FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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 501 C 3

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 7/1/2010 to 6/30/11 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) _____ 9/28/2011 (Date)
(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: 7/1/2010 Ending: 6/30/11

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	92	ICF/DD 16 or Less	92	33,580	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	32,889			32,889	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,889			32,889	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.94%

D. How many bed-hold days during this year were paid by the Department?
ALL (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 [X] 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	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

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

Tax Year: 7/1/2010 Fiscal Year: 6/30/2011

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2010 Ending: 6/30/11

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	291,394		102,000	393,394		393,394		393,394			1
2	Food Purchase		249,450		249,450		249,450		249,450			2
3	Housekeeping		28,424		28,424		28,424		28,424			3
4	Laundry		71,553		71,553		71,553		71,553			4
5	Heat and Other Utilities			94,023	94,023		94,023		94,023			5
6	Maintenance	78,341	34,653	143,091	256,085		256,085		256,085			6
7	Other (specify):*											7
8	TOTAL General Services	369,735	384,080	339,114	1,092,929		1,092,929		1,092,929			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,393,217	77,401		2,470,618		2,470,618		2,470,618			10
10a	Therapy											10a
11	Activities		2,277		2,277		2,277		2,277			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			843,846	843,846		843,846		843,846			15
16	TOTAL Health Care and Programs	2,393,217	79,678	843,846	3,316,741		3,316,741		3,316,741			16
	C. General Administration											
17	Administrative	99,124	3,482		102,606		102,606		102,606			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			1,326	1,326		1,326		1,326			20
21	Clerical & General Office Expenses	38,909			38,909		38,909		38,909			21
22	Employee Benefits & Payroll Taxes			666,096	666,096		666,096		666,096			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,814	3,814		3,814		3,814			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,838	38,838		38,838		38,838			26
27	Other (specify):*			74,290	74,290		74,290		74,290			27
28	TOTAL General Administration	138,033	3,482	784,364	925,879		925,879		925,879			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,900,985	467,240	1,967,324	5,335,549		5,335,549		5,335,549			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:** 7/1/2010 **Ending:** 6/30/11

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			226,042	226,042		226,042		226,042			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,569	36,569		36,569		36,569			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			262,611	262,611		262,611		262,611			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			275,587	275,587		275,587		275,587			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			275,587	275,587		275,587		275,587			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,900,985	467,240	2,505,522	5,873,747		5,873,747		5,873,747			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: 7/1/2010 Ending: 6/30/11

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: 7/1/2010

Ending: 6/30/11

	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:** 7/1/2010 **Ending:** 6/30/11

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:** 7/1/2010 **Ending:** 6/30/11

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: 7/1/2010 Ending: 6/30/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
none		CLEARBROOK EAST	ROLLING MEADOWS	CRH, INC.	ROLLING MEADOWS	HUD
none		CLEARBROOK WEST	ROLLING MEADOWS	CRH, INC.	ROLLING MEADOWS	HUD
none		CLEARBROOK WRIGHT HOME	GURNEE	AUGUSTANA GROU	GURNEE	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: 7/1/2010 Ending: 6/30/11

VII. RELATED PARTIES

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

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2010 Ending: 6/30/11

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: 7/1/2010 Ending: 6/30/11

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	18,302,468		$ 262,560	$	2,900,990	$ 41,616	1
2	17	ADMIN SALARIES	SALARIES	18,302,468		1,266,237	1,266,237	2,900,990	200,702	2
3	19	PROFESSIONAL SVCS	SALARIES	18,302,468		170,387		2,900,990	27,007	3
4	20	DUES, FEES, SUBSCRIPTIONS	SALARIES	18,302,468		26,641		2,900,990	4,223	4
5	21	CLERICAL GEN OFFCIE	SALARIES	18,302,468		290,209		2,900,990	45,999	5
6	22	EMP BENEFITS AND TAXES	SALARIES	18,302,468		253,905		2,900,990	40,245	6
7	23	INSVC TRAINING	SALARIES	18,302,468		27,439		2,900,990	4,349	7
8	25	OTHER ADMIN & TRANS	SALARIES	18,302,468		30,690		2,900,990	4,864	8
9	26	INSURANCE	SALARIES	18,302,468		19,666		2,900,990	3,117	9
10	32	INTEREST	SALARIES	18,302,468		23,220		2,900,990	3,680	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					$ 2,370,954	$ 1,266,237		$ 375,802	25

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2010 Ending: 6/30/11

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	CONSRUCT BUILDING	VARIABLE	10/15/2008	$ 5,400,000	$ 4,970,000	10/14/2033	VARIABL	$ 36,569	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,400,000	$ 4,970,000			$ 36,569	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	$ 4,970,000			$ 36,569	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 36,569 **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:** 7/1/2010 **Ending:** 6/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

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

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2010 Ending: 6/30/11

X. BUILDING AND GENERAL INFORMATION:

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

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:
(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: 7/1/2010 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92		1985	1985	$ 4,357,440	$ 129,845	40	$ 129,845	$	$ 2,779,465	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements Prior to 2002				269,206	9,962		9,962		160,883	9
10	Bolier Valves			2000	1,444		10			1,444	10
11	Windows			2000	6,704	268	25	268		3,804	11
12	Sprinkler System			2000	8,873	444	20	444		5,102	12
13	Windows			2001	6,704	268	25	268		2,816	13
14	Equipment Survey			2001	2,000	100	20	100		1,050	14
15	Brick Wall			2001	700	35	20	35		368	15
16	Gas Line			2001	3,018	101	30	101		1,056	16
17	Generator			2001	12,159	608	20	608		6,383	17
18	Fire Alarm			2001	1,952	98	20	98		1,025	18
19	Fuel Tank			2001	2,922	146	20	146		1,535	19
20	Floor Tile			2001	1,420	71	20	71		746	20
21	Pool Chemical Controller			2001	2,886		10			2,886	21
22	HVAC Repairs			2001	20,763	1,038	20	1,038		10,900	22
23	Kitchen Remodeling			2001	61,420	2,457	25	2,457		25,550	23
24	Floor Tile			2001	1,555	78	20	78		816	24
25	AC Compressor			2001	15,223	762	20	762		7,997	25
26	Concrete Repair			2001	1,200	60	20	60		630	26
27	AC Repairs			2001	14,767	713	20	713		7,753	27
28	Wall Protector			2001	5,379	268	20	268		2,555	28
29	HVAC Upgrade			2002	25,761	1,288	20	1,288		12,236	29
30	Kitchen Remodeling			2002	5,300	265	20	265		2,517	30
31	AC Compressor			2002	2,500	125	20	125		1,240	31
32	HVAC Repairs			2002	23,430	1,171	20	1,171		11,129	32
33	Fire Alarm			2002	1,576	158	10	158		1,344	33
34	Wall Paper			2002	1,800	180	10	180		1,530	34
35	Flooring			2003	3,100	310	10	310		2,738	35
36	Security Equipment			2003	3,800		5			3,800	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: 7/1/2010 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tile	2003	$ 3,100	$	5	$	$	$ 3,100	37
38	Pool Repair	2003	8,260		7			8,260	38
39	Plumbing	2003	8,562		7			8,562	39
40	Doors	2003	976		5			976	40
41	Tile	2003	3,100		5			3,100	41
42	Elevator Repairs	2003	2,813		5			2,813	42
43	Bathroom Remodeling	2004	18,970	1,897	10	1,897		14,227	43
44	Roof Repair	2004	5,100	510	10	510		3,825	44
45	Elevator Repairs	2004	6,913	691	10	691		5,183	45
46	Infra Red Door	2005	1,881		3			1,881	46
47	Alarm Systems	2005	13,800	1,380	10	1,380		9,430	47
48	Bathroom Remodeling	2006	66,523	4,435	15	4,435		40,526	48
49	Bathroom Remodeling	2006	8,892		5			8,892	49
50	Bathroom Remodeling	2006	20,641	2,064	10	2,064		10,664	50
51	Elevator Repairs	2006	3,250	542	5	542		2,872	51
52	Temperture Equipment	2006	7,116		5			7,116	52
53	Fire Protection Pipe	2007	1,587	317	5	317		1,480	53
54	Carpet	2007	1,935	387	5	387		1,709	54
55	Carpet	2007	930		3			930	55
56	Toliet Syetem	2007	1,055		3			1,055	56
57	Carpet	2007	2,147	429	5	429		1,895	57
58	Glass Door	2007	656		3			656	58
59	Glass Door	2008	656		3			656	59
60	Bathroom Remodeling	2008	43,007	4,300	10	4,300		14,514	60
61	Bathroom Remodeling Plans	2009	5,821	1,164	5	1,164		4,268	61
62	Lighting Engineer	2009	4,991	654	7	654		1,962	62
63	Ceramic Tile	2009	3,177	477	5	477		1,431	63
64	Install Linoleum	2009	1,850	463	3	463		1,389	64
65	Duct Service	2009	7,230	516	7	516		1,548	65
66	Lighting Engineer	2009	42,000	2,100	10	2,100		6,300	66
67	Repair Front Door	2009	1,300	144	3	144		432	67
68	Painting	2009	7,125	369	5	369		1,107	68
69	Well Pump	2009	2,998	150	5	150		450	69
70	TOTAL (lines 4 thru 69)		$ 5,173,364	$ 173,809		$ 173,809	$	$ 3,234,507	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: 7/1/2010 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,173,364	$ 173,809		$ 173,809	$	$ 3,234,507	1
2	Painting	2009	1,190	60	5	60		180	2
3	Painting	2009	1,360	67	5	67		201	3
4	Tile	2009	1,670	56	5	56		168	4
5	Door Protector	2009	1,898	633	3	633		1,266	5
6	Install Furnace	2009	4,500	250	3	250		750	6
7	Lighting Replacement	2009	4,114	654	7	654		1,962	7
8	Washer & Dryer	2009	1,229	410	3	410		820	8
9	Laundry Vents	2009	3,258	996	3	996		1,992	9
10	Building Materials	2009	1,117	419	2	419		1,018	10
11	Repair Water Leaks	2009	1,645	685	2	685		1,370	11
12	Lighting Replacement	2009	27,350	2,279	10	2,279		5,039	12
13	Door Protector	2009	1,901	554	2	554		1,108	13
14	Repair Sprinkler	2010	1,351	135	5	135		270	14
15	Paint Hallways	2010	1,450	363	2	363		1,088	15
16	Fire Alarm System	2010	14,467	241	15	241		1,211	16
17	Replace Lighting Fixtures	2010	3,525	705	5	705		835	17
18	Linoleum Flooring	2010	110	92	3	92		458	18
19	Lighting Replacement	2010	710	35	5	35		70	19
20	Lighting Replacement	2010	27,350	570	20	570		1,943	20
21	Lighting Replacement	2010	3,300	69	20	69		234	21
22	Teknoflor	2010	1,896	32	5	32		417	22
23	Carpet	2010	1,221	610	2	610		611	23
24	Window Replacement	2010	5,000	500	10	500		458	24
25	Teknoflor	2010	1,290	645	2	645		591	25
26	Vinyl Tecno Flooring	2010	2,102	1,051	2	1,051		876	26
27	Air Test	2010	4,500	1,500	3	1,500		1,125	27
28	Roof Replacement	2010	7,600	760	10	760		570	28
29	Window Replacement	2010	11,560	771	15	771		514	29
30	Bathroom Remodeling	2010	3,863	773	5	773		515	30
31	Hydraulic Glider	2010	4,999	1,000	5	1,000		583	31
32	Repair Nurse Call System	2010	12,160	1,216	10	1,216		709	32
33	Motorized Wheelchairs	2011	13,110	1,311	10	1,311		656	33
34	TOTAL (lines 1 thru 33)		$ 5,346,160	$ 193,249		$ 193,249	$	$ 3,264,116	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: 7/1/2010 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,346,160	$ 193,249		$ 193,249	$	$ 3,264,116	1
2	Field Survey	2011	2,700	1,350	2	1,350		450	2
3	Geotechnical Engineering	2011	3,400	1,700	2	1,700		567	3
4	Hydraulic Lift Seat	2011	2,876	575	5	575		192	4
5	Roof Replacement	2011	533	266	2	266		133	5
6	Construction Documents	2011	2,900	1,450	2	1,450		363	6
7	HVAC, Plumbing and Electric	2011	2,700	540	5	540		135	7
8	Roofing	2011	112,000	5,600	20	5,600		3,733	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,473,268	$ 204,731		$ 204,731	$	$ 3,269,688	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: 7/1/2010 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	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)	$	5,473,268	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	204,731	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	204,731	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)	$	3,269,688	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: 7/1/2010 Ending: 6/30/11

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

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: 7/1/2010 Ending: 6/30/11

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: 7/1/2010 Ending: 6/30/11

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: 7/1/2010 Ending: 6/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/11 (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	$	$ 2,679,196	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,250)		4,538,169	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		230,361	6
7	Other Prepaid Expenses		241,157	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 7,688,883	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,962,440	13
14	Buildings, at Historical Cost		20,815,149	14
15	Leasehold Improvements, at Historical Cost		210,425	15
16	Equipment, at Historical Cost		1,564,068	16
17	Accumulated Depreciation (book methods)		(8,904,923)	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):		(319,888)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 17,333,190	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 25,022,073	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 1,011,245	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		224,441	28
29	Short-Term Notes Payable		370,621	29
30	Accrued Salaries Payable		1,795,023	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,801	32
33	Accrued Interest Payable		13,622	33
34	Deferred Compensation		145,564	34
35	Federal and State Income Taxes		58,816	35
	Other Current Liabilities(specify):			
36	due to temp restricted		836,796	36
37	deferred revenue		587,661	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 5,067,590	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,564,993	40
41	Bonds Payable		4,970,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	due to HUD		163,153	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,698,146	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 13,765,736	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,256,337	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,256,337	$ 13,765,736	48

*(See instructions.)

Facility Name & ID Number CLEARBROOK CENTER **#** 0030023 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,915,124	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,915,124	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	118,233	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	222,980	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 341,213	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)**	$ 11,256,337	24 *

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2010 Ending: 6/30/11

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	$ 5,062,559	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,062,559	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	30,921	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		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)**	$ 30,921	23
	D. Non-Operating Revenue		
24	Contributions	54,584	24
25	Interest and Other Investment Income***	70	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,654	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)**	$ 5,148,134	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,092,929	31
32	Health Care	2,472,895	32
33	General Administration	925,879	33
	B. Capital Expense		
34	Ownership	262,611	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	275,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,029,901	40
41	**Income before Income Taxes (line 30 minus line 40)****	118,233	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 118,233	43

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

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

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

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2010 Ending: 6/30/11

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		16,866	346,287	20.53	3
4	Licensed Practical Nurses		14,823	278,968	18.82	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		2,849	31,422	11.03	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants		13,343	121,300	9.09	15
16	Dishwashers					16
17	Maintenance Workers		7,603	78,341	10.30	17
18	Housekeepers		19,739	170,094	8.62	18
19	Laundry					19
20	Administrator		3,224	99,124	30.75	20
21	Assistant Administrator		2,080	35,018	16.84	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical		2,080	38,909	18.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		11,754	184,065	15.66	28
29	Resident Services Coordinator		3,537	71,268	20.15	29
30	Habilitation Aides (DD Homes)		147,150	1,432,487	9.73	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)		275	13,702	49.83	33
34	TOTAL (lines 1 - 33)		245,323	$ 2,900,985 *	$ 11.83	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	41	3,079	15	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	350	26,949	15	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)	95	13,815	15	46
47		55	9,720	15	47
48					48
49	TOTAL (lines 35 - 48)	661	$ 77,563		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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2010 Ending: 6/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joe Lawler	Admin		$ 67,381
Jean Adaskevich	Admin		21,468
Stacey Bellomo	Other Admin		10,275
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,124

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	$ 72,251
Unemployment Compensation Insurance	31,006
FICA Taxes	219,397
Employee Health Insurance	287,188
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403b	56,254
TOTAL (agree to Schedule V, line 22, col.8)	$ 666,096

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	1,326
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,326

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	551
Seminar Expense	
	3,263
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,814

**See instructions.

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2010 Ending: 6/30/11

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:** 7/1/2010 **Ending:** 6/30/11

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? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,701** 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. $ **275,587**
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? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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?
Firm Name: **blackman Kallick LLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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.