618,958	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 237,403	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 237,403	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)	$ 3,216,163	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-Care Assets Building	$ 28,449,474	$ 1,095,986	$ 12,675,754	86
87	Non-Care Assets Equipment	3,917,082	61,111	3,683,479	87
88	Non-Care Assets Vehicles	221,469	16,882	155,355	88
89					89
90					90
91	TOTALS	$ 32,588,025	$ 1,173,979	$ 16,514,588	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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 57,343 Description: Beds, mattresses, chair recliners, Leg Pump, Portable Oxygen tanks, Floor mats, 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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	$	9,122	$ 514,359	$	9,122	$ 514,359	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,573	86,545		1,573	86,545	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		13,918	589,990		13,918	589,990	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				446,885		446,885	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3					30,289		30,289	12
13	Other (specify): X-Ray	39-3					24,594		24,594	13
14	TOTAL			$	24,613	$ 1,190,894	$ 501,768	24,613	$ 1,692,662	14

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

STATE OF ILLINOIS

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2020 (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	$ 3,623,916	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 304,893)	1,535,490		3
4	Supply Inventory (priced at cost)	58,138		4
5	Short-Term Investments			5
6	Prepaid Insurance	350,696		6
7	Other Prepaid Expenses	1,292,748		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,860,988	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	34,244,676		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,962,307		16
17	Accumulated Depreciation (book methods)	(21,611,932)		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	600,000		22
23	Other(specify): See Attached	401,374		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,596,425	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 25,457,413	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 959,680	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	280,400		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,473,715		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		670,000		36
37	Other Accrued Expenses	454,128		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,837,923	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	86,010,617		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	42,713,829		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 128,724,446	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 133,562,369	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (108,104,956)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 25,457,413	$	48

***(See instructions.)**

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (102,975,454)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(71,671)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (103,047,125)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,057,831)	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)**	$ (5,057,831)	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)**	$ (108,104,956)	24 *

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

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	$ 9,081,439	1
2	Discounts and Allowances for all Levels	(2,692,742)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,388,697	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,762,705	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,762,705	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	4,639	13
14	Non-Patient Meals	10,525	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	446,549	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,433	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 494,146	23
	D. Non-Operating Revenue		
24	Contributions	653,985	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 653,985	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**IL Revenue**	7,281,961	28
28a	**Other Revenue**	855,976	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,137,937	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,437,470	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,477,329	31
32	Health Care	6,845,591	32
33	General Administration	7,249,192	33
	B. Capital Expense		
34	Ownership	5,214,432	34
	C. Ancillary Expense		
35	Special Cost Centers	564,269	35
36	Provider Participation Fee	144,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 24,495,301	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,057,831)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,057,831)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 537,516	44
45	Private Pay - Net Inpatient Revenue	3,534,211	45
46	Medicare - Net Inpatient Revenue	2,160,776	46
47	Other-(specify) **Managed Care**	156,194	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,388,697	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 CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,154	$ 125,224	$ 58.14	1
2	Assistant Director of Nursing	2,914	3,246	125,088	38.54	2
3	Registered Nurses	24,816	33,926	1,100,910	32.45	3
4	Licensed Practical Nurses	27,037	38,776	1,082,388	27.91	4
5	CNAs & Orderlies	63,174	89,329	1,174,908	13.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,854	4,244	137,359	32.37	9
10	Activity Assistants	12,193	13,539	229,762	16.97	10
11	Social Service Workers	3,143	3,685	91,561	24.85	11
12	Dietician	1,952	2,089	65,521	31.36	12
13	Food Service Supervisor	1,210	1,331	55,386	41.62	13
14	Head Cook	752	760	22,243	29.27	14
15	Cook Helpers/Assistants	55,975	60,826	887,518	14.59	15
16	Dishwashers	8,049	8,833	107,104	12.12	16
17	Maintenance Workers	18,998	21,399	451,636	21.11	17
18	Housekeepers	31,029	36,196	538,581	14.88	18
19	Laundry					19
20	Administrator	2,184	2,272	131,986	58.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	192	444	8,946	20.15	23
24	Clerical	28,577	30,982	827,810	26.72	24
25	Vocational Instruction	7,083	7,789	289,954	37.23	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,863	2,086	69,062	33.11	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Resident Assistant	1,719	1,765	21,225	12.03	33
34	TOTAL (lines 1 - 33)	298,690	365,671	$ 7,544,173 *	$ 20.63	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	132	34,000	10-3	36
37	Medical Records Consultant	14	878	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	132	7,041	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,330	10-3	44
45	Social Service Consultant	12	830	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	310	$ 44,079		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,171	$ 132,782	10-3	50
51	Licensed Practical Nurses	1,085	53,735	10-3	51
52	Certified Nurse Assistants/Aides	4,751	145,375	10-3	52
53	TOTAL (lines 50 - 52)	8,007	$ 331,892		53

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Norm Gross	Administrator		$ 10,209
John Hurley	Administrator		96,874
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,083

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
CLA	Accounting	$ 11,622
Polsinelli PC	Legal	1,247,212
Perkins Coie	Legal	576,479
SOLIC Financial Advisors	Financial Advisor	573,510
Stretto	Other	233,122
Arch Consultants	Other	10,000
CRE Surveys	Other	14,995
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 2,666,940

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 195,176
Unemployment Compensation Insurance	46,471
FICA Taxes	557,788
Employee Health Insurance	536,412
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	49,931
Employee Retention	9,818
Life Insurance	28,144
Less: Non-Allowable Benefits	(549,564)
TOTAL (agree to Schedule V, line 22, col.8)	$ 874,176

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,640
Advertising: Employee Recruitment	37,177
Health Care Worker Background Check	
(Indicate # of checks performed 137)	16,016
Patient Background Checks 211	2,110
Dues and Subscriptions	32,407
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 94,350

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	187
Seminar Expense	15,552
Less: Non-Allowable Travel	(8,800)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,939

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Assisi Health CC Clare Oaks # 0047613 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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 & ILASN - $27,127**

(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?

(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. $ **32,404** 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. $ **144,488**
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. $ **10,525**

(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? **No**
Firm Name:

(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.