FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0014290

Facility Name: The Clayberg

Address: East Monroe Street, P.O. Box 200 (Number) Cuba (City) 61427 (Zip Code)

County: Fulton

Telephone Number: (309) 785-5012 **Fax #** (309) 785-5376

HFS ID Number:

Date of Initial License for Current Owners: 7/6/69

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	x	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	x	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Martha Danielson **Telephone Number:** (309) 785-5012
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/09 to 11/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Martha Danielson
(Title) Administrator

Paid Preparer

(Signed) Compilation report is attached (Date)
(Print Name and Title) Helen Barrick, Partner
(Firm Name & Address) Clifton Gunderson, LLP, 301 SW Adams St., Ste. 900, P.O. Box 1835 Peoria, IL 61656-
(Telephone) (309) 671-4500 Fax # (309) 671-4508

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

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 49

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	10,767	4,335		15,102	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,767	4,335		15,102	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.44%

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)
none

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 7/6/69

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 11/30/10 Fiscal Year: 11/30/10

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

Facility Name & ID Number The Clayberg # 0014290 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,656	10,785	4,452	218,893		218,893		218,893			1
2	Food Purchase		92,633		92,633		92,633	(6,515)	86,118			2
3	Housekeeping	126,492	10,144		136,636		136,636		136,636			3
4	Laundry		9,435		9,435		9,435		9,435			4
5	Heat and Other Utilities			86,491	86,491		86,491	(2,608)	83,883			5
6	Maintenance	62,583	16,366	28,309	107,258		107,258		107,258			6
7	Other (specify):*											7
8	**TOTAL General Services**	392,731	139,363	119,252	651,346		651,346	(9,123)	642,223			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	931,874	62,616	5,329	999,819		999,819		999,819			10
10a	Therapy	53,964		6,550	60,514		60,514		60,514			10a
11	Activities	73,168	14,203	517	87,888		87,888		87,888			11
12	Social Services	34,438		518	34,956		34,956		34,956			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,093,444	76,819	12,914	1,183,177		1,183,177		1,183,177			16
	C. General Administration											
17	Administrative	70,258		2,695	72,953		72,953		72,953			17
18	Directors Fees											18
19	Professional Services			4,525	4,525		4,525		4,525			19
20	Dues, Fees, Subscriptions & Promotions			8,580	8,580		8,580	(5,826)	2,754			20
21	Clerical & General Office Expenses	52,004	30,281	2,988	85,273		85,273	5,830	91,103			21
22	Employee Benefits & Payroll Taxes			558,823	558,823		558,823		558,823			22
23	Inservice Training & Education			2,898	2,898		2,898		2,898			23
24	Travel and Seminar			2,042	2,042		2,042		2,042			24
25	Other Admin. Staff Transportation			1,146	1,146		1,146		1,146			25
26	Insurance-Prop.Liab.Malpractice			32,228	32,228		32,228		32,228			26
27	Other (specify):*											27
28	**TOTAL General Administration**	122,262	30,281	615,925	768,468		768,468	4	768,472			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,608,437	246,463	748,091	2,602,991		2,602,991	(9,119)	2,593,872			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 The Clayberg #0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,657	38,657		38,657		38,657			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,758	1,758		1,758		1,758			35
36	Other (specify):*											36
37	**TOTAL Ownership**			40,415	40,415		40,415		40,415			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,243		5,243		5,243		5,243			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,830	26,830		26,830		26,830			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		5,243	26,830	32,073		32,073		32,073			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,608,437	251,706	815,336	2,675,479		2,675,479	(9,119)	2,666,360			45

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	(6,515)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,608)	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				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	(5,826)	20		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)**	$ (14,949)		$	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)	5,830	SchVII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,830		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,119)		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		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

The Clayberg

ID# 0014290

Report Period Beginning: 12/1/09

Ending: 11/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	None	$		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
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**	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number The Clayberg **#** 0014290 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,515)	0	0	0	0	0	0	0	0	0	0	(6,515)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,608)	0	0	0	0	0	0	0	0	0	0	(2,608)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,123)	0	0	0	0	0	0	0	0	0	0	(9,123)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	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	(5,826)	0	0	0	0	0	0	0	0	0	0	(5,826)	20
21	Clerical & General Office Expenses	0	5,830	0	0	0	0	0	0	0	0	0	5,830	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,826)	5,830	0	0	0	0	0	0	0	0	0	4	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,949)	5,830	0	0	0	0	0	0	0	0	0	(9,119)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Clayberg # 0014290 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,949)	5,830	0	0	0	0	0	0	0	0	0	(9,119)	45

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Fulton County	100	None		Fulton County	Lewistown	County Gov't

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. [x] YES [ ] NO

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

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		21	Payroll	$	Fulton County	100.00%	$ 5,830	$ 5,830	1
2	V		22	Health Insurance	127,310	Fulton County	100.00%	127,310		2
3	V		22	IMRF	135,350	Fulton County	100.00%	135,350		3
4	V		22	FICA	123,046	Fulton County	100.00%	123,046		4
5	V		22	Workers' Comp Insurance	45,994	Fulton County	100.00%	45,994		5
6	V		22	Unemployment Insurance	3,042	Fulton County	100.00%	3,042		6
7	V		17	Committee Per Diem Expense	2,695	Fulton County	100.00%	2,695		7
8	V		26	Property & Liability Insurance	32,228	Fulton County	100.00%	32,228		8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 469,665			$ 475,495	$ * 5,830	14

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	None								$		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 The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	None						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	None											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number The Clayberg **#** 0014290 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ none	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.)		$ none	2
3. Under or (over) accrual (line 2 minus line 1).		$ none	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ none	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.)**		$ none	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.)**		$ none	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		$ none	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Clayberg COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0014290

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 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,920 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories one

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

none

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building Site	217,800	1969	$ 5,000	1
2					2
3	TOTALS	217,800		$ 5,000	3

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	49		1969		$ 271,336	$	40	$	$	$ 271,336	4
5			1978		8,009		20			8,009	5
6			1979		52,592		30			52,592	6
7											7
8											8
	Improvement Type**										
9	windows and plaster repair			1981	17,092		3 to 10			17,092	9
10	front porch and patio			1982	6,110		5 to 20			6,110	10
11	office remodeling			1983	3,272		5 to 10			3,272	11
12	roof			1984	2,005		10			2,005	12
13	canvas, floors, sewer, box, sign, door			1985	17,304	121	15 to 25	121		17,304	13
14	shutters			1986	1,591	16	15 to 25	16		1,590	14
15	shed, roof and flor tile			1987	17,275	50	15 to 25	50		17,188	15
16	heating and cooling system			1988	9,166		20			9,166	16
17	IDPA adjustment			1989	1,806	90	20	90		1,264	17
18	new shed			1990	8,284		15			8,284	18
19	new shed			1991	10,876		15			10,876	19
20	drain			1992	743		15			743	20
21	roof and greenhouse			1993	62,282		15			62,282	21
22	road repair			1994	13,496		5			13,496	22
23	storage building addition			1994	4,265	213	20	213		3,217	23
24	storage building addition			1996	12,141	607	20	607		8,887	24
25	laundry facility			1997	15,274	764	20	764		10,405	25
26	carpet, H/C system			2000	6,298	257	10 to 20	257		4,054	26
27	walk path			2001	4,177	278	15	278		2,552	27
28	walk path			2002	1,357	90	15	90		762	28
29	aviary			2002	4,740	316	15	316		2,660	29
30	flooring			2004	635	64	10	64		429	30
31	two A/C units			2004	4,583	458	10	458		2,903	31
32	floor tile			2005	289	12	25	12		68	32
33	electrical box			2005	141	6	25	6		33	33
34	seal parking lot			2005	1,260		4			1,260	34
35	two metal doors			2005	1,166	39	30	39		223	35
36	wall coverings			2005	697	35	5	35		697	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 The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	egress lights	2005	$ 423	$ 28	15	$ 28	$	$ 162	37
38	smoke detectors	2005	2,915	291	10	291		1,676	38
39	new corridor wall	2005	367	15	25	15		84	39
40	paint walls	2005	112		3			112	40
41	kitchen fire system	2005	2,877	82	35	82		459	41
42	sidewalk	2005	802	53	15	53		294	42
43	labor for bldg improvements	2005	5,904	393	15	393		2,165	43
44	heating and cooling units	2005	2,729	273	10	273		1,433	44
45	harbor in garden	2005	868	35	25	35		180	45
46	base board heaters	2006	278	19	15	19		91	46
47	wall board and glue	2006	168	34	5	34		163	47
48	floor tile	2006	640	26	25	26		122	48
49	East egress	2006	1,701	113	15	113		520	49
50	East egress soil	2006	390	13	30	13		60	50
51	door and frame	2006	614	20	30	20		94	51
52	water main	2006	9,291	232	40	232		1,007	52
53	water main walkway	2006	1,031	69	15	69		298	53
54	door locks	2006	474	31	15	31		131	54
55	labor for bldg improvements	2006	4,098	273	15	273		1,229	55
56	steel door	2007	630	21	30	21		75	56
57	sprinkler system/ceiling upgrade	2007	151,553	10,104	15	10,104		33,678	57
58	wiring/electrical outlets	2007	635	32	20	32		103	58
59	4 A/C units	2007	1,668	167	10	167		542	59
60	Sentricon Baiting system	2008	1,272	85	15	85		254	60
61	packaged unit and duct work	2008	6,105	407	15	407		848	61
62	Roof work	2008	28,174	1,878	15	1,878		3,756	62
63	generator repair	2009	2,170	145	15	145		169	63
64	Fire Protection - Sprinkler system	2009	25,825	1,722	15	1,722		1,722	64
65	Wallpaper	2010	6,294	315	15	315		315	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 820,270	$ 20,292		$ 20,292	$	$ 592,501	70

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 183,132	$ 17,306	$ 17,306	$	5 to 20	$ 106,791	71
72	Current Year Purchases	13,545	869	869		5 to 10	869	72
73	Fully Depreciated Assets	210,396	190	190		5 to 20	210,396	73
74								74
75	TOTALS	$ 407,073	$ 18,365	$ 18,365	$		$ 318,056	75

D. Vehicle Depreciation (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	patient transportation	2000 Chevy Bus	2000	$ 42,641	$	$	$	5	$ 42,641	76
77	pickup, delivery & plowing	2001 Ford Truck with Plow	2001	23,817				5	23,817	77
78										78
79										79
80	TOTALS			$ 66,458	$	$	$		$ 66,458	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)	$ 1,298,801	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,657	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,657	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)	$ 977,015	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 1,758 Description: copier 146.48/month
    (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 The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

No nurses aides were trained during this report period because the facility hired only aides who were already certified.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		36	6,550		36	6,550	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): Stock Drugs	39-2					5,243		5,243	12
13	Other (specify):									13
14	TOTAL			$	36	$ 6,550	$ 5,243	36	$ 11,793	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 The Clayberg **#** 0014290 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/10 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 684,349	$	1
2	Cash-Patient Deposits	3,319		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	27,275		3
4	Supply Inventory (priced at Cost)	3,818		4
5	Short-Term Investments	211,188		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Property Tax Rec.	385,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,314,949	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	820,270		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	473,531		16
17	Accumulated Depreciation (book methods)	(977,015)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 321,786	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,636,735	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 15,128	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,319		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,088		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Property Tax	385,000		36
37	Due to Cty GF and Accr. Comp Abs.	163,825		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 618,360	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	60,131		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Comp. Absences	6,559		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 66,690	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 685,050	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 951,685	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,636,735	$	48

***(See instructions.)**

Facility Name & ID Number The Clayberg **#** 0014290 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 809,233	1
2	Restatements (describe):		2
3	**Additional Adjustment made to County Contribution**		3
4	**to State during County Audit**	42,546	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 851,779	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(369,759)	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)**	$ (369,759)	17
	B. Transfers (Itemize):		
18	**Transfer in from County IMRF Fund**	135,350	18
19	**Transfer in from County FICA Fund**	123,046	19
20	**Transfer in from County General Fund**	130,005	20
21	**Transfer in from County Insurance Fund**	78,222	21
22	**Transfer in from County Unemployment Fund**	3,042	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 469,665	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 951,685	24 *

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,862,317	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,862,317	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	3,103	13
14	Non-Patient Meals	6,515	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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,618	23
	D. Non-Operating Revenue		
24	Contributions	45,533	24
25	Interest and Other Investment Income***	13,573	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,106	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Property Taxes	374,679	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 374,679	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,305,720	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	651,346	31
32	Health Care	1,183,177	32
33	General Administration	768,468	33
	B. Capital Expense		
34	Ownership	40,415	34
	C. Ancillary Expense		
35	Special Cost Centers	5,243	35
36	Provider Participation Fee	26,830	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,675,479	40
41	**Income before Income Taxes (line 30 minus line 40)****	(369,759)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (369,759)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 64,265	$ 30.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,976	3,212	79,692	24.81	3
4	Licensed Practical Nurses	12,820	13,446	282,504	21.01	4
5	CNAs & Orderlies	39,120	42,418	459,646	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,313	4,022	53,964	13.42	8
9	Activity Director	1,764	2,032	30,492	15.01	9
10	Activity Assistants	3,299	3,783	42,676	11.28	10
11	Social Service Workers	1,885	2,099	34,438	16.41	11
12	Dietician					12
13	Food Service Supervisor	1,815	2,036	39,407	19.36	13
14	Head Cook	9,891	11,187	113,936	10.18	14
15	Cook Helpers/Assistants	4,869	5,488	50,313	9.17	15
16	Dishwashers					16
17	Maintenance Workers	3,575	4,128	62,583	15.16	17
18	Housekeepers	11,360	12,720	126,492	9.94	18
19	Laundry					19
20	Administrator	2,080	2,080	70,258	33.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,300	52,004	22.61	23
24	Clerical					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					31
32	Other Health Ca Care Plan Coord	1,710	1,945	45,767	23.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,637	114,976	$ 1,608,437 *	$ 13.99	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,452	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,329	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	12	517	11-3	44
45	Social Service Consultant	13	518	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	121	$ 10,816		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Martha Danielson	Administrator	0	$ 70,258
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,258

B. Administrative - Other

Description	Amount
Health Committee of County Board expenses	$ 2,695
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 2,695

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson LLP	CPA	$ 4,525
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,525

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,994
Unemployment Compensation Insurance	3,042
FICA Taxes	123,046
Employee Health Insurance	248,484
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	135,350
Employee Physicals	2,907
TOTAL (agree to Schedule V, line 22, col.8)	$ 558,823

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	339
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	2,415
non-allowable advertising	5,826
Less: Public Relations Expense	( )
Non-allowable advertising	(5,826)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,754

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Mileage and hotel	1,238
Seminars	804
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,042

**See instructions.

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	Amount of Expense Amortized Per Year								
					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 The Clayberg **#** 0014290 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **CNHA 400, INHA 100**

(3) Did the nursing home make political contributions or payments to a politica
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**

(6) Indicate the total amount of both disposable and non-disposable diaper expens
and the location of this expense on Sch. V. $ **6,565** Line **10**

(7) Have all costs reported on this form been determined using accounting procedure
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 fo
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 Departmen
during this cost report period. $ **26,830**
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 classifiec
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 fo
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 benefit
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **6,515**

(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 fo
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 othe
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjustec
out of the cost report? **N/A**
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: **Clifton Gunderson, LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of service
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees