

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0047613</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Assissi Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2010</u> to <u>6/30/2011</u> 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.																							
Address: <u>829 Carrilon Drive</u> <u>Bartlett</u> <u>60103</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>630-372-1983</u> Fax # <u>630-289-8846</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Chad D. Kunze, CPA</u> <u>Principal</u></td></tr><tr><td>(Firm Name & Address) <u>LarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800</u></td></tr><tr><td>(Telephone) <u>314-925-4321</u> Fax # <u>314-925-4350</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Chad D. Kunze, CPA</u> <u>Principal</u>	(Firm Name & Address) <u>LarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800</u>	(Telephone) <u>314-925-4321</u> Fax # <u>314-925-4350</u>												
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	(Telephone) <u>314-925-4321</u> Fax # <u>314-925-4350</u>																								
Date of Initial License for Current Owners: <u>6/2/2008</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501c3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501c3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Gigi Walker</u> Telephone Number: <u>630-483-4730</u> Email Address: _____																									

Facility Name & ID Number	Assissi Health Care Center
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0047613 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

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 to 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?

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

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

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

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 18,292

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL	X	MODIFIED CASH*		CASH*	
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/2011 **Fiscal Year:** 6/30/2011

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

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,182	5,948	19,319	32,449	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,182	5,948	19,319	32,449	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.08%

Facility Name & ID Number Assissi Health Care Center # 0047613 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	1,052,688	40,876	91,901	1,185,465		1,185,465	(608,579)	576,886			1
2	Food Purchase		603,390		603,390		603,390	(313,235)	290,155			2
3	Housekeeping	379,413	40,551	157,775	577,739		577,739	(495,132)	82,607			3
4	Laundry											4
5	Heat and Other Utilities			741,457	741,457		741,457	(659,077)	82,380			5
6	Maintenance	326,953	37,983	410,592	775,528		775,528	(647,915)	127,613			6
7	Other (specify):* Trash Removal			28,288	28,288		28,288	(23,602)	4,686			7
8	TOTAL General Services	1,759,054	722,800	1,430,013	3,911,867		3,911,867	(2,747,540)	1,164,327			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,591,154	236,886	1,034,225	4,862,265		4,862,265	(427,728)	4,434,537			10
10a	Therapy			1,758,950	1,758,950		1,758,950		1,758,950			10a
11	Activities	157,292	8,851	53,887	220,030		220,030	(9,347)	210,683			11
12	Social Services	264,728		13,024	277,752		277,752	(2,934)	274,818			12
13	CNA Training											13
14	Program Transportation			73,204	73,204		73,204	(77)	73,127			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,013,174	245,737	2,933,290	7,192,201		7,192,201	(440,086)	6,752,115			16
	C. General Administration											
17	Administrative	253,874			253,874		253,874	(179,967)	73,907			17
18	Directors Fees											18
19	Professional Services			449,458	449,458		449,458		449,458			19
20	Dues, Fees, Subscriptions & Promotions			5,999	5,999		5,999		5,999			20
21	Clerical & General Office Expenses	471,551	13,665	1,387,601	1,872,817		1,872,817	(1,375,306)	497,511			21
22	Employee Benefits & Payroll Taxes			1,285,976	1,285,976		1,285,976	(450,349)	835,627			22
23	Inservice Training & Education											23
24	Travel and Seminar			47,352	47,352		47,352	(11,628)	35,724			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			7,438	7,438		7,438	(6,206)	1,232			26
27	Other (specify):* Marketing	175,348	6,561	487,485	669,394		669,394	(669,394)				27
28	TOTAL General Administration	900,773	20,226	3,671,309	4,592,308		4,592,308	(2,692,850)	1,899,458			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,673,001	988,763	8,034,612	15,696,376		15,696,376	(5,880,476)	9,815,900			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			3,838,095	3,838,095		3,838,095	(3,474,954)	363,141			30
31	Amortization of Pre-Op. & Org.			617,347	617,347		617,347	(515,082)	102,265			31
32	Interest			5,898,416	5,898,416		5,898,416	(4,921,333)	977,083			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			40,000	40,000		40,000	(33,374)	6,626			34
35	Rent-Equipment & Vehicles			49,568	49,568		49,568	(41,357)	8,211			35
36	Other (specify):*											36
37	TOTAL Ownership			10,443,426	10,443,426		10,443,426	(8,986,100)	1,457,326			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			958,042	958,042		958,042		958,042			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,500	49,500		49,500		49,500			42
43	Other (specify):* AL/IL & School	68,899		17,447	86,346		86,346	(86,346)				43
44	TOTAL Special Cost Centers	68,899		1,024,989	1,093,888		1,093,888	(86,346)	1,007,542			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,741,900	988,763	19,503,027	27,233,690		27,233,690	(14,952,922)	12,280,768			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.)

	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	(5,088)	3		4
5	Telephone, TV & Radio in Resident Rooms	(40,444)	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				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	(3,167)	21		18
19	Entertainment				19
20	Contributions	(150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(669,394)	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	(14,234,679)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,952,922)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (14,952,922)		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

Report Period Beginning:

Ending:

ID#

0047613

7/1/2010

6/30/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Non-Allowable (AL & IL) Dietary	\$ (608,579)	1	1
2	Non-Allowable (AL & IL) Food	(309,761)	2	2
3	Non-Allowable (AL & IL) Housekeeping	(482,036)	3	3
4	Non-Allowable (AL & IL) Utilities	(618,633)	5	4
5	Non-Allowable (AL & IL) Maintenance	(647,060)	6	5
6	Non-Allowable (AL & IL) Nursing	(427,728)	10	6
7	Non-Allowable (AL & IL) Administrative	(179,967)	17	7
8	Non-Allowable (AL & IL) Clerical and Office	(1,327,609)	21	8
9	Non-Allowable (AL & IL) Benefits & Payroll Taxes	(450,349)	22	9
10	Non-Allowable (AL & IL) Property/Liability Insurance	(6,206)	26	10
11	Non-Allowable (AL & IL) Depreciation	(3,474,954)	30	11
12	Non-Allowable (AL & IL) Amortization	(515,082)	31	12
13	Non-Allowable (AL & IL) Interest	(4,921,333)	32	13
14	Non-Allowable (AL & IL) Expenses	(86,346)	43	14
15	Non-Allowable (AL & IL) Travel and Seminar	(11,628)	24	15
16	Non-Allowable (AL & IL) Trash Removal Expense	(23,602)	7	16
17	Non-Allowable Food	(3,474)	2	17
18	Non-Allowable (AL & IL) Ground Lease Expense	(33,374)	34	18
19	Non-Allowable (AL & IL) Equipment Rental	(41,357)	35	19
20	Transportation Revenue	(77)	14	20
21	Resident Activities	(2,934)	12	21
22	Housekeeping	(5,023)	3	22
23	Guest Accomodations	(9,363)	21	23
24	Wellness Services	(9,347)	11	24
25	Laundry Service	(2,985)	3	25
26	Maintenance Income	(855)	6	26
27	Misc Revenue	(35,017)	21	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(14,234,679)		49

Summary A

6/30/2011

[illegible]

Summary B

6/30/2011

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest	\$ 155,000	Sisters of St. Joseph	0.00%	\$ 155,000	\$	1
2	V	34	Ground Lease Expense	40,000	Sisters of St. Joseph	0.00%	40,000		2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 195,000			\$ 195,000	\$ *	14

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

Facility Name & ID Number Assissi Health Care Center # 0047613 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Ending: 3/30/2011

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Series 2006 Bonds		X	Construction & Equipment		7/19/2006	\$ 109,125,000	\$ 95,390,490	Varies	Varies	\$ 4,955,310	1
2	LOC and Bank Fees		X								781,311	2
3												3
4	Note Payable	X		Development & Construction		7/1/2006	3,100,000	3,100,000	6/30/2021	5.0000	155,000	4
5												5
	Working Capital											
6	Life Care Services	X		Operations		11/12/2010	200,000	200,000	12/31/2012	5.0000	3,342	6
7	Sisters of St. Joseph	X		Operations		11/12/2010	200,000	200,000	12/31/2012	5.0000	3,453	7
8												8
9	TOTAL Facility Related						\$ 112,625,000	\$ 98,890,490			\$ 5,898,416	9
	B. Non-Facility Related*											
10	Less: Non-allowable portion of above bonds										(4,921,333)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (4,921,333)	14
15	TOTALS (line 9+line14)						\$ 112,625,000	\$ 98,890,490			\$ 977,083	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

[illegible]

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Assissi Health Care Center</u>	COUNTY	<u>Cook</u>
---------------	-----------------------------------	--------	-------------

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 2010 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 2010.

(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?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,088

B. General Construction Type: Exterior Brick and CompositeFrame Steel and ConcreteNumber 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: 10,593,318

2. Number of Years Over Which it is Being Amortized: Marketing - 13; Financing - 33

3. Current Period Amortization: 558,468

4. Dates Incurred: 2/1/2008

Nature of Costs: Deferred marketing costs and deferred financing 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 Assissi Health Care Center

0047613

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation		
4	120		2008	2008	\$ 8,529,283	\$ 213,232	40	\$ 213,232	\$	\$ 639,696	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Fall Prevention Gate Locks			2008	7,270	485	15	485		1,414	9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,536,553	\$ 213,717		\$ 213,717	\$	\$ 641,110	70

**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	\$1,322,109	\$135,283	\$135,283	\$	Various	\$402,544	71
72	Current Year Purchases	3,230	215	215		5	215	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,325,339	\$135,498	\$135,498	\$		\$402,759	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transportation of Residents	2008 Chevrolet Starcraft Van	2008	\$69,631	\$13,926	\$13,926	\$	5	\$39,206	76
77										77
78										78
79										79
80	TOTALS			\$69,631	\$13,926	\$13,926	\$		\$39,206	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$9,931,524	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$363,141	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$363,141	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,083,075	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Allowable (AL & IL) Building	\$85,157,279	\$2,990,107	\$8,721,256	86
87	Non-Allowable (AL & IL) Equipment	2,026,730	478,091	1,381,337	87
88	Non-Allowable (AL & IL) Vehicles	33,780	6,756	19,686	88
89					89
90					90
91	TOTALS	\$87,217,789	\$3,474,954	\$10,122,279	91

G. Construction-in-Progress

	Description	Cost	
92	GMP Construction Contract	\$798,573	92
93	Contingency Amount	272,871	93
94			94
95		\$1,071,444	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.

		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:
- *

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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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

☐

☐

Clare Oaks only hires certified CNAs.

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)	\$			

- (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.

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	

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	10,076	\$ 694,372	\$	10,076	\$ 694,372	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,340	240,555		3,340	240,555	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		11,830	824,023		11,830	824,023	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	25,247	\$ 1,758,950	\$	25,247	\$ 1,758,950	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,187,656	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 192,102)	2,113,274		3
4	Supply Inventory (priced at)	52,798		4
5	Short-Term Investments			5
6	Prepaid Insurance	70,533		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,424,261	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	198,400		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	93,693,833		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,455,480		16
17	Accumulated Depreciation (book methods)	(11,205,354)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	141,549		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attachment	16,492,698		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 102,776,606	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 107,200,867	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,353,748	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	235,862		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,811,999		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accured Paid Time Off	202,184		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,603,793	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	98,890,490		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attachment	34,461,682		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 133,352,172	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 136,955,965	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (29,755,098)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 107,200,867	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (27,857,969)	1
2	Restatements (describe):		2
3	2010 Audit Adjustments	4,248,889	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (23,609,080)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,146,018)	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)	\$ (6,146,018)	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)	\$ (29,755,098)	24 *

* This must agree with page 17, line 47.

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,506,181	1
2	Discounts and Allowances for all Levels	(1,576,520)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,929,661	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,559,113	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,559,113	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	7,373	13
14	Non-Patient Meals	5,088	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	105,603	19
20	Radiology and X-Ray		20
21	Other Medical Services	20	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 118,084	23
	D. Non-Operating Revenue		
24	Contributions	300,964	24
25	Interest and Other Investment Income***	1,373,949	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,674,913	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attachment	6,805,901	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,805,901	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,087,672	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,911,867	31
32	Health Care	7,192,201	32
33	General Administration	4,592,308	33
	B. Capital Expense		
34	Ownership	10,443,426	34
	C. Ancillary Expense		
35	Special Cost Centers	1,044,388	35
36	Provider Participation Fee	49,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 27,233,690	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,146,018)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,146,018)	43

* 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.

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	2,080	\$ 85,518	\$ 41.11	1
2	Assistant Director of Nursing	3,112	3,318	108,236	32.62	2
3	Registered Nurses	32,930	35,198	1,085,035	30.83	3
4	Licensed Practical Nurses	23,935	25,286	610,434	24.14	4
5	CNAs & Orderlies	97,245	103,306	1,316,562	12.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,274	2,378	66,343	27.90	9
10	Activity Assistants	4,722	5,132	90,949	17.72	10
11	Social Service Workers	12,326	13,475	264,728	19.65	11
12	Dietician	2,040	2,080	65,829	31.65	12
13	Food Service Supervisor	2,080	2,080	80,875	38.88	13
14	Head Cook	2,710	2,882	64,841	22.50	14
15	Cook Helpers/Assistants	70,387	75,329	841,143	11.17	15
16	Dishwashers					16
17	Maintenance Workers	14,924	16,212	326,953	20.17	17
18	Housekeepers	34,291	36,741	379,413	10.33	18
19	Laundry					19
20	Administrator	4,160	4,160	253,874	61.03	20
21	Assistant Administrator					21
22	Other Administrative	12,669	13,264	319,766	24.11	22
23	Office Manager	1,888	2,080	44,086	21.20	23
24	Clerical	8,027	8,474	107,699	12.71	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	4,079	4,363	83,357	19.11	31
32	Other Health Care: MDS Coordinator	11,087	11,848	302,012	25.49	32
33	Other(specify) Marketing/AL/IL/	5,736	6,341	244,247	38.52	33
34	TOTAL (lines 1 - 33)	352,702	376,027	\$ 6,741,900 *	\$ 17.93	34

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	213	\$ 10,643	1-3	35
36	Medical Director	96	30,000	10-1	36
37	Medical Records Consultant	30	1,950	10-3	37
38	Nurse Consultant	189	14,048	10-3	38
39	Pharmacist Consultant	240	7,020	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	768	\$ 63,661		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,345	\$ 347,100	10-3	50
51	Licensed Practical Nurses	3,234	136,883	10-3	51
52	Certified Nurse Assistants/Aides	7,257	158,736	10-3	52
53	TOTAL (lines 50 - 52)	16,835	\$ 642,719		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Michelle Hart-Carlson	Executive Director	0	\$ 106,935
Paula Bartolozzi	Executive Director	0	146,939
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 253,874
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
LarsonAllen LLP	Accounting	\$	98,765
Feigel	Public Relations		4,000
Laurie&Brennan LLP	Legal		32,341
Polsinelli Shughart	Legal		4,166
Ungaretti & Harris	Legal		235,652
Morrisroe & Associates	Legal		600
Gordon Arata McCollum Duplantis	Legal		5,070
Duane Morris	Legal		61,978
O'Hagan Spencer	Legal		6,107
Glankler Brown, PLLC	Legal		780
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 449,458
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	246,647
Unemployment Compensation Insurance			
FICA Taxes			521,654
Employee Health Insurance			250,748
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
FUTA/SUI Expense			162,043
Employee Claim Settlements			2,000
Employee Vaccinations/Hiring Expense			3,803
Employee Recruitment			62,598
Drug/Background Checks			30,068
Employee Retention			6,415
Less: Non-Allowable Benefits			(450,349)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 835,627
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			
Dues and Subscriptions			5,999
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 5,999
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			11,415
Seminar Expense			24,309
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	35,724

*** Attach copy of IMRF notifications**

****See instructions.**

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 - \$4,153
- (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.

\$

31,306

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.

\$

49,500

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.

\$

5,088
- (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?

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)

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.