FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0030023

Facility Name: CLEARBROOK CENTER

Address: 3201 WEST CAMPBELL STREET (Number) ROLLING MEADOWS (City) 60008 (Zip Code)

County: COOK

Telephone Number: 847-870-7711 **Fax #** 847-870-9926

HFS ID Number:

Date of Initial License for Current Owners: 11/1/1985

Type of Ownership:

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

IRS Exemption Code 501C3

In the event there are further questions about this report, please contact:
Name: JOAN KEARNEY **Telephone Number:** 847-385-5065
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2009 to 6/30/2010 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) 9/28/2010

(Type or Print Name) CARL M LAMELL

(Title) PRESIDENT

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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 CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 92

	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		Intermediate (ICF)			3
4	92	Intermediate/DD	92	33,580	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	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
11	ICF/DD	33,130			33,130	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,130			33,130	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.66%

D. How many bed-hold days during this year were paid by the Department?
1,592 (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 11/1/85

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 11/1/85 NO [ ]

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 [ ] NO [ ]

Tax Year: 07/1/2009 Fiscal Year: 2010

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	119,747		102,000	221,747		221,747		221,747			1
2	Food Purchase		246,588		246,588		246,588		246,588			2
3	Housekeeping	170,062	109,517		279,579		279,579		279,579			3
4	Laundry											4
5	Heat and Other Utilities			81,128	81,128		81,128		81,128			5
6	Maintenance	85,971	31,509	125,246	242,726		242,726	66,867	309,593			6
7	Other (specify):*											7
8	**TOTAL General Services**	375,780	387,614	308,374	1,071,768		1,071,768	66,867	1,138,635			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,397,700	84,129		2,481,829		2,481,829		2,481,829			10
10a	Therapy											10a
11	Activities	30,318	1,763		32,081		32,081		32,081			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			610	610		610		610			14
15	Other (specify):*			711,460	711,460		711,460		711,460			15
16	**TOTAL Health Care and Programs**	2,428,018	85,892	712,070	3,225,980		3,225,980		3,225,980			16
	C. General Administration											
17	Administrative	102,625			102,625		102,625	197,680	300,305			17
18	Directors Fees											18
19	Professional Services							32,642	32,642			19
20	Dues, Fees, Subscriptions & Promotions			709	709		709	4,228	4,937			20
21	Clerical & General Office Expenses	37,295	3,584		40,879		40,879	16,647	57,526			21
22	Employee Benefits & Payroll Taxes			637,444	637,444		637,444	40,919	678,363			22
23	Inservice Training & Education							5,230	5,230			23
24	Travel and Seminar			4,024	4,024		4,024		4,024			24
25	Other Admin. Staff Transportation							4,647	4,647			25
26	Insurance-Prop.Liab.Malpractice			43,254	43,254		43,254	3,690	46,944			26
27	Other (specify):*			96,207	96,207		96,207		96,207			27
28	**TOTAL General Administration**	139,920	3,584	781,638	925,142		925,142	305,683	1,230,825			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,943,718	477,090	1,802,082	5,222,890		5,222,890	372,550	5,595,440			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 CLEARBROOK CENTER #0030023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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			210,060	210,060		210,060		210,060			30
31	Amortization of Pre-Op. & Org.			3,584	3,584		3,584		3,584			31
32	Interest			38,099	38,099		38,099	2,405	40,504			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,540	26,540		26,540		26,540			35
36	Other (specify):*											36
37	**TOTAL Ownership**			278,283	278,283		278,283	2,405	280,688			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			277,440	277,440		277,440		277,440			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			277,440	277,440		277,440		277,440			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,943,718	477,090	2,357,805	5,778,613		5,778,613	374,955	6,153,568			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 CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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				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)**	$		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		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

CLEARBROOK CENTER

ID# 0030023

Report Period Beginning: 7/1/2009

Ending: 6/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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 CLEARBROOK CENTER **#** 0030023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLEARBROOK CENTER # 0030023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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
NONE		CLEARBROOK EAST	ROLLING MEADOWS	CRH, INC	ROLLING MEADOWS	NON PROFIT/HUD
NONE		CLEARBROOK WEST	ROLLING MEADOWS	CRH, INC	ROLLING MEADOWS	NON PROFIT/HUD
NONE		CLEARBROOK WRIGHT HOME	GURNEE	AUGUSTANA GROU	GURNEE	NON PROFIT/HUD

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 [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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									$		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 CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 [X] NO [ ]

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	6	MAINTENANCE	SALARIES	17,807,737		$ 404,506	$	2,943,716	$ 66,867	1
2	17	ADMIN SALAIRES	SALARIES	17,807,737		1,195,844	1,195,844	2,943,716	197,680	2
3	19	PROFESSIONAL SVCS	SALARIES	17,807,737		197,463		2,943,716	32,642	3
4	20	DUES, FEES, SUBSCRIPTIONS	SALARIES	17,807,737		25,579		2,943,716	4,228	4
5	21	CLERICAL & GEN OFFICE	SALARIES	17,807,737		100,702		2,943,716	16,647	5
6	22	EMP BENEFITS & PR TAXES	SALARIES	17,807,737		247,537		2,943,716	40,919	6
7	23	INSVC TRAINING	SALARIES	17,807,737		31,641		2,943,716	5,230	7
8	25	OTHER ADMIN & TRANS	SALARIES	17,807,737		28,114		2,943,716	4,647	8
9	26	INSURANC	SALARIES	17,807,737		22,321		2,943,716	3,690	9
10	32	INTEREST	SALARIES	17,807,737		14,546		2,943,716	2,405	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					$ 2,268,253	$ 1,195,844		$ 374,955	25

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IRB		X	CONTRUCT BUILDING	VARIABLE	10/15/2008	$ 5,400,000	$ 5,185,000	10/14/2033	VARIABL	$ 38,099	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,400,000	$ 5,185,000			$ 38,099	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,400,000	$ 5,185,000			$ 38,099	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 38,099 **Line #** 32

*** 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 CLEARBROOK CENTER **#** 0030023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	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 CLEARBROOK CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0030023

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 CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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).

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:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs: BOND FEES TO FINANCE DEBT ON BUILDING
(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 DONATED	50,000	1985	$	1
2					2
3	TOTALS	50,000		$	3

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	92		1985	1985	$ 4,357,440	$ 129,845	40	$ 129,845	$	$ 2,775,736	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements Prior to 2002				269,206	9,962		9,962		150,921	9
10	Boiler Valves			2000	1,444	75	10	75		1,444	10
11	Windows			2000	6,704	268	25	268		2,571	11
12	Sprinkler System			2000	8,873	444	20	444		4,661	12
13	Windows			2001	6,704	268	25	268		2,546	13
14	Equipment Survey			2001	2,000	100	20	100		950	14
15	Brick Wall			2001	700	35	20	35		333	15
16	Gas Line			2001	3,018	101	30	101		958	16
17	Generator			2001	12,159	608	20	608		5,776	17
18	Fire Alarm			2001	1,952	98	20	98		931	18
19	Fuel Tank			2001	2,922	146	20	146		1,387	19
20	Floor Tile			2001	1,420	71	20	71		674	20
21	Pool Chemical Controller			2001	2,886	289	10	289		2,746	21
22	HVAC Repairs			2001	20,763	1,038	20	1,038		9,861	22
23	Kitchen Remodeling			2001	61,419	2,457	25	2,457		23,758	23
24	Floor Tile			2001	1,555	78	20	78		740	24
25	AC Compressor			2001	15,223	762	20	762		7,239	25
26	Tile			2001	14,760	738	20	738		7,011	26
27	Concrete Repair			2001	1,200	120	10	120		1,140	27
28	AC Repairs			2001	14,267	713	20	713		6,773	28
29	Wall Protector			2001	14,777	739	10	739		6,651	29
30	HVAC Repairs			2002	25,761	2,576	10	2,576		21,896	30
31	Kitchen Remodeling			2002	5,300	530	10	530		4,505	31
32	AC Compressor			2002	2,500	250	10	250		2,125	32
33	HVAC Repairs			2002	23,430	2,343	10	2,343		19,916	33
34	Fire Alarm System			2002	1,576	158	10	158		1,344	34
35	Wall Paper			2002	1,800	180	10	180		1,530	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	Flooring	2003	$ 3,100	$ 310	10	$ 310	$	$ 2,325	37
38	Security Equipment	2003	3,800		5			3,800	38
39	Tile	2003	3,100		5			3,100	39
40	Pool Repair	2003	8,260	1,121	7	1,121		8,260	40
41	Plumbing	2003	8,562	1,223	7	1,223		7,399	41
42	Doors	2003	976		5			976	42
43	Tile	2003	3,100		5			3,100	43
44	Elevator Repairs	2003	2,813		5			2,813	44
45	Bathroom Remodeling	2004	18,970	1,897	10	1,897		12,330	45
46	Roof Repair	2004	5,100	510	10	510		3,315	46
47	Elevator Repairs	2004	6,913	691	10	691		4,492	47
48	Infra Red Door	2005	1,881		3			1,881	48
49	Alarm System	2005	13,800	1,380	10	1,380		8,280	49
50	Bathroom Remodeling	2006	66,523	4,435	15	4,435		36,091	50
51	Bathroom Remodeling	2006	8,892	1,778	5	1,778		7,291	51
52	Bathroom Remodeling	2006	20,641	2,064	10	2,064		8,600	52
53	Elevator Repairs	2006	3,250	542	5	542		2,330	53
54	Temperture Equipment	2006	7,116	1,423	5	1,423		5,948	54
55	Fire Protection Pipe	2007	1,587	317	5	317		1,163	55
56	Carpet	2007	1,935	387	5	387		1,322	56
57	Carpet	2007	930	129	3	129		930	57
58	Toilet System	2007	1,055	87	3	87		1,055	58
59	Carpet	2007	2,147	429	5	429		1,466	59
60	Glass Door	2007	656	200	3	200		656	60
61	Glass Door	2008	656	219	3	219		602	61
62	Bathroom Remodeling	2008	43,007	4,300	10	4,300		10,214	62
63	Bathroom Remodeling Plans	2009	5,821	1,164	5	1,164		3,104	63
64	Lighting Engineer	2009	4,991	654	7	654		1,308	64
65	Ceramic Tile	2009	3,177	477	5	477		954	65
66	Install Linoleum Floor	2009	1,850	463	3	463		926	66
67	Duct Service	2009	7,230	516	7	516		1,032	67
68	Lighting Replacement	2009	42,000	2,100	10	2,100		4,200	68
69	Repair Front Door	2009	1,300	144	3	144		288	69
70	TOTAL (lines 4 thru 69)		$ 5,186,898	$ 183,952		$ 183,952	$	$ 3,217,674	70

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	
1	Totals from Page 12A, Carried Forward		$ 5,186,898	$ 183,952		$ 183,952	$	$ 3,217,674	1
2	Painting	2009	7,125	369	5	369		738	2
3	Well Pump	2009	2,998	150	5	150		300	3
4	Painting	2009	1,190	60	5	60		120	4
5	Painting	2009	1,360	67	5	67		134	5
6	Tile	2009	1,670	56	5	56		112	6
7	Door Protector	2009	1,898	633	3	633		633	7
8	Install Furnace	2009	4,500	250	3	250		500	8
9	Lighting Replacement	2009	4,114	654	7	654		1,308	9
10	Washer & Dryer	2009	1,229	410	3	410		410	10
11	Laundry Vent Repairs	2009	3,258	996	3	996		996	11
12	Building Materials	2009	1,117	419	2	419		419	12
13	Repair Water Leaks	2009	1,645	685	2	685		685	13
14	Lighting Replacement	2009	27,350	2,279	10	2,279		2,279	14
15	Door Protector	2009	1,901	554	2	554		554	15
16	Repair Sprinkler System	2010	1,351	135	5	135		135	16
17	Paint Hallway	2010	1,450	363	2	363		363	17
18	Fire Alarm System	2010	14,467	241	15	241		241	18
19	Replace Lighting Fixtures	2010	3,525	118	5	118		118	19
20	Linoleum Flooring	2010	1,100	92	3	92		92	20
21	Lighting Replacement	2010	710	35	5	35		35	21
22	Lighting Replacement	2010	27,350	570	20	570		570	22
23	Lighting Replacement	2010	3,300	69	20	69		69	23
24	Teknoflor Installation	2010	1,896	32	5	32		32	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,303,403	$ 193,187		$ 193,187	$	$ 3,228,515	34

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	5,303,403	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	193,187	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	193,187	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	3,228,515	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 CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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? [X] 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 [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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		hrs							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			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2010 (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	$	$ 1,679,479	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 68,407)		6,311,625	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		432,764	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 8,423,868	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,800,121	13
14	Buildings, at Historical Cost		20,836,501	14
15	Leasehold Improvements, at Historical Cost		448,281	15
16	Equipment, at Historical Cost		3,735,024	16
17	Accumulated Depreciation (book methods)		(11,285,435)	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):		5,919	22
23	Other(specify):		(382,238)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 17,158,173	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 25,582,041	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 2,248,607	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		56,250	28
29	Short-Term Notes Payable		354,613	29
30	Accrued Salaries Payable		1,554,678	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		33,256	32
33	Accrued Interest Payable		13,623	33
34	Deferred Compensation		203,300	34
35	Federal and State Income Taxes		56,305	35
	Other Current Liabilities(specify):			
36	due to temp/perm restricted		1,328,022	36
37	deferred revenue		154,817	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 6,003,471	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,534,477	40
41	Bonds Payable		5,185,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	due to govt agencies		174,710	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,894,187	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 14,897,658	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,684,383	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,684,383	$ 14,897,658	48

*(See instructions.)

Facility Name & ID Number CLEARBROOK CENTER **#** 0030023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,295,219	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,295,219	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(602,179)	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) **clearbrook net of commons**	991,343	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 389,164	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)**	$ 10,684,383	24 *

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	$ 5,017,581	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,017,581	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	85,257	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,400	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)**	$ 89,657	23
	D. Non-Operating Revenue		
24	Contributions	69,196	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 69,196	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,176,434	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,071,768	31
32	Health Care	3,225,980	32
33	General Administration	925,142	33
	B. Capital Expense		
34	Ownership	278,283	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	277,440	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,778,613	40
41	**Income before Income Taxes (line 30 minus line 40)****	(602,179)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (602,179)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.**

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

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,849	20,849	422,392	20.26	3
4	Licensed Practical Nurses	11,898	11,898	229,029	19.25	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,719	2,719	30,318	11.15	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,974	12,974	119,747	9.23	15
16	Dishwashers					16
17	Maintenance Workers	9,406	9,406	85,971	9.14	17
18	Housekeepers	19,369	19,369	170,062	8.78	18
19	Laundry					19
20	Administrator	3,129	3,129	108,184	34.57	20
21	Assistant Administrator	633	633	15,966	25.22	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,962	2,962	37,295	12.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,093	11,093	176,424	15.90	28
29	Resident Services Coordinator	3,746	3,746	77,845	20.78	29
30	Habilitation Aides (DD Homes)	146,128	146,128	1,456,898	9.97	30
31	Medical Records					31
32	Other Health Care(specify)	290	290	13,587	46.85	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	245,196	245,196	$ 2,943,718 *	$ 12.01	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	120	24,000	15	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	178	22,163	15	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	psychologists	170	25,481	15	47
48	nuerologist	60	11,880	15	48
49	TOTAL (lines 35 - 48)	528	$ 83,524		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
Joe Lawler	Admin		$ 65,650
Jean Adaskevich	Admin		22,167
Stacey Bellomo	Other Admin		14,808
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,625

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
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,919
Unemployment Compensation Insurance	21,233
FICA Taxes	220,643
Employee Health Insurance	271,974
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403b pension	50,675
TOTAL (agree to Schedule V, line 22, col.8)	$ 637,444

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
dues and subscriptions	709
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,024
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,024

**See instructions.

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 CLEARBROOK CENTER # 0030023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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? no
If YES, give association name and amount.

(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? 5 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 42,065 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. $ 277,440
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? Indicate the amount. $

(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? 95
d. Have vehicle usage logs been maintained?
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? na
g. Does the facility transport residents to and from day training? yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: BLACKMAN KALLICK

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

(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? na
Attach invoices and a summary of services for all architect and appraisal fees.