FOR BHF USE

LL1

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

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0014290

Facility Name: THE CLAYBERG

Address: EAST MONROE STREET (Number) CUBA (City) 61427 (Zip Code)

County: FULTON

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

HFS ID Number:

Date of Initial License for Current Owners: 7/6/1969

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2015 to 11/30/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MARCOS A PEREZ
(Title) ADMINISTRATOR

Paid Preparer

(Signed) Compilation Report is attached (Date)
(Print Name and Title) JEFF MCPHERSON, PARTNER
(Firm Name & Address) GRAY HUNTER STENN LLP, 500 MAINE STREET, QUINCY, IL 62301
(Telephone) (217) 222-0304 Fax # (217) 222-1691

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6	92	1,068	1,166	8
9	SNF/PED					9
10	ICF	10,560	5,212		15,772	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,566	5,304	1,068	16,938	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.45%

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)
MEAL DELIVERY

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/6/1969

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 [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 1,068

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 11/30/2016 Fiscal Year: 11/30/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	218,024	10,335	4,070	232,429		232,429		232,429			1
2	Food Purchase		109,898		109,898		109,898	(8,643)	101,255			2
3	Housekeeping	159,231	10,768		169,999		169,999		169,999			3
4	Laundry		13,350		13,350		13,350		13,350			4
5	Heat and Other Utilities			80,430	80,430		80,430	(3,216)	77,214			5
6	Maintenance	68,857	6,457	59,931	135,245		135,245		135,245			6
7	Other (specify):*											7
8	TOTAL General Services	446,112	150,808	144,431	741,351		741,351	(11,859)	729,492			8
	B. Health Care and Programs											
9	Medical Director			500	500		500		500			9
10	Nursing and Medical Records	1,130,375	122,975	27,810	1,281,160		1,281,160		1,281,160			10
10a	Therapy											10a
11	Activities	82,094	4,683	1,250	88,027		88,027		88,027			11
12	Social Services	44,886			44,886		44,886		44,886			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,257,355	127,658	29,560	1,414,573		1,414,573		1,414,573			16
	C. General Administration											
17	Administrative	74,175			74,175		74,175		74,175			17
18	Directors Fees											18
19	Professional Services			22,631	22,631		22,631		22,631			19
20	Dues, Fees, Subscriptions & Promotions			21,581	21,581		21,581	(7,189)	14,392			20
21	Clerical & General Office Expenses	58,742	11,167	9,825	79,734		79,734		79,734			21
22	Employee Benefits & Payroll Taxes			711,094	711,094		711,094		711,094			22
23	Inservice Training & Education			226	226		226		226			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,860	1,860		1,860		1,860			25
26	Insurance-Prop.Liab.Malpractice			42,859	42,859		42,859		42,859			26
27	Other (specify):*											27
28	TOTAL General Administration	132,917	11,167	810,076	954,160		954,160	(7,189)	946,971			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,836,384	289,633	984,067	3,110,084		3,110,084	(19,048)	3,091,036			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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: 12/1/2015 Ending: 11/30/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			46,378	46,378		46,378		46,378			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			3,087	3,087		3,087		3,087			35
36	Other (specify):*											36
37	**TOTAL Ownership**			49,465	49,465		49,465		49,465			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,280	2,280		2,280		2,280			38
39	Ancillary Service Centers	81,476	10,136	250,705	342,317		342,317		342,317			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,663	115,663		115,663		115,663			42
43	Other (specify):*			3,714	3,714		3,714		3,714			43
44	**TOTAL Special Cost Centers**	81,476	10,136	372,362	463,974		463,974		463,974			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,917,860	299,769	1,405,894	3,623,523		3,623,523	(19,048)	3,604,475			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	(8,643)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,216)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,189)	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)**	$ (19,048)		$	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))**	$ (19,048)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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
FULTON COUNTY	100					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		IMRF	$ 205,220	FULTON COUNTY	100.00%	$ 205,220	$	1
2	V		FICA	136,823	FULTON COUNTY	100.00%	136,823		2
3	V		WORKERS' COMP INSURANCE	94,218	FULTON COUNTY	100.00%	94,218		3
4	V		UNEMPLOYMENT INSURANCE	8,528	FULTON COUNTY	100.00%	8,528		4
5	V		PROPERTY & LIABILITY INSURAN	42,859	FULTON COUNTY	100.00%	42,859		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			$ 487,648			$ 487,648	$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 1/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	FIRST MIDSTATE INC.		X	CAPITAL IMPROVEMENTS	$6,392.00	11/30/16	$ 1,000,000	$ 1,000,000	12/1/2036	4.5000	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$6,392.00		$ 1,000,000	$ 1,000,000			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,000,000	$ 1,000,000			$	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.)**

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 12/1/2015 Ending: 11/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,920 B. General Construction Type: Exterior BRICK Frame CONCRETE & 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).

NONE

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	49		1969		$ 271,336	$	40	$	$	$ 271,336	4
5			1978		8,009		20			8,009	5
6			1979		52,096		30			52,096	6
7											7
8											8
	Improvement Type**										
9	OFFICE REMODEL			1983	2,546		10			2,546	9
10	SHED, ROOF AND FLOOR TILE			1987	5,429		20 TO 25			5,429	10
11	IDPA ADJUSTMENT			1989	1,806	90	20	90		1,715	11
12	ROOF			1993	61,283		15			61,283	12
13	ROAD REPAIR			1994	13,496		5			13,496	13
14	STORAGE BUILDING ADDITION			1994	4,265		20			4,265	14
15	STORAGE BUILDING ADDITION			1996	12,141	219	20	219		12,141	15
16	LAUNDRY FACILITY			1997	15,274	764	20	764		14,987	16
17	H/C SYSTEM			2000	4,564	228	20	228		3,689	17
18	WALK, PATH			2001	4,177	232	15	232		4,177	18
19	WALK, PATH			2002	1,357	90	15	90		1,304	19
20	AVIARY			2002	4,740	316	15	316		4,556	20
21	TWO A/C UNITS			2004	4,583		10			4,583	21
22	FLOOR TILE			2005	290	12	25	12		137	22
23	ELECTRICAL BOX			2005	141	6	25	6		67	23
24	TWO METAL DOORS			2005	1,166	39	30	39		456	24
25	WALL COVERINGS			2005	697		5			697	25
26	EGRESS LIGHTS			2005	423	28	15	28		331	26
27	SMOKE DETECTORS			2005	2,915		10			2,915	27
28	NEW CORRIDOR WALL			2005	367	15	25	15		173	28
29	KITCHEN FIRE SYSTEM			2005	2,877	82	35	82		952	29
30	SIDEWALK			2005	802	53	15	53		615	30
31	LABOR FOR BLDG IMPROVEMENT			2005	5,904	394	15	394		4,526	31
32	WALL H/C UNITS			2005	2,729		10			2,729	32
33	HARBOR IN GARDEN			2005	868	35	25	35		387	33
34	BASE BOARD HEATERS			2006	278	18	15	18		203	34
35	FLOOR TILE			2006	640	26	25	26		275	35
36	EAST EGRESS			2006	1,701	113	15	113		1,200	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	EAST EGRESS SOIL	2006	$ 390	$ 13	30	$ 13	$	$ 138	37
38	DOOR AND FRAME	2006	614	20	30	20		217	38
39	WATER MAIN	2006	9,291	232	40	232		2,400	39
40	WATER MAIN WALKWAY	2006	1,031	69	15	69		710	40
41	DOOR LOCKS	2006	474	32	15	32		321	41
42	LABOR FOR BLDG IMPROVEMENT	2006	4,098	273	15	273		2,869	42
43	STEEL DOOR	2007	630	21	30	21		201	43
44	SPRINKLER SYSTEM/CEILING UPGRADE	2007	151,553	10,103	15	10,103		94,300	44
45	WIRING/ELECTRICAL OUTLETS	2007	635	32	20	32		293	45
46	4 A/C UNITS	2007	1,668	167	10	167		1,543	46
47	SENTRICON BAITING SYSTEM	2008	1,272	85	15	85		763	47
48	PACKAGED UNIT AND DUCT WORK	2008	6,105	407	15	407		3,290	48
49	ROOF WORK	2008	28,174	1,878	15	1,878		15,026	49
50	GENERATOR REPAIR	2009	2,170	145	15	145		1,037	50
51	FIRE PROTECTION - SPRINKLER SYSTEM	2009	25,825	1,722	15	1,722		12,052	51
52	WALL PAPER	2010	6,294	420	15	420		2,832	52
53	GARAGE DOOR	2012	848	85	10	85		402	53
54	DINING DOOR	2012	3,092	103	30	103		489	54
55	HEAT/COOL WALL AIR CONDITIONER	2012	1,912	191	10	191		908	55
56	3 HEAT/COOL WALL AIR CONDITIONERS	2012	2,166	217	10	217		957	56
57	FLOOR FINISH	2012	599	24	25	24		98	57
58	OFFICE CARPET	2012	1,601	160	10	160		640	58
59	LINEN CLOSET DOORS	2013	2,072	104	20	104		380	59
60	JUICE BAR FOR DINING ROOM	2013	550	27	20	27		99	60
61	4 THROUGH WALL H/C UNITS	2013	4,607	461	10	461		1,558	61
62	DOOR ALARM AND OPENERS	2013	31,838	1,592	20	1,592		5,174	62
63	ENTRANCE REPLACEMENT	2013	123,864	4,129	30	4,129		13,075	63
64	FLOWER BOXES AND LANDSCAPING	2013	4,281	285	15	285		880	64
65	WALL KIOSK	2014	8,254	825	10	825		2,132	65
66	FLOOR - DINING ROOM	2015	11,222	748	15	748		748	66
67	AMANA AIR CONDITIONER	2015	2,709	181	15	181		181	67
68	FIRE WALL PROTECTION BARRIERS	2016	10,000	300	15	300		300	68
69	UNIVERSAL GAS WATER HEATER	2016	6,228	311	15	311		311	69
70	TOTAL (lines 4 thru 69)		$ 944,967	$ 28,122		$ 28,122	$	$ 647,599	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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		$ 944,967	$ 28,122		$ 28,122	$	$ 647,599	1
2	SILENT KNIGHT 10 ZONE ALARM	2016	2,560	71	15	71		71	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
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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)		$ 947,527	$ 28,193		$ 28,193	$	$ 647,670	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	$ 166,450	$ 18,185	$ 18,185	$	3 TO 20	$ 106,395	71
72	Current Year Purchases	3,018				10		72
73	Fully Depreciated Assets	192,131				3 TO 20	192,131	73
74								74
75	TOTALS	$ 361,599	$ 18,185	$ 18,185	$		$ 298,526	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 TRANSPORTATI	2000 CHEVROLET BUS	2000	$ 42,641	$	$	$	5	$ 42,641	76
77	PICKUP, DELIVERY, & PL	2001 FORD TRUCK W/ 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)	$ 1,380,584	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 46,378	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 46,378	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)	$ 1,012,654	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	WINDOW REPLACEMENT	$ 1,830	92
93	REMODEL/ADDITION	11,980	93
94			94
95		$ 13,810	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 3,087 Description: Copier $183.23 per month and dish washing machine $74 per 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

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

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

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

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

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

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	39-3	hrs	$	1,720	$ 130,403	$	1,720	$ 130,403	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		327	17,869		327	17,869	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		1,164	98,811		1,164	98,811	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts		6,661	3,622		6,661	3,622	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): STOCK DRUGS	39-2					10,136		10,136	12
13	Other (specify): RADIOLOGY	43-3				1,770			1,770	13
14	TOTAL			$	9,872	$ 252,475	$ 10,136	9,872	$ 262,611	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2016 (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	$ 2,283,646	$	1
2	Cash-Patient Deposits	3,934		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	383,575		3
4	Supply Inventory (priced at COST)	4,267		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	455,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,130,422	$	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	947,527		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	428,057		16
17	Accumulated Depreciation (book methods)	(1,012,654)		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 (spe CIP	13,810		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 381,740	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,512,162	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 52,320	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,934		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,601		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	134,856		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO GENERAL FUND	62,500		36
37	DEFERRED PROPERTY TAXES	455,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 804,211	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,000,000		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)**	$ 1,000,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,804,211	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,707,951	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,512,162	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,420,444	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,420,444	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(200,141)	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)**	$ (200,141)	17
	B. Transfers (Itemize):		
18	**Transfer in from County IMRF Fund**	205,220	18
19	**Transfer in from County FICA Fund**	136,823	19
20	**Transfer in from County Insurance Fund**	137,077	20
21	**Transfer in from County Unemployment Fund**	8,528	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 487,648	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,707,951	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	$ 2,973,341	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,973,341	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		13
14	Non-Patient Meals	8,643	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)**	$ 8,643	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,135	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,135	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PROPERTY TAXES	434,360	28
28a	MISCELLANEOUS RECEIPTS	2,903	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 437,263	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,423,382	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	741,351	31
32	Health Care	1,414,573	32
33	General Administration	954,160	33
	B. Capital Expense		
34	Ownership	49,465	34
	C. Ancillary Expense		
35	Special Cost Centers	348,311	35
36	Provider Participation Fee	115,663	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,623,523	40
41	**Income before Income Taxes (line 30 minus line 40)****	(200,141)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (200,141)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,613,901	44
45	Private Pay - Net Inpatient Revenue	673,422	45
46	Medicare - Net Inpatient Revenue	686,018	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,973,341	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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,254	$ 62,009	$ 27.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,635	11,070	317,342	28.67	3
4	Licensed Practical Nurses	9,712	11,144	237,512	21.31	4
5	CNAs & Orderlies	34,866	39,463	470,407	11.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,634	6,643	81,476	12.26	8
9	Activity Director	1,771	2,086	33,966	16.28	9
10	Activity Assistants	3,720	4,589	48,128	10.49	10
11	Social Service Workers	1,849	2,210	44,886	20.31	11
12	Dietician					12
13	Food Service Supervisor	1,827	2,145	45,108	21.03	13
14	Head Cook	7,600	8,945	103,452	11.57	14
15	Cook Helpers/Assistants	6,449	6,997	69,464	9.93	15
16	Dishwashers					16
17	Maintenance Workers	3,613	4,301	68,857	16.01	17
18	Housekeepers	12,091	14,243	159,231	11.18	18
19	Laundry					19
20	Administrator	2,160	2,322	74,175	31.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,263	58,742	25.96	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: CARE PLAN COO	1,252	1,903	43,105	22.65	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,339	122,578	$ 1,917,860 *	$ 15.65	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,070		35
36	Medical Director		500		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,622		39
40	Physical Therapy Consultant	1,164	98,811		40
41	Occupational Therapy Consultant	1,720	130,403		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	327	17,869		43
44	Activity Consultant	20	1,250		44
45	Social Service Consultant				45
46	Other(specify) RADIOLOGY		1,770		46
47	LAB		1,884		47
48					48
49	TOTAL (lines 35 - 48)	3,327	$ 260,179		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 THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEBORAH SIMAYTIS	ADMINISTRATOR (FORMER	0	$ 34,078
MARCOS PEREZ	ADMINISTRATOR	0	40,097
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,175

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
CHANEY TECHNOLOGY	IT SUPPORT	$ 5,803
MILLER, HALL & TRIGGS	LEGAL	14,438
TEMPLIN HEALTHCARE ACCT	ACCOUNTING CONSULTING	2,140
RAMIREZ CONSULTING	CONSULTING	250
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 22,631

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,218
Unemployment Compensation Insurance	8,528
FICA Taxes	136,823
Employee Health Insurance	263,061
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	205,220
EMPLOYEE PHYSICALS	2,185
DRUG TESTING	446
BONDING	100
NAME TAGS	513
TOTAL (agree to Schedule V, line 22, col.8)	$ 711,094

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,709
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 36	1,250
NON ALLOWABLE ADVERTISING	7,189
DUES AND SUBSCRIPTIONS	10,433
Less: Public Relations Expense	( )
Non-allowable advertising	(7,189)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,392

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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 $3,234**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **11,497** 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 fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **115,663**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **8,643**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all 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: **Gray Hunter Stenn LLP**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

Page 4, line 43	Radiology	$	1,770
	Laboratory		1,944
Page 19, line 28	Property Taxes	$	434,360
Page 19, line 28A	Misc. Reimbursements	$	2,903

Page 21,XIX, C. Legal Invoice Detail

Payee	Type of Service	Amount
Miller, Hall and Triggs	Union Negotiation	4,826
Miller, Hall and Triggs	Union Negotiation	8,002
Miller, Hall and Triggs	Employee Issues	165
Miller, Hall and Triggs	Union Negotiation	1,307
Miller, Hall and Triggs	Employee Issues	137