

Facility Name & ID Number The Clayberg

0014290 Report Period Beginning: 12/1/11 Ending: 11/30/12

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 49

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			894	894	8
9	SNF/PED					9
10	ICF	10,274	5,459		15,733	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,274	5,459	894	16,627	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.71%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 49 and days of care provided 894

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2012 Fiscal Year: 11/30/2012

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

Facility Name & ID Number

The Clayberg

0014290

Report Period Beginning:

12/1/11

Ending:

11/30/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	200,909	11,877	4,717	217,503		217,503		217,503		1
2	Food Purchase		118,264		118,264		118,264	(6,519)	111,745		2
3	Housekeeping	149,056	10,308		159,364		159,364		159,364		3
4	Laundry		9,631		9,631		9,631		9,631		4
5	Heat and Other Utilities			73,338	73,338		73,338	(3,705)	69,633		5
6	Maintenance	80,503	12,120	36,051	128,674		128,674		128,674		6
7	Other (specify):*										7
8	TOTAL General Services	430,468	162,200	114,106	706,774		706,774	(10,224)	696,550		8
	B. Health Care and Programs										
9	Medical Director			375	375		375		375		9
10	Nursing and Medical Records	992,356	109,598	11,700	1,113,654		1,113,654		1,113,654		10
10a	Therapy	52,109		95,872	147,981		147,981		147,981		10a
11	Activities	65,385	4,088	1,444	70,917		70,917		70,917		11
12	Social Services	36,005		1,444	37,449		37,449		37,449		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,145,855	113,686	110,835	1,370,376		1,370,376		1,370,376		16
	C. General Administration										
17	Administrative	62,516		4,005	66,521		66,521		66,521		17
18	Directors Fees										18
19	Professional Services			11,657	11,657		11,657		11,657		19
20	Dues, Fees, Subscriptions & Promotions			24,205	24,205		24,205	(18,844)	5,361		20
21	Clerical & General Office Expenses	50,082	19,980	3,884	73,946		73,946	6,655	80,601		21
22	Employee Benefits & Payroll Taxes			654,682	654,682		654,682		654,682		22
23	Inservice Training & Education			1,235	1,235		1,235		1,235		23
24	Travel and Seminar			1,645	1,645		1,645		1,645		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,770	29,770		29,770		29,770		26
27	Other (specify):*										27
28	TOTAL General Administration	112,598	19,980	731,083	863,661		863,661	(12,189)	851,472		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,688,921	295,866	956,024	2,940,811		2,940,811	(22,413)	2,918,398		29

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

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

Facility Name & ID Number The Clayberg

#0014290

Report Period Beginning:

12/1/11

Ending:

11/30/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			41,994	41,994		41,994	41,994				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,973	3,973		3,973	3,973				35
36	Other (specify):*											36
37	TOTAL Ownership			45,967	45,967		45,967	45,967				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,981		7,981		7,981	7,981				39
40	Barber and Beauty Shops		320		320		320	320				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			122,412	122,412		122,412	122,412				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		8,301	122,412	130,713		130,713	130,713				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,688,921	304,167	1,124,403	3,117,491		3,117,491	(22,413)	3,095,078			45

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

Facility Name & ID Number The Clayberg

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,519)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,705)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,930)	20		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	(15,914)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,068)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	6,655	Sch VII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,655		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (22,413)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

The Clayberg

ID# 0014290

Report Period Beginning: 12/1/11

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Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

1	None	\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Clayberg# 0014290

Report Period Beginning:

12/1/11

Ending:

11/30/12

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,519)	0	0	0	0	0	0	0	0	0	0	(6,519)	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	(3,705)	0	0	0	0	0	0	0	0	0	0	(3,705)	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	(10,224)	0	0	0	0	0	0	0	0	0	0	(10,224)	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	(18,844)	0	0	0	0	0	0	0	0	0	0	(18,844)	20
21	Clerical & General Office Expenses	0	6,655	0	0	0	0	0	0	0	0	0	6,655	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	(18,844)	6,655	0	0	0	0	0	0	0	0	0	(12,189)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,068)	6,655	0	0	0	0	0	0	0	0	0	(22,413)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/11

Ending:

11/30/12

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	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)	(29,068)	6,655	0	0	0	0	0	0	0	0	0	(22,413)	45

Facility Name & ID Number The Clayberg

0014290

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Ending:

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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
<u>Fulton County</u>	<u>100</u>					

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 Payroll	\$	<u>Fulton County</u>	<u>100.00%</u>	\$ <u>6,655</u>	\$ <u>6,655</u>	1
2	V	22 Health Insurance		<u>Fulton County</u>	<u>100.00%</u>			2
3	V	22 IMRF	<u>172,467</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>172,467</u>		3
4	V	22 FICA	<u>129,202</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>129,202</u>		4
5	V	22 Worker's Comp Insurance	<u>72,060</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>72,060</u>		5
6	V	22 Unemployment Insurance	<u>8,032</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>8,032</u>		6
7	V	17 Committee Per Diem Expnese	<u>4,005</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>4,005</u>		7
8	V	26 Property & Liability Insurance	<u>29,770</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>29,770</u>		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>415,536</u>			\$ <u>422,191</u>	\$ * <u>6,655</u>	14

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

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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	None								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

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Report Period Beginning:

12/1/11

Ending:

11/30/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	None						\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7	None																
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10	None																
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2011 report.		\$	<u>none</u>		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.)		\$	<u>none</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>none</u>		3														
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>none</u>		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.)		\$	<u>none</u>		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.)		\$	<u>none</u>		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>none</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2007 _____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$ _____</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2008 _____	9																	
	2009 _____	10																	
	2010 _____	11																	
	2011 _____	12																	

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Clayberg COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0014290

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number The Clayberg

0014290 Report Period Beginning:

12/1/11 Ending:

11/30/12

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

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

None

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Building Site</u>	<u>217,800</u>	<u>1969</u>	<u>\$ 5,000</u>	1
2					2
3	TOTALS	217,800		\$ 5,000	3

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/11

Ending:

11/30/12

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49	1969		\$ 271,336	\$	40	\$	\$	\$ 271,336	4
5		1978		8,009		20			8,009	5
6		1979		52,592		30			52,592	6
7										7
8										8
	Improvement Type**									
9	windows and plaster repair	1981		17,092		3 to 10			17,092	9
10	front porch and patio	1982		6,110		5 to 20			6,110	10
11	office remodeling	1983		3,272		5 to 10			3,272	11
12	roof	1984		432		10			432	12
13	canvas, floors, sewer, box, sign, door	1985		17,304		15 to 25			17,304	13
14	shutters	1986		1,591		15 to 25			1,591	14
15	shed, roof and flor tile	1987		17,275	37	15 to 25	37		17,275	15
16	IDPA adjustment	1989		1,806	90	20	90		1,445	16
17	new shed	1990		8,284		15			8,284	17
18	new shed	1991		10,876		15			10,876	18
19	drain	1992		743		15			743	19
20	roof and greenhouse	1993		62,282		15			62,282	20
21	road repair	1994		13,496		5			13,496	21
22	storage building addition	1994		4,265	213	20	213		3,643	22
23	storage building addition	1996		12,141	607	20	607		10,101	23
24	laundry facility	1997		15,274	764	20	764		11,933	24
25	carpet, H/C system	2000		6,298	228	10 to 20	228		4,511	25
26	walk path	2001		4,177	278	15	278		3,109	26
27	walk path	2002		1,357	90	15	90		942	27
28	aviary	2002		4,740	316	15	316		3,292	28
29	flooring	2004		635	64	10	64		556	29
30	two A/C units	2004		4,583	458	10	458		3,819	30
31	floor tile	2005		289	12	25	12		91	31
32	electrical box	2005		141	6	25	6		44	32
33	seal parking lot	2005		1,260		4			1,260	33
34	two metal doors	2005		1,166	39	30	39		301	34
35	wall coverings	2005		697		5			697	35
36	egress lights	2005		423	28	15	28		218	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/11

Ending:

11/30/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	smoke detectors	2005	\$ 2,915	\$ 291	10	\$ 291	\$	\$ 2,259	37
38	new corridor wall	2005	367	15	25	15		114	38
39	paint walls	2005	112		3			112	39
40	kitchen fire system	2005	2,877	82	35	82		623	40
41	sidewalk	2005	802	53	15	53		401	41
42	labor for bldg improvements	2005	5,904	393	15	393		2,952	42
43	heating and cooling units	2005	2,729	273	10	273		1,978	43
44	harbor in garden	2005	868	35	25	35		249	44
45	base board heaters	2006	278	19	15	19		128	45
46	wall board and glue	2006	168		5			168	46
47	floor tile	2006	640	26	25	26		173	47
48	East egress	2006	1,701	113	15	113		747	48
49	East egress soil	2006	390	13	30	13		86	49
50	door and frame	2006	614	20	30	20		135	50
51	water main	2006	9,291	232	40	232		1,471	51
52	water main walkway	2006	1,031	69	15	69		435	52
53	door locks	2006	474	32	15	32		195	53
54	labor for bldg improvements	2006	4,098	273	15	273		1,776	54
55	steel door	2007	630	21	30	21		117	55
56	sprinkler system/ceiling upgrade	2007	151,553	10,104	15	10,104		53,886	56
57	wiring/electrical outlets	2007	635	32	20	32		166	57
58	4 A/C units	2007	1,668	167	10	167		876	58
59	Sentricon Baiting system	2008	1,272	85	15	85		424	59
60	packaged unit and duct work	2008	6,105	407	15	407		1,662	60
61	Roof work	2008	28,174	1,878	15	1,878		7,513	61
62	generator repair	2009	2,170	145	15	145		458	62
63	Fire Protection - Sprinkler system	2009	25,825	1,722	15	1,722		5,165	63
64	Wallpaper	2010	6,294	420	15	420		1,154	64
65	Garage Door	2012	848	64	10	64		64	65
66	Dining Door	2012	3,092	77	30	77		77	66
67	Heat/Cool Wall Air Conditioner	2012	1,912	143	10	143		143	67
68	3 Heat/Cool Wall Air Conditioners	2012	2,166	90	10	90		90	68
69	Flor Finish	2012	599	2	25	2		2	69
70	TOTAL (lines 4 thru 69)		\$ 818,148	\$ 20,526		\$ 20,526	\$	\$ 622,455	70

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

Facility Name & ID Number The Clayberg

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 818,148	\$ 20,526		\$ 20,526	\$	\$ 622,455	1
2	Office Carpet	2012	1,601		10				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	TOTAL (lines 1 thru 33)		\$ 819,749	\$ 20,526		\$ 20,526	\$	\$ 622,455	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 194,678	\$ 19,698	\$ 19,698	\$	5 to 20	\$ 116,688	71
72	Current Year Purchases	21,136	1,098	1,098		5 to 20	1,098	72
73	Fully Depreciated Assets	221,958	672	672		5 to 20	221,958	73
74								74
75	TOTALS	\$ 437,772	\$ 21,468	\$ 21,468	\$		\$ 339,744	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	Patient Transportation	2000 Chevy Bus	2000	\$ 42,641	\$	\$	\$	5	\$ 42,641	76
77	Pickup, Delivery, & Plowing	2001 Ford Truck with Plow	2001	23,817				5	23,817	77
78										78
79										79
80	TOTALS			\$ 66,458	\$	\$	\$		\$ 66,458	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,328,979	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,994	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,994	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,028,657	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	Entrance Replacement	\$ 38,563	92
93			93
94			94
95		\$ 38,563	95

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

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/11

Ending: 11/30/12

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

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 3,973 Description: Copiers \$146.18/month and \$184.58/month

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/11 Ending: 11/30/12
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a-3	hrs		2,875	95,872		2,875	95,872	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Stock Drugs</u>	39-2					7,981		7,981	12	
13	Other (specify):									13	
14	TOTAL			\$	2,875	\$ 95,872	\$ 7,981	2,875	\$ 103,853	14	

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/11

Ending:

11/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/12

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 554,764	\$	1
2	Cash-Patient Deposits	2,370		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,199,606		3
4	Supply Inventory (priced at <u>cost</u>)	4,364		4
5	Short-Term Investments	217,336		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prop Tax Rec</u>	400,775		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,379,215	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	819,749		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	504,230		16
17	Accumulated Depreciation (book methods)	(1,028,657)		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 (spec <u>Construction in Proce</u>)	38,563		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 338,885	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,718,100	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 115,803	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,370		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,556		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Deferred Property Tax</u>	400,775		36
37	<u>Due to Cty GF and Accr. Comp. Abs.</u>	164,028		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 755,532	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	60,131		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 60,131	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 815,663	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,902,437	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,718,100	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,603,537	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,603,537	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	82,103	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 82,103	17
B. Transfers (Itemize):			
18	Transfer in from County IMRF Fund	172,467	18
19	Transfer in from County FICA Fund	129,202	19
20	Transfer in from County General Fund	(194,734)	20
21	Transfer in from County Insurance Fund	101,830	21
22	Transfer in from County Unemployment Fund	8,032	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 216,797	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,902,437	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 2,795,896	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,795,896	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care	1,523	13	
14	Non-Patient Meals	6,519	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)	\$ 8,042	23	
D. Non-Operating Revenue				
24	Contributions	7,961	24	
25	Interest and Other Investment Income***	8,240	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,201	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Property Taxes	379,455	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 379,455	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,199,594	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	706,774	31	
32	Health Care	1,370,376	32	
33	General Administration	863,661	33	
B. Capital Expense				
34	Ownership	45,967	34	
C. Ancillary Expense				
35	Special Cost Centers	8,301	35	
36	Provider Participation Fee	122,412	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,117,491	40	
41	Income before Income Taxes (line 30 minus line 40)**	82,103	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 82,103	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,844,710	44
45	Private Pay - Net Inpatient Revenue	679,036	45
46	Medicare - Net Inpatient Revenue	272,150	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,795,896	49

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

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

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

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/11

Ending:

11/30/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 63,568	\$ 30.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,234	6,519	161,141	24.72	3
4	Licensed Practical Nurses	11,299	12,263	235,164	19.18	4
5	CNAs & Orderlies	43,816	47,220	483,664	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,577	4,290	52,109	12.15	8
9	Activity Director	1,556	1,896	24,705	13.03	9
10	Activity Assistants	3,881	4,194	40,680	9.70	10
11	Social Service Workers	2,070	2,264	36,005	15.90	11
12	Dietician					12
13	Food Service Supervisor	2,115	2,270	44,025	19.39	13
14	Head Cook	8,650	9,434	93,666	9.93	14
15	Cook Helpers/Assistants	7,069	7,392	63,218	8.55	15
16	Dishwashers					16
17	Maintenance Workers	5,128	5,570	80,503	14.45	17
18	Housekeepers	13,823	15,627	149,056	9.54	18
19	Laundry					19
20	Administrator	2,080	2,080	62,516	30.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	50,082	24.08	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Care Plan</u>	1,934	2,163	48,819	22.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,392	127,342	\$ 1,688,921 *	\$ 13.26	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	108	\$ 1,949	1-3	35
36	Medical Director	5	375	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,064	10-3	39
40	Physical Therapy Consultant	2,875	95,872	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	1,444	11-3	44
45	Social Service Consultant	9	1,444	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,006	\$ 105,148		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Martha Danielson	Administrator	0	\$ 62,516	Workers' Compensation Insurance	\$ 72,060	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	8,032	Advertising: Employee Recruitment	337	
				FICA Taxes	129,202	Health Care Worker Background Check	585	
				Employee Health Insurance	271,080	(Indicate # of checks performed <u>58</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*	172,467	Dues and Subscriptions	3,389	
				Employee Physicals	1,841	Non-Allowable Advertising	15,914	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,516	TOTAL (agree to Schedule V, line 22, col.8)		\$ 5,361		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(2,930)	
Health Committee of County Board Expense			\$ 4,005				Non-allowable advertising	
							(15,914)	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 4,005				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
CliftonLarsonAllen LLP	CPA		\$ 9,925				Out-of-State Travel	\$
Proactive Technology Group	Information Systems		1,732					
							In-State Travel	
							Seminar Expense	
							Mileage and Hotel	447
							Seminars	1,198
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,657	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,645	

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number The Clayberg# 0014290Report Period Beginning: 12/1/11Ending: 11/30/12**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$2,930
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,067 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. \$ 122,412
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,519
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

General	Health Care	Admin	Ownership
	65,252.81	69,178.57	2,950.00
152,154.00	93,501.09	501,715.28	15,146.64
125,440.00	282,230.06	31,275.20	26,849.00
59,259.00	466,447.10	47,849.67	
6,136.00	52,362.62	33,984.90	
270,430.07	48,666.60	29,674.44	
3,827.48	34,235.94	18,939.71	
16,681.50	42,943.47	102,056.58	
23,968.00	8,537.88		
39,198.39	52,330.13	128,961.58	
95,031.85	4,630.33		
92,115.03	10,600.32		
4,618.46	60,403.63		
363.82			
1,005.30			
3,007.65			
9,867.16			
16,128.35			
2,129.34			
13,012.69			
1,178.47			
60.00			
3,704.36			
12,120.60			
40,477.76			
455.97			
671,961.00	1,219,936.00	803,809.00	44,907.00
(320,410.25)	(2,205.98)	(159,826.93)	(38.64)