FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 W CAMPBELL ST (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: 7/7/92

Type of Ownership:

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

IRS Exemption Code 501C3

In the event there are further questions about this report, please contact:
Name: JOAN KEARNEY **Telephone Number:** 847-870-7711 X 5004
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 7/1/2013 to 6/30/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date) 9/30/2014

(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: 7/1/2013 Ending: 6/30/2014

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 7/7/92

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	32,317			32,317	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,317			32,317	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.24%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/7/92

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

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

Medicare Intermediary no

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30 Fiscal Year: 2014

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	145,810	299,645	102,000	547,455		547,455		547,455			1
2	Food Purchase											2
3	Housekeeping	140,138	37,372		177,510		177,510		177,510			3
4	Laundry		86,263		86,263		86,263		86,263			4
5	Heat and Other Utilities			92,602	92,602		92,602		92,602			5
6	Maintenance	86,048	31,753	194,058	311,859		311,859	20,420	332,279			6
7	Other (specify):*											7
8	TOTAL General Services	371,996	455,033	388,660	1,215,689		1,215,689	20,420	1,236,109			8
	B. Health Care and Programs											
9	Medical Director	13,583	86,238		99,821		99,821		99,821			9
10	Nursing and Medical Records	710,371		69,771	780,142		780,142		780,142			10
10a	Therapy											10a
11	Activities	10,935	3,133		14,068		14,068		14,068			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	1,942,439		613,327	2,555,766		2,555,766		2,555,766			15
16	TOTAL Health Care and Programs	2,677,328	89,371	683,098	3,449,797		3,449,797		3,449,797			16
	C. General Administration											
17	Administrative	150,851			150,851		150,851	243,481	394,332			17
18	Directors Fees											18
19	Professional Services			6,396	6,396		6,396	37,787	44,183			19
20	Dues, Fees, Subscriptions & Promotions							4,660	4,660			20
21	Clerical & General Office Expenses	26,975		4,917	31,892		31,892	26,232	58,124			21
22	Employee Benefits & Payroll Taxes			675,643	675,643		675,643	42,748	718,391			22
23	Inservice Training & Education			17,641	17,641		17,641	8,536	26,177			23
24	Travel and Seminar			4,485	4,485		4,485		4,485			24
25	Other Admin. Staff Transportation							70,969	70,969			25
26	Insurance-Prop.Liab.Malpractice			41,144	41,144		41,144	5,146	46,290			26
27	Other (specify):*		4,246	2,974	7,220		7,220		7,220			27
28	TOTAL General Administration	177,826	4,246	753,200	935,272		935,272	439,559	1,374,831			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,227,150	548,650	1,824,958	5,600,758		5,600,758	459,979	6,060,737			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:** 7/1/2013 **Ending:** 6/30/2014

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			233,473	233,473		233,473	3,427	236,900			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,334	8,334		8,334	11,096	19,430			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			241,807	241,807		241,807	14,523	256,330			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			294,582	294,582		294,582		294,582			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			294,582	294,582		294,582		294,582			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,227,150	548,650	2,361,347	6,137,147		6,137,147	474,502	6,611,649			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: 7/1/2013 Ending: 6/30/2014

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: 7/1/2013

Ending: 6/30/2014

	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:** 7/1/2013 **Ending:** 6/30/2014

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	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:** 7/1/2013 **Ending:** 6/30/2014

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: 7/1/2013 Ending: 6/30/2014

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

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			$			$	$	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: 7/1/2013 Ending: 6/30/2014

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: 7/1/2013 Ending: 6/30/2014

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column 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								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: 7/1/2013 Ending: 6/30/2014

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: CLEARBROOK
Street Address: 1835 W CENTRAL ROAD
City / State / Zip Code: ARLINGTON HTS., IL 60005
Phone Number: (847-870-7711
Fax Number: (847-870-9926

	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	21,442,035		$ 135,674	$	3,227,150	$ 20,420	1
2	17	ADMIN SALARIES	SALARIES	21,442,035		1,617,755	1,617,755	3,227,150	243,481	2
3	19	PROFESSIONAL SVCS	SALARIES	21,442,035		251,069		3,227,150	37,787	3
4	20	DUES,FEES, SUBSCRIPTIONS	SALARIES	21,442,035		30,962		3,227,150	4,660	4
5	21	CLERICAL, GEN OFFICE	SALARIES	21,442,035		174,291		3,227,150	26,232	5
6	22	EMP BENEFITS & TAXES	SALARIES	21,442,035		284,028		3,227,150	42,748	6
7	23	IN SVC TRAINING	SALARIES	21,442,035		56,717		3,227,150	8,536	7
8	25	OTHER ADMIN & TRAINING	SALARIES	21,442,035		471,534		3,227,150	70,969	8
9	26	INSURNACE	SALARIES	21,442,035		34,191		3,227,150	5,146	9
10	32	INTEREST	SALARIES	21,442,035		73,722		3,227,150	11,096	10
11	30	DEPRECIATION	SALARIES	21,442,035		22,773		3,227,150	3,427	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					$ 3,152,716	$ 1,617,755		$ 474,502	25

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

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

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

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:		
2009		8
2010		9
2011		10
2012		11
2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 7/1/2013 Ending: 6/30/2014

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING DONATED	50,000	1985	$	1
2					2
3	TOTALS	50,000		$	3

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	$	$ 3,105,942	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements Prior to 2000				269,206	9,962		9,962		180,807	9
10	Bolier Valves			2000	1,444		10			1,444	10
11	Install New Windows			2000	6,704	268	25	268		4,608	11
12	Sprinkler System			2000	8,873	444	20	444		6,434	12
13	Install New Windows			2001	6,704	268	25	268		3,620	13
14	Equipment Survey			2001	2,000	100	20	100		1,350	14
15	Replace Brick Wall			2001	700	35	25	35		473	15
16	Install New Gas Line			2001	3,018	101	30	101		1,359	16
17	Kohler 35RZ Gas Generator			2001	12,159	608	20	608		8,207	17
18	Simplex Fire Alarm System			2001	1,952	98	20	98		1,319	18
19	Replace Fuel Tank			2001	2,922	146	20	146		1,973	19
20	Install New Floor Tile			2001	1,420	71	20	71		959	20
21	Pool Chemical Controller			2001	2,886		10			2,886	21
22	HVC Repairs			2001	20,763	1,038	20	1,038		14,014	22
23	Kitchen Remodeling			2001	61,420	2,457	25	2,457		32,921	23
24	Install New Tile Flooring			2001	1,555	75	20	78		1,050	24
25	New AC Compressor			2001	15,223	762	20	762		10,283	25
26	Concrete Repair			2001	1,200	60	20	60		810	26
27	AC repairs			2001	14,767	713	20	713		9,892	27
28	Wall Protectors			2001	5,379	268	20	268		3,359	28
29	HVAC Upgrade			2002	25,761	1,288	20	1,288		16,100	29
30	Kitchen Remodeling			2002	5,300	265	20	265		3,312	30
31	AC Compressor			2002	2,500	125	20	125		1,615	31
32	HVAC Repairs			2002	23,430	1,171	20	1,171		14,642	32
33	Fire Alarm			2002	1,576		10			1,576	33
34	Wall Paper			2002	1,800		10			1,800	34
35	Install New Flooring			2003	3,100		10			3,100	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: 7/1/2013 Ending: 6/30/2014

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	Install New Tile Flooring	2003	$ 3,100	$	5	$	$	$ 3,100	37
38	Pool Repairs	2003	8,260		7			8,260	38
39	Plumbing Repairs	2003	8,562		7			8,562	39
40	Install New Doors	2003	976		5			976	40
41	Install New Tile Flooring	2003	3,100		5			3,100	41
42	Elevator Repairs	2003	2,813		5			2,813	42
43	Bathroom Remodeling	2004	18,970		10			18,970	43
44	Roof Repairs	2004	5,100		10			5,100	44
45	Elevator Repairs	2004	6,913		10			6,913	45
46	Infra Red Door	2005	1,881		3			1,881	46
47	Alarm Systems	2005	13,800	1,380	10	1,380		13,570	47
48	Bathroom Remodeling	2006	66,523	4,435	15	4,435		53,831	48
49	Bathroom Remodeling	2006	8,892		5			8,892	49
50	Bathroom Remodeling	2006	20,641	2,064	10	2,064		16,856	50
51	Elevator Repairs	2006	3,250		5			3,250	51
52	Temperature Equipment	2006	7,116		5			7,116	52
53	Fire Protection Pipe	2007	1,587		5			1,587	53
54	Install New Carpet	2007	1,935		5			1,935	54
55	Install New Carpet	2007	930		3			930	55
56	New Toilet System	2007	1,055		3			1,055	56
57	Install New Carpet	2007	2,147		5			2,147	57
58	Install Glass Door	2007	656		3			656	58
59	Install Glass Door	2008	656		3			656	59
60	Bathroom Remodeling	2008	43,007	4,300	10	4,300		27,414	60
61	Bathroom Remodeling Plans	2008	5,821		5			5,821	61
62	Engineer for Lighting	2009	4,991	654	7	654		3,924	62
63	Install New Ceramic Tile	2009	3,177	477	5	477		2,862	63
64	Install Linoleum	2009	1,850		3			1,850	64
65	Duct Service	2009	7,230	516	7	516		3,096	65
66	Engineer for Lighting	2009	42,000	2,100	10	2,100		12,600	66
67	Repair Front Door	2009	1,300		3			1,300	67
68	Painting Common Areas	2009	7,125		5			7,125	68
69	Well Pump	2009	2,998		5			2,998	69
70	TOTAL (lines 4 thru 69)		$ 5,173,364	$ 166,094		$ 166,097	$	$ 3,680,801	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: 7/1/2013 Ending: 6/30/2014

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	$ 166,094		$ 166,097	$ 3	$ 3,680,801	1
2	Wall Repairs /Painting	2009	1,190		5			1,190	2
3	Wall Repairs /Painting	2009	1,360		5			1,360	3
4	Install New Floor Tile	2009	1,670		5			1,670	4
5	Door Protectors	2009	1,898		3			1,898	5
6	Install Lenox Furnace	2009	4,500		3			4,500	6
7	Light replacements	2009	4,114		7			4,114	7
8	Washer & Dryer	2009	1,229		3			1,229	8
9	Install New Laundry Vents	2009	3,258		3			3,258	9
10	Building Materials	2009	1,117		2			1,117	10
11	Repair Water Leaks	2009	1,645		2			1,645	11
12	Light replacements	2010	27,350	2,760	10	2,760		13,319	12
13	Door Protectors	2009	1,901		2			1,901	13
14	Repair Sprinkler	2010	1,351	270	5	270		1,216	14
15	Paint Hallways	2010	1,450		2			1,450	15
16	Fire Alarm System	2010	14,467	970	15	970		4,121	16
17	Replace Lighting Fixtures	2010	3,525	705	5	705		2,987	17
18	Linoleum Flooring	2010	110		3			110	18
19	Light replacements	2010	710	35	5	35		603	19
20	Light replacements	2010	27,350	1,094	25	1,094		6,063	20
21	Light replacements	2010	3,300	165	20	165		732	21
22	Teknoflor	2010	1,896	379	5	379		1,575	22
23	Install New Carpeting	2010	1,221		2			1,221	23
24	Window Replacement	2010	5,000	500	10	500		1,958	24
25	Teknoflor	2010	1,290		2			1,290	25
26	Vinyl Tecno Floor	2010	2,102		2			2,102	26
27	Air Testing	2010	4,500		3			4,500	27
28	Roof Replacement	2010	7,600	760	10	760		2,850	28
29	Window Replacement	2010	11,560	771	15	771		2,826	29
30	Bathroom Remodeling	2010	3,863	773	5	773		2,833	30
31	Hydraulic Glider	2010	4,999	1,000	5	1,000		3,583	31
32	Repair Nurse Call System	2010	12,160	1,216	10	1,216		4,357	32
33	Motorized Wheel Chairs	2011	13,110	1,311	10	1,311		4,589	33
34	TOTAL (lines 1 thru 33)		$ 5,346,160	$ 178,803		$ 178,806	$ 3	$ 3,768,967	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: 7/1/2013 Ending: 6/30/2014

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	$ 178,803		$ 178,806	$ 3	$ 3,768,967	1
2	Field Survey for HVAC, Plumbing & Electrical Engineering	2011	2,700		2			2,700	2
3	Geotechnical Engineering Services, 24 hour Water Level Reading	2011	3,400		2			3,400	3
4	Hydraulic Loife Seat, flat back 19"	2011	2,876	575	5	575		1,917	4
5	Roof Replacement, Bid Documents, Bid Phase, Constuction Phase	2011	533		2			533	5
6	Structural Design and Construction Documents, Shop Drawings	2011	2,900		2			2,900	6
7	Electrical Engineering for HVAC, P,umbing and Electric	2011	2,700	540	5	540		1,755	7
8	Weatherguard Roof Single Replacement entire building	2011	112,000	5,600	20	5,600		20,533	8
9	Removal of old and set up of new Kenmore Industrial Washing Ma	2011	1,355	271	5	271		790	9
10	Removal of old and set up of new Kenmore Industrial Washing Ma	2011	1,218	244	5	244		1,150	10
11	Removal of old and set up of new Kenmore Industrial Dryer	2012	1,002	334	3	334		780	11
12	Install Ice maker cresent cube, Ice bin top hinged, Hoshizaki Wate	2012	3,169	634	5	634		1,426	12
13	Remove and Replace Handicap Accessible Ramp, 12 Linear Feet of	2011	5,250	525	10	525		1,181	13
14	Remove and Replace Glass & Aluminum Double Doors at main ent	2011	8,000	800	10	800		2,133	14
15	Site Survey and Soil Investigation fees for Pool removal	2012	3,323	665	5	665		1,717	15
16	Bid Documents and Bidding Construction for Fire Sprinkler Pipe r	2012	6,578	439	15	439		1,096	16
17	Replace plumbling and dryer vents at Krause Building in laundry s	2012	3,062	612	5	612		1,582	17
18	Replacement of the dry protion of the fire sprinkler system	2012	45,000	2,250	20	2,250		5,250	18
19	Replacement of the dry protion of the fire sprinkler system	2012	6,578	657	10	657		1,096	19
20	Remove Drywall, install new durock, New Tile Base Board and nev	2012	8,462	847	10	847		1,763	20
21	Replacement of the dry protion of the fire sprinkler system	2012	1,950		2			1,950	21
22	Install new industrial Oven and dryer, remove existing.	2012	4,268	854	5	854		2,134	22
23	72 New Pewter Gray frame dining room chairs, stackable	2012	7,204	480	15	480		1,001	23
24	Remove (3) 5-Ton Amana rooftop (1) 2.5 - Ton Amana rooftop and	2011	24,000	1,600	15	1,600		4,800	24
25	Replace Lift Station pump & Controls - Parking Lot Lift Stations -	2011	8,986	899	10	899		2,321	25
26	Replace (3) pairs of Doors & Frames at West & East sides of buildi	2012	16,800	840	20	840		1,960	26
27	Convert Greenhouse into conference room. Demo existing glass, fra	2012	15,950	1,063	15	1,063		2,215	27
28	Install Industrial Washing Machine, remove old	2012	1,425	475	3	475		990	28
29	Install Industrial Washing Machine, remove old	2012	1,413	471	3	471		981	29
30	Architectural Fees for window replacememt	2012	6,750	1,350	5	1,350		2,700	30
31	Replace 17 Horn/Strobe MC Red fire alarm systems	2012	5,310	759	7	759		1,517	31
32	Replace (2) Solstice Standard Gas Fryers, Heavy Duty, 110,000 BT	2012	3,721	1,240	3	1,240		2,481	32
33	Permit Fee for Greenhouse conversion	2012	311	129	2	129		285	33
34	TOTAL (lines 1 thru 33)		$ 5,664,354	$ 203,956		$ 203,959	$ 3	$ 3,848,004	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: 7/1/2013 Ending: 6/30/2014

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 12C, Carried Forward		$ 5,664,354	$ 203,956		$ 203,959	$ 3	$ 3,848,004	1
2	City or Rolling Meadows Permit fee for Window installation	2012	1,723	718	2	718		1,579	2
3	Removal and disposal of old and installation of 55 new window uni	2012	175,000	5,833	20	5,833		14,583	3
4	1st payment of pool removal. Fill in pool with concrete, patching, te	2012	47,764	1,592	30	1,592		2,521	4
5	Engineer Fee for Pool Project Removal	2012	834	417	2	417		660	5
6	Installation of Digital Video Surveillance Protection and install new	2012	5,155	2,578	2	2,578		4,916	6
7	Architectural Work for building floor replacement	2013	7,500	1,500	5	1,500		2,250	7
8	2nd payment of pool removal. Midwest wrecking, concrete, masona	2013	119,610	3,987	30	3,987		5,981	8
9	Replace Automatic Sprinkler System, Nitrogen generation system,	2013	88,901	4,445	20	4,445		6,668	9
10	3rd payment of pool removal. Repairs to colums supporting roof, d	2013	145,483	4,849	30	4,849		6,870	10
11	Install Energy Efficient Equipment to reduce electricty bills	2013	6,150	615	10	615		871	11
12	4th payment for pool removal. Electrical work and replace window	2013	53,126	1,771	30	1,771		2,361	12
13	5th payment for pool removal. Vengar contruction group labor cal	2013	80,899	2,696	30	2,696		3,371	13
14	1st payment for Floor Replacement for pool area project	2013	41,127	2,742	15	2,742		3,199	14
15	Final Payment for pool project. Rental equipment	2013	13,023	434	30	434		506	15
16	True# TSD-47G 54" S/S exterior galls slide door refrigerator	2013	3,500	1,750	2	1,750		1,896	16
17	Architectural Drawings/Work for New Living Space created in old	2013	136,005	4,534	30	4,534		4,911	17
18	2nd payment for Floor Replacement for pool area project	2013	30,436	2,029	15	2,029		2,029	18
19	Remove existing cabinets, repair drywall, install new kitchen cabin	2013	4,850	970	5	970		1,051	19
20	Remove & Replace concrete ramps at fire exit doors in 5 hallway lo	2013	14,174	1,181	10	1,181		1,181	20
21	Install 2 dry chrome pendent sprinklers in northeast entrance over	2013	1,864	311	5	311		311	21
22	Remval of old and installation of Commerical Washer & Dryer and	2013	20,000	1,500	10	1,500		1,500	22
23	Remove existing cabinets, repair drywall, install new kitchen cabin	2013	4,985	1,523	3	1,523		1,523	23
24	3rd payment for Floor Replacement for pool area project	2013	30,436	1,521	15	1,521		1,521	24
25	Replace Floor in all 92 Bedrooms. Remove old flooring and replace	2013	171,500	5,717	20	5,717		5,717	25
26	Remove & Replace concrete ramps at fire exit doors in 5 locations	2013	26,174	3,054	5	3,054		3,054	26
27	Architectural Drawings/work for sewer replacment for entire build	2014	11,500	685	7	685		685	27
28	Architectural Drawings/work for sewer replacment for entire build	2014	3,927	327	3	327		327	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,910,000	$ 263,232		$ 263,235	$ 3	$ 3,930,043	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: 7/1/2013 Ending: 6/30/2014

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)	$	6,910,000	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	263,232	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	263,235	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	3	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	3,930,043	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: 7/1/2013 Ending: 6/30/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: 7/1/2013 Ending: 6/30/2014

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   ☐ YES
   ☐ NO

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

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

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

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: 7/1/2013 Ending: 6/30/2014

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: 7/1/2013 Ending: 6/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2014 (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	$	$ 2,202,644	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		521,974	5
6	Prepaid Insurance		155,598	6
7	Other Prepaid Expenses		379,295	7
8	Accounts Receivable (owners or related parties)		5,056,490	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 8,316,001	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,365,656	13
14	Buildings, at Historical Cost		23,213,385	14
15	Leasehold Improvements, at Historical Cost		262,846	15
16	Equipment, at Historical Cost		2,168,310	16
17	Accumulated Depreciation (book methods)		(11,860,918)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 18,155,198	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 26,471,199	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 1,024,916	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		144,654	28
29	Short-Term Notes Payable		400,322	29
30	Accrued Salaries Payable		846,660	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,704	32
33	Accrued Interest Payable		368,070	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED EMP BENEFITS		1,329,457	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 4,190,783	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,198,871	40
41	Bonds Payable		4,325,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO HUD		131,039	43
44	DUE TO TEMP RESTRICTED		1,584,244	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,239,154	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 14,429,937	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,041,262	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,041,262	$ 14,429,937	48

*(See instructions.)

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,146,295	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,146,295	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,207,813)	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	1,102,780	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (105,033)	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)**	$ 12,041,262	24 *

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,233,531	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,233,531	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	26,071	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)**	$ 26,071	23
	D. Non-Operating Revenue		
24	Contributions	144,234	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 144,234	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)**	$ 5,403,836	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,236,109	31
32	Health Care	3,449,797	32
33	General Administration	1,374,831	33
	B. Capital Expense		
34	Ownership	256,330	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	294,582	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,611,649	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,207,813)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,207,813)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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: 7/1/2013 Ending: 6/30/2014

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	17,775	17,775	564,879	31.78	3
4	Licensed Practical Nurses	5,455	5,455	145,492	26.67	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,040	1,040	10,935	10.51	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,550	13,550	145,810	10.76	15
16	Dishwashers					16
17	Maintenance Workers	5,160	5,160	86,048	16.68	17
18	Housekeepers	12,230	12,230	140,138	11.46	18
19	Laundry					19
20	Administrator	3,750	3,750	112,612	30.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,820	1,820	26,975	14.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	240	240	13,583	56.60	27
28	Qualified MR Prof. (QMRP)	15,005	15,005	216,240	14.41	28
29	Resident Services Coordinator	1,820	1,820	38,239	21.01	29
30	Habilitation Aides (DD Homes)	26,674	26,674	1,726,199	64.71	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,519	104,519	$ 3,227,150 *	$ 30.88	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	25,000	15	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	120	1,943	15	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	350	15	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)	50	5,400	15	46
47		165	15,180	15	47
48		220	21,239	15	48
49	TOTAL (lines 35 - 48)	679	$ 69,112		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: 7/1/2013 Ending: 6/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JESSICA SMART	ADMINISTRATOR		$ 75,617
SUSAN KAUFMAN	VP PROGRAMS		20,000
ROD ISHMAN	COORDINATOR		38,239
STACEY BELLOMO	PROGRAM DEV		16,995
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 150,851

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
NWC HOSPITAL	STAFF ED EXAMS	$ 5,434
MOVING AND RECRUITING	MONSTER.COM	877
BMO HARRIS	BANK FEES	85
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 6,396

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,703
Unemployment Compensation Insurance	33,200
FICA Taxes	238,564
Employee Health Insurance	276,064
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	55,112
TOTAL (agree to Schedule V, line 22, col.8)	$ 675,643

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

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MILEAGE REIMBURSEMENT	4,485
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,485

**See instructions.

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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: 7/1/2013 Ending: 6/30/2014

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. **no**

(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? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,552** Line **24**

(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. **na**

(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. $ **294,582**
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. $ **none** Has any meal income been offset against related costs? **na** 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? **yes**
g. Does the facility transport residents to and from day training? yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **plante moran**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **na**
Attach invoices and a summary of services for all architect and appraisal fees.