

Facility Name & ID Number Assisi HCC at Clare Oaks

0047613 Report Period Beginning: 7/1/12 Ending: 6/30/2013

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF	6,951	11,950	16,665	35,566	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,951	11,950	16,665	35,566	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.20%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Day Care for Assisted Living Residents

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 6/2/2008

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 120 and days of care provided 14,533

Medicare Intermediary National Government Services Inc

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name & ID Number

Assisi HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	1,055,268	57,240	122,395	1,234,903	658	1,235,561	(541,103)	694,458		1
2	Food Purchase		822,832		822,832		822,832	(362,684)	460,148		2
3	Housekeeping	471,596	54,456	142,406	668,458		668,458	(557,787)	110,671		3
4	Laundry										4
5	Heat and Other Utilities			825,547	825,547		825,547	(742,016)	83,531		5
6	Maintenance	355,013	40,639	568,877	964,529	1,869	966,398	(804,753)	161,645		6
7	Other (specify):*							(35,620)	(35,620)		7
8	TOTAL General Services	1,881,877	975,167	1,659,225	4,516,269	2,527	4,518,796	(3,043,963)	1,474,833		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	4,019,782	212,709	327,581	4,560,072	3,317	4,563,389	(487,008)	4,076,381		10
10a	Therapy			1,629,537	1,629,537		1,629,537		1,629,537		10a
11	Activities	404,179	29,091	52,493	485,763		485,763		485,763		11
12	Social Services	104,131		115	104,246	644	104,890		104,890		12
13	CNA Training										13
14	Program Transportation	28,780		33,382	62,162		62,162	(362)	61,800		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,556,872	241,800	2,043,108	6,841,780	3,961	6,845,741	(487,370)	6,358,371		16
	C. General Administration										
17	Administrative	265,138			265,138	5,689	270,827	(165,339)	105,488		17
18	Directors Fees										18
19	Professional Services			173,447	173,447		173,447		173,447		19
20	Dues, Fees, Subscriptions & Promotions			16,888	16,888		16,888		16,888		20
21	Clerical & General Office Expenses	564,074	13,569	4,183,792	4,761,435		4,761,435	(3,497,817)	1,263,618		21
22	Employee Benefits & Payroll Taxes			1,424,043	1,424,043		1,424,043	(498,700)	925,343		22
23	Inservice Training & Education										23
24	Travel and Seminar			42,438	42,438	(12,177)	30,261	(17,379)	12,882		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,956	3,956		3,956	(3,301)	655		26
27	Other (specify):* Marketing	189,004	8,182	628,182	825,368		825,368	(825,368)			27
28	TOTAL General Administration	1,018,216	21,751	6,472,746	7,512,713	(6,488)	7,506,225	(5,007,904)	2,498,321		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,456,965	1,238,718	10,175,079	18,870,762		18,870,762	(8,539,237)	10,331,525		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 HCC at Clare Oaks

#0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,377,570	1,377,570	1,377,570	(1,149,372)	228,198				30
31	Amortization of Pre-Op. & Org.			510,133	510,133	510,133	(425,629)	84,504				31
32	Interest			2,826,351	2,826,351	2,826,351	(2,358,664)	467,687				32
33	Real Estate Taxes			186,668	186,668	186,668		186,668				33
34	Rent-Facility & Grounds						(155,746)	(155,746)				34
35	Rent-Equipment & Vehicles			16,095	16,095	16,095	(13,429)	2,666				35
36	Other (specify):*											36
37	TOTAL Ownership			4,916,817	4,916,817	4,916,817	(4,102,840)	813,977				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			748,730	748,730	748,730		748,730				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			200,581	200,581	200,581		200,581				42
43	Other (specify):* AL/IL School	200,011		(2,526)	197,485	197,485	(197,485)					43
44	TOTAL Special Cost Centers	200,011		946,785	1,146,796	1,146,796	(197,485)	949,311				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,656,976	1,238,718	16,038,681	24,934,375	24,934,375	(12,839,562)	12,094,813				45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,419)	1		4
5	Telephone, TV & Radio in Resident Rooms	(88,842)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(503)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				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	(825,368)	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)	\$ (919,132)		\$	30

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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (919,132)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Assisi HCC at Clare Oaks

ID#	0047613
Report Period Beginning:	7/1/12
Ending:	6/30/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable (AL & IL) Dietary	\$ (536,684)	1	1
2	Non-Allowable (AL & IL) Food	(357,599)	2	2
3	Non-Allowable (AL & IL) Housekeeping	(557,727)	3	3
4	Non-Allowable (AL & IL) Utilities	(653,174)	5	4
5	Non-Allowable (AL & IL) Maintenance	(804,753)	6	5
6	Non-Allowable (AL & IL) Nursing	(487,008)	10	6
7	Non-Allowable (AL & IL) Administrative	(165,339)	17	7
8	Non-Allowable (AL & IL) Clerical and Office	(3,488,169)	21	8
9	Non-Allowable (AL & IL) Benefits & Payroll Taxes	(498,700)	22	9
10	Non-Allowable (AL & IL) Property/Liability Insurance	(3,301)	26	10
11	Non-Allowable (AL & IL) Depreciation	(1,149,372)	30	11
12	Non-Allowable (AL & IL) Amortization	(425,629)	31	12
13	Non-Allowable (AL & IL) Interest	(2,358,161)	32	13
14	Non-Allowable (AL & IL) Expenses	(197,485)	43	14
15	Non-Allowable (AL & IL) Travel and Seminar	(4,678)	24	15
16	Non-Allowable (AL & IL) Trash Removal Expense	(35,620)	7	16
17	Non-Allowable Food	(5,085)	2	17
18	Non-Allowable (AL & IL) Ground Lease Expense	(155,746)	34	18
19	Non-Allowable (AL & IL) Equipment Rental	(13,429)	35	19
20	Guest Accomodations	(8,914)	21	20
21	Laundry Services	(60)	3	21
22	Misc Revenue	(734)	21	22
23	Transporation Revenue	(362)	14	23
24	Non-Allowable Travel & Seminar Expense	(12,701)	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	(11,920,430)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Assisi HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(541,103)	0	0	0	0	0	0	0	0	0	0	(541,103)	1
2	Food Purchase	(362,684)	0	0	0	0	0	0	0	0	0	0	(362,684)	2
3	Housekeeping	(557,787)	0	0	0	0	0	0	0	0	0	0	(557,787)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(742,016)	0	0	0	0	0	0	0	0	0	0	(742,016)	5
6	Maintenance	(804,753)	0	0	0	0	0	0	0	0	0	0	(804,753)	6
7	Other (specify):*	(35,620)	0	0	0	0	0	0	0	0	0	0	(35,620)	7
8	TOTAL General Services	(3,043,963)	0	(3,043,963)	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	(487,008)	0	0	0	0	0	0	0	0	0	0	(487,008)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(362)	0	0	0	0	0	0	0	0	0	0	(362)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(487,370)	0	(487,370)	16									
	C. General Administration													
17	Administrative	(165,339)	0	0	0	0	0	0	0	0	0	0	(165,339)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(3,497,817)	0	0	0	0	0	0	0	0	0	0	(3,497,817)	21
22	Employee Benefits & Payroll Taxes	(498,700)	0	0	0	0	0	0	0	0	0	0	(498,700)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(17,379)	0	0	0	0	0	0	0	0	0	0	(17,379)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(3,301)	0	0	0	0	0	0	0	0	0	0	(3,301)	26
27	Other (specify):*	(825,368)	0	0	0	0	0	0	0	0	0	0	(825,368)	27
28	TOTAL General Administration	(5,007,904)	0	(5,007,904)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,539,237)	0	(8,539,237)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Assisi HCC at Clare Oaks# 0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(1,149,372)	0	0	0	0	0	0	0	0	0	0	(1,149,372)	30
31	Amortization of Pre-Op. & Org.	(425,629)	0	0	0	0	0	0	0	0	0	0	(425,629)	31
32	Interest	(2,358,664)	0	0	0	0	0	0	0	0	0	0	(2,358,664)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(155,746)	0	0	0	0	0	0	0	0	0	0	(155,746)	34
35	Rent-Equipment & Vehicles	(13,429)	0	0	0	0	0	0	0	0	0	0	(13,429)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,102,840)	0	0	0	0	0	0	0	0	0	0	(4,102,840)	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):*	(197,485)	0	0	0	0	0	0	0	0	0	0	(197,485)	43
44	TOTAL Special Cost Centers	(197,485)	0	0	0	0	0	0	0	0	0	0	(197,485)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(12,839,562)	0	0	0	0	0	0	0	0	0	0	(12,839,562)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	34	Ground Lease Expense	\$ 186,668	Sisters of St. Joseph	0.00%	\$ 186,668	\$	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		\$ 186,668			\$ 186,668	\$ *		14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	See attached listing of board of directors							\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		13

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

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

Facility Name & ID Number Assisi HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending: 7/30/2013

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

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	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Series 2006 Bonds		X	Construction & Equipment		7/19/2006	\$ 106,125,000	\$ 0		12/1/2012	Varies	\$ 1,536,529	1					
2		LOC and Bank Fees		X									0	2					
3		Series 2012 Bonds		X	Refinancing		12/1/2012	89,000,068	89,000,068		11/15/2052	Varies	1,289,822	3					
4		Notes Payable	X		Development & Construction		7/1/2006	3,100,000	0		12/1/2012	5.0000	0	4					
5														5					
		Working Capital																	
6		LifeCare Services	X		Operations		11/12/2010	200,000	0		12/31/2012	5.0000	0	6					
7		Sisters of St. Joseph	X		Operations		11/12/2010	200,000	0		12/31/2012	5.0000	0	7					
8														8					
9		TOTAL Facility Related						\$ 198,625,068	\$ 89,000,068				\$ 2,826,351	9					
		B. Non-Facility Related*																	
10		Less: Non-allowable portion of above bonds											(2,354,633)	10					
11														11					
12														12					
13														13					
14		TOTAL Non-Facility Related						\$	\$				(2,354,633)	14					
15		TOTALS (line 9+line14)						\$ 198,625,068	\$ 89,000,068				\$ 471,718	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 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 2013 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:	2008 _____	8	FOR BHF USE ONLY		
	2009 _____	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
	2010 _____	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2011 _____	11	15	LESS REFUND FROM LINE 6 \$	15
	2012 _____	12	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Assisi HCC at Clare Oaks COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047613

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 HCC at Clare Oaks

0047613 Report Period Beginning:

7/1/12 Ending:

6/30/2013

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? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Clare Oaks, Independent Living Facility (154 Apartments, 10 Cottages)

Clare Oaks, Assisted Living Facility (17 units)

Clare Oaks, Memory Support (16 units)

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

1. Total Amount Incurred: 8,537,561 2. Number of Years Over Which it is Being Amortized: Marketing 13 years/Financing 3
 3. Current Period Amortization: 510,133 4. Dates Incurred: 2/1/2008 & 12/1/2012

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Assisi HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120	2008	2008	\$ 26,298,344	\$ 219,153	40	\$ 219,153	\$	\$ 6,376,872	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	2008 Fixed Assets	2008		1,866,356	21,216	Various	21,216		637,006	9
10	2009 Fixed Assets	2009		55,774	513	Various	513		26,194	10
11	Maple Sugar #006 apt conversion	2010		1,754	-		-		1,754	11
12	Asbestos removal	2010		1,135	-		-		1,135	12
13	Requisition #35 pd 11/19/2010	2010		261,606	2,180		2,180		42,236	13
14	Asphalt repairs school parking lot	2010		2,000	100		100		1,333	14
15	drainage repair Cornerstone Partners 11/20/10	2010		5,764	288		288		3,266	15
16	drainage repairs Cornerstone Partners 11/23/10	2010		2,602	130		130		1,475	16
17	drainage repairs Cornerstone Partners 11/29/10	2010		378	19		19		215	17
18	Convert unit from Handicap to Std	2011		1,517	76		76		1,299	18
19	Labor for HVAC Repair	2011		1,600	40		40		293	19
20	New concrete sidewalks	2011		3,860	16		16		155	20
21										21
22	Gutters	2012		2,451	31		31		156	22
23	Drainage system improvement	2012		2,150	54		54		323	23
24	Boiler - De-aertor equipment - 1st draw	2012		28,000	140		140		1,260	24
25	New granite counter tops and sinks	2012		12,850	643		643		3,213	25
26	Refriderant supply lines improvements	2012		8,564	306		306		1,529	26
27	Apartment/Cottage upgrades - faucets, lighting	2012		1,667	83		83		389	27
28	WSHP water load system	2012		2,800	70		70		350	28
29	New appliances for cottage upgrade	2012		3,983	199		199		929	29
30	New pendant system	2012		73,164	3,658		3,658		15,852	30
31	New security camera system	2012		25,490	637		637		3,186	31
32	New grease trap for main kitchen	2012		24,500	1,225		1,225		5,717	32
33	Boiler - De-aertor equipment - 2nd draw	2012		52,135	261		261		1,477	33
34	Boiler - Steam boiler treatment and control system	2012		21,855	109		109		619	34
35	WSHP Replacement units	2012		20,580	515		515		2,230	35
36	4 compressors for WSHP units	2012		3,142	157		157		681	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 HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Boiler - Installation	2013	\$ 48,860	\$ 244		\$ 244		\$ 1,384	37
38	Apartment/Cottage upgrades - labor	2013	2,366	118		118		513	38
39	HVAC unit install	2013	1,094	55		55		237	39
40	Soft start drive controls for cooling tower	2013	4,795	240		240		1,039	40
41	Replacement interior doors in HC	2013	3,302	14		14		459	41
42	Replace compressor in unit 219	2013	3,083	154		154		617	42
43	Electrical line - new pendent	2013	1,018	51		51		204	43
44	Apartment/Cottage upgrades - Painting	2013	7,107	355		355		1,421	44
45	Apartment/Cottage upgrades - Additional lighting fixt.	2013	689	34		34		138	45
46	Refurbish unit 232	2013	1,548	77		77		310	46
47	Flooring upgrade - IL305	2013	1,952	49		49		179	47
48	Boiler - De-aertor equipment - 4th draw	2013	13,400	67		67		246	48
49	Boiler - De-aertor equipment - 3rd draw	2013	16,600	83		83		332	49
50	New laminate countertops for IL 232 & 131	2013	2,164	108		108		398	50
51	Boiler - De-aertor equipment - 5th and Final draw	2013	27,165	136		136		498	51
52	Upgrades to IL 310	2013	1,586	79		79		264	52
53	New push button systems for main entrance doors	2013	2,549	64		64		212	53
54	Boiler - RO system	2013	9,018	45		45		150	54
55	Fire safety doors for Clare Woods Academy	2013	10,896	272		272		999	55
56	Additon of a walkway to access pond	2013	3,850	8		8		331	56
57	Parking lot - sealcoating, restriping, repair cracks	2013	24,000	1,200		1,200		5,600	57
58	Asphalt sealing for bike path	2013	2,380	119		119		555	58
59	Speed bumps	2013	2,400	60		60		260	59
60	Sewer cover repair & assembly	2013	1,708	-		-		-	60
61									61
62									62
63	Outlets for generator in main phone room	2013	1,184	49		49		148	63
64	American Elm Cottage/Hickory Model upgrades	2013	72,035	3,602		3,602		9,675	64
65	Boiler Project - Deareator insulation	2013	1,050	9		9		23	65
66	Model Upgrades - New Appliances	2013	3,541	177		177		354	66
67	Model Upgrades - New Countertops	2013	3,150	158		158		315	67
68	Boiler - completion of chemical feed	2013	7,700	38		38		77	68
69	Replace unit disconnect	2013	3,565	178		178		238	69
70	TOTAL (lines 4 thru 69)		\$ 29,071,775	\$ 259,663		\$ 259,663		\$ 7,158,320	70

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

Facility Name & ID Number Assisi HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 29,071,775	\$ 259,663		\$ 259,663	\$	\$ 7,158,320	1
2	Discovery Room Upgrade Chairs/table Marketing	2013	4,247	106		106		142	2
3	Breakroom Upgrade bar stools/chairs	2013	11,583	290		290		386	3
4	Model Upgrades (residual) carpet/painting	2013	16,496	825		825		1,100	4
5	IL Hallway Project Prep/Paint/drywall building 827	2013	18,650	466		466		622	5
6									6
7	Reconciling Items Due to Bankruptcy			777,271		777,271		1,248,942	7
8	AL/IL Allocation		(24,262,062)	(866,255)		(866,255)		(6,996,666)	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,860,688	\$ 172,366		\$ 172,366	\$	\$ 1,412,845	34

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

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	\$ 401,668	\$ 44,630	\$ 44,630	\$	Various	\$ 422,656	71
72	Current Year Purchases	247,664	11,202	11,202		Various	33,773	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 649,332	\$ 55,832	\$ 55,832	\$		\$ 456,429	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	\$ 0	\$ 0	\$	5	\$ 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)	\$ 5,579,651	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 228,198	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 228,198	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)	\$ 1,938,905	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Allowable (AL & IL) Building	\$ 24,262,062	\$ 866,255	\$ 6,996,666	86
87	Non-Allowable (AL & IL) Equipment	3,241,132	278,686	2,278,261	87
88	Non-Allowable (AL & IL) Vehicles	66,734	4,431	36,187	88
89					89
90					90
91	TOTALS	\$ 27,569,928	\$ 1,149,372	\$ 9,311,114	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.

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Assisi HCC at Clare Oaks # 0047613 Report Period Beginning: 7/1/12 Ending: 6/30/2013
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	10,108	\$ 640,161	\$	10,108	\$ 640,161	1	
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,201	203,217		3,201	203,217	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A-3	hrs		11,948	786,159		11,948	786,159	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	25,257	\$ 1,629,537	\$	25,257	\$ 1,629,537	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 HCC at Clare Oaks# 0047613Report Period Beginning: 7/1/12

Ending:

6/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2013

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,106,072	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>539,574</u>)	2,400,272		3
4	Supply Inventory (priced at)	24,783		4
5	Short-Term Investments			5
6	Prepaid Insurance	60,787		6
7	Other Prepaid Expenses	1,535,898		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,127,812	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	29,122,749		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,026,829		16
17	Accumulated Depreciation (book methods)	(11,250,019)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See supplemental Schedule</u>	14,851,100		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 36,750,659	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 42,878,471	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,368,691	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	192,626		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	322,455		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	239,233		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,123,005	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	89,000,068		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Supplemental Schedule</u>	34,823,732		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 123,823,800	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 125,946,805	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (83,068,332)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 42,878,473	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (38,895,909)	1
2	Restatements (describe):		2
3	Impairment of Assets	(61,683,684)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (100,579,593)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	17,511,261	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)	\$ 17,511,261	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)	\$ (83,068,332)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Assisi HCC at Clare Oaks# 0047613Report Period Beginning: 7/1/12Ending: 6/30/2013

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,135,860	1
2	Discounts and Allowances for all Levels	(3,838,517)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,297,343	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,694,592	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,694,592	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	7,376	13
14	Non-Patient Meals	31,284	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	96,827	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 135,487	23
D. Non-Operating Revenue			
24	Contributions	8,640	24
25	Interest and Other Investment Income***	506	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,146	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	6,763,203	28
28a	See Supplemental Schedule	23,545,865	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,309,068	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 42,445,636	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	4,516,269	31
32	Health Care	6,841,780	32
33	General Administration	6,687,345	33
B. Capital Expense			
34	Ownership	4,916,817	34
C. Ancillary Expense			
35	Special Cost Centers	748,730	35
36	Provider Participation Fee	200,581	36
D. Other Expenses (specify):			
37	<u>Marketing</u>	1,022,853	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 24,934,375	40
41	Income before Income Taxes (line 30 minus line 40)**	17,511,261	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 17,511,261	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,710,020	44
45	Private Pay - Net Inpatient Revenue	3,150,836	45
46	Medicare - Net Inpatient Revenue	2,361,048	46
47	Other-(specify) <u>Managed Care</u>	13,036	47
48	Other-(specify) <u>Hospice</u>	62,403	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,297,343	49

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

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

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

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

Facility Name & ID Number Assisi HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,096	\$ 99,380	\$ 47.41	1
2	Assistant Director of Nursing	2,090	2,106	73,144	34.73	2
3	Registered Nurses	44,203	44,534	1,440,397	32.34	3
4	Licensed Practical Nurses	27,802	28,010	727,029	25.96	4
5	CNAs & Orderlies	102,894	103,664	1,387,591	13.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,233	2,250	72,987	32.44	9
10	Activity Assistants	12,895	12,991	165,951	12.77	10
11	Social Service Workers	3,904	3,933	89,921	22.86	11
12	Dietician					12
13	Food Service Supervisor	55,444	55,859	684,244	12.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,685	15,802	278,732	17.64	15
16	Dishwashers	10,837	10,918	104,225	9.55	16
17	Maintenance Workers	18,351	18,489	355,227	19.21	17
18	Housekeepers	44,501	44,834	474,114	10.57	18
19	Laundry					19
20	Administrator	4,262	4,294	265,097	61.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	29,782	30,005	688,554	22.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,095	31,835	15.20	31
32	Other Health Care(specify)	15,057	15,169	358,605	23.64	32
33	Other(specify) <u>Marketing</u>	14,662	14,772	352,183	23.84	33
34	TOTAL (lines 1 - 33)	408,762	411,821	\$ 7,649,216 *	\$ 18.57	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	474	\$ 23,713	10-3	35
36	Medical Director	176	63,000	10-3	36
37	Medical Records Consultant	24	1,560	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	240	7,020	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	15	1,275	10-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	929	\$ 96,568		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Assisi HCC at Clare Oaks

0047613

Report Period Beginning:

7/1/12

Ending:

6/30/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$6,610
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,907 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 200,581
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,419
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.