



Facility Name & ID Number The Clayberg

# 0014290 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

**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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,003	2,639	949	5,591	8
9	SNF/PED					9
10	ICF	8,095	3,275	0	11,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,098	5,914	949	16,961	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 94.83%

**D. How many bed reserve days during this year were paid by the Department?**  
0 (Do not include bed reserve 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

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

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

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

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 49 and days of care provided 949

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 11/30/2017 Fiscal Year: 11/30/2017

\* 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: 12/1/2016 Ending: 11/30/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	242,505	7,272	4,059	253,836		253,836		253,836		1
2	Food Purchase		123,779		123,779		123,779	(8,670)	115,109		2
3	Housekeeping	180,881	14,499		195,380		195,380		195,380		3
4	Laundry		14,754		14,754		14,754		14,754		4
5	Heat and Other Utilities			76,026	76,026		76,026	(3,703)	72,323		5
6	Maintenance	68,563	4,980	99,304	172,847		172,847		172,847		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	491,949	165,284	179,389	836,622		836,622	(12,373)	824,249		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			500	500		500		500		9
10	Nursing and Medical Records	1,112,848	106,914	27,631	1,247,393		1,247,393		1,247,393		10
10a	Therapy										10a
11	Activities	89,932	7,543	2,720	100,195		100,195		100,195		11
12	Social Services	43,180			43,180		43,180		43,180		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,245,960	114,457	30,851	1,391,268		1,391,268		1,391,268		16
	<b>C. General Administration</b>										
17	Administrative	82,808			82,808		82,808		82,808		17
18	Directors Fees										18
19	Professional Services			24,397	24,397		24,397		24,397		19
20	Dues, Fees, Subscriptions & Promotions			28,848	28,848		28,848	(17,261)	11,587		20
21	Clerical & General Office Expenses	57,822	13,792	12,756	84,370		84,370		84,370		21
22	Employee Benefits & Payroll Taxes			736,643	736,643		736,643		736,643		22
23	Inservice Training & Education			1,974	1,974		1,974		1,974		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			2,001	2,001		2,001		2,001		25
26	Insurance-Prop.Liab.Malpractice			39,457	39,457		39,457		39,457		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	140,630	13,792	846,076	1,000,498		1,000,498	(17,261)	983,237		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,878,539	293,533	1,056,316	3,228,388		3,228,388	(29,634)	3,198,754		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 &amp; ID Number

The Clayberg

#0014290

Report Period Beginning:

12/1/2016

Ending:

11/30/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			43,711	43,711		43,711		43,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,131	33,131		33,131		33,131			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,986	3,986		3,986		3,986			35
36	Other (specify):*			46,547	46,547		46,547		46,547			36
37	<b>TOTAL Ownership</b>			127,375	127,375		127,375		127,375			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			2,607	2,607		2,607		2,607			38
39	Ancillary Service Centers	119,608	10,530	159,354	289,492		289,492		289,492			39
40	Barber and Beauty Shops		29		29		29		29			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,741	124,741		124,741		124,741			42
43	Other (specify):* lab and radiology			3,905	3,905		3,905		3,905			43
44	<b>TOTAL Special Cost Centers</b>	119,608	10,559	290,607	420,774		420,774		420,774			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,998,147	304,092	1,474,298	3,776,537		3,776,537	(29,634)	3,746,903			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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,670)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,703)	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	(17,261)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (29,634)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (29,634)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	

**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.**  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	22 IMRF	\$ 211,754	Fulton County	100.00%	\$ 211,754	\$	1
2	V	22 FICA	150,912	Fulton County	100.00%	150,912		2
3	V	22 Workers' Comp Insurance	101,083	Fulton County	100.00%	101,083		3
4	V	26 Property & Liability Insurance	39,457	Fulton County	100.00%	39,457		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		\$ 503,206			\$ 503,206	\$ *	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: 12/1/2016 Ending: 11/30/2017

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg

# 0014290

Report Period Beginning:

12/1/2016

Ending: 1/30/2017

**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

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

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number

The Clayberg

# 0014290

Report Period Beginning:

12/1/2016

Ending:

11/30/2017

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	First Midstate Inc.		X	Capital Improvements	\$6,304.69	11/30/16	\$ 1,000,000	\$ 985,000	12/1/2036	4.5000	\$ 33,131	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$6,304.69		\$ 1,000,000	\$ 985,000			\$ 33,131	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,000,000	\$ 985,000			\$ 33,131	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.)



**2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1.	_____	\$ _____	\$ _____
2.	_____	\$ _____	\$ _____
3.	_____	\$ _____	\$ _____
4.	_____	\$ _____	\$ _____
5.	_____	\$ _____	\$ _____
6.	_____	\$ _____	\$ _____
7.	_____	\$ _____	\$ _____
8.	_____	\$ _____	\$ _____
9.	_____	\$ _____	\$ _____
10.	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>          </u>	\$ <u>          </u>

**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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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:

12/1/2016 Ending:

11/30/2017

**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?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number The Clayberg

# 0014290

Report Period Beginning:

12/1/2016

Ending:

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49	1969		\$ 271,336	\$	40	\$	\$	\$ 271,336	4
5		1978		8,009		20			8,009	5
6		1979		52,096		30			52,096	6
7										7
8										8
	<b>Improvement Type**</b>									
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	91	20	91		1,806	11
12	ROAD REPAIR		1994	13,496		5			13,496	12
13	STORAGE BUILDING ADDITION		1995	4,265		20			4,265	13
14	STORAGE BUILDING ADDITION		1996	12,141		20			12,141	14
15	LAUNDRY FACILITY		1997	15,274	255	20	255		15,242	15
16	H/C SYSTEM		2000	4,564	228	20	228		3,918	16
17	WALK, PATH		2001	4,177		15			4,177	17
18	WALK, PATH		2002	1,357	53	15	53		1,357	18
19	AVIARY		2002	4,740	184	15	184		4,740	19
20	TWO A/C UNITS		2004	4,583		10			4,583	20
21	TWO METAL DOORS		2005	1,166	39	30	39		495	21
22	WALL COVERINGS		2005	697		5			697	22
23	SMOKE DETECTORS		2005	2,915		10			2,915	23
24	KITCHEN FIRE SYSTEM		2005	2,877	82	35	82		1,034	24
25	SIDEWALK		2005	802	53	15	53		668	25
26	WALL H/C UNITS		2005	2,729		10			2,729	26
27	HARBOR IN GARDEN		2005	868	35	25	35		422	27
28	WATER MAIN		2006	9,291	233	40	233		2,633	28
29	SPRINKLER SYSTEM/CEILING UPGRADE		2007	138,564	9,238	15	9,238		95,455	29
30	PACKAGED UNIT AND DUCT WORK		2008	6,105	407	15	407		3,697	30
31	FIRE PROTECTION - SPRINKLER SYSTEM		2009	14,700	980	15	980		7,840	31
32	WALL PAPER		2010	6,294	420	15	420		3,252	32
33	DINING DOOR		2012	3,092	103	30	103		592	33
34	HEAT/COOL WALL AIR CONDITIONER		2012	1,912	191	10	191		1,099	34
35	3 HEAT/COOL WALL AIR CONDITIONERS		2012	2,166	216	10	216		1,173	35
36	4 THROUGH WALL H/C UNITS		2013	4,607	460	10	460		2,018	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

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 DOOR ALARM AND OPENERS	2013	\$ 31,838	\$ 1,592	20	\$ 1,592	\$	\$ 6,766	37
38 ENTRANCE REPLACEMENT	2013	122,450	4,082	30	4,082		17,007	38
39 FLOOR - DINING ROOM	2015	11,222	748	15	748		1,496	39
40 AMANA AIR CONDITIONER	2015	2,709	181	15	181		362	40
41 FIRE WALL PROTECTION BARRIERS	2016	10,000	400	15	400		700	41
42 UNIVERSAL GAS WATER HEATER	2016	6,228	416	15	416		727	42
43 SILENT KNIGHT 10 ZONE ALARM	2016	2,560	171	15	171		242	43
44 PARKING LOT EXTENSION	2017	54,387	1,209	15	1,209		1,209	44
45 ROOF REPLACEMENT	2017	257,439	2,860	15	2,860		2,860	45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,103,437	\$ 24,927		\$ 24,927	\$	\$ 563,229	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:

12/1/2016

Ending:

11/30/2017

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	\$ 154,108	\$ 16,879	\$ 16,879	\$	3 to 20	\$ 107,913	71
72	Current Year Purchases	36,175	1,905	1,905		5 to 10	1,905	72
73	Fully Depreciated Assets	174,364				3 to 20	174,364	73
74								74
75	TOTALS	\$ 364,647	\$ 18,784	\$ 18,784	\$		\$ 284,182	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2000 Chevrolet Bus	2000	\$ 42,641	\$	\$	\$	5	\$ 42,641	76
77	Pickup, delivery, & plowing	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)	\$ 1,539,542	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,711	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,711	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)	\$ 913,869	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	\$ 102,967	92
93	Remodel/Addition	51,882	93
94	HVAC Modification	5,490	94
95		\$ 160,339	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: 12/1/2016

Ending: 11/30/2017

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 3,986

Description: Copier \$262.35 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	<b>TOTAL</b>		\$	\$	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



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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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.)

	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	\$	1,250	\$ 68,612	\$	1,250	\$ 68,612	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		243	16,763		243	16,763	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		1,127	69,738		1,127	69,738	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 prescripts		5,989	4,241		5,989	4,241	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Stock Drugs</u>	39-2					10,530		10,530	12
13	Other (specify): <u>Radiology</u>	39-3				1,070			1,070	13
14	<b>TOTAL</b>			\$	8,609	\$ 160,424	\$ 10,530	8,609	\$ 170,954	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:      **12/1/2016**Ending:      **11/30/2017****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of      **11/30/2017**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,942,079	\$	1
2	Cash-Patient Deposits	3,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	559,591		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): <b>Property Tax Receivable</b>	476,000		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,984,937	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	1,103,437		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	431,105		16
17	Accumulated Depreciation (book methods)	(913,869)		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 <b>Construction in Progr</b> )	160,339		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 786,012	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,770,949	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 95,593	\$	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	123,345		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	143,473		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Deferred Property Taxes</b>	476,000		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 842,345	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	985,000		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 985,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,827,345	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,943,604	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,770,949	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,707,951</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,707,951</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(330,053)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (330,053)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<u>Transfer in from County IMRF Fund</u>	211,754	<b>18</b>
<b>19</b>	<u>Transfer in from County FICA Fund</u>	150,912	<b>19</b>
<b>20</b>	<u>Transfer in from County Insurance Fund</u>	140,540	<b>20</b>
<b>21</b>	<u>Transfer in from County General Fund</u>	62,500	<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 565,706	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,943,604	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg# 0014290Report Period Beginning: 12/1/2016Ending: 11/30/2017**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,976,474	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,976,474	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	8,670	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 8,670	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Property Taxes</u>	454,595	28
28a	<u>Miscellaneous Income</u>	6,745	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 461,340	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,446,484	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	836,622	31
32	Health Care	1,391,268	32
33	General Administration	1,000,498	33
<b>B. Capital Expense</b>			
34	Ownership	127,375	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	296,033	35
36	Provider Participation Fee	124,741	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,776,537	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(330,053)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (330,053)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,644,356	44
45	Private Pay - Net Inpatient Revenue	864,384	45
46	Medicare - Net Inpatient Revenue	467,734	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,976,474	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:

12/1/2016

Ending:

11/30/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 66,313	\$ 31.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,415	11,848	309,919	26.16	3
4	Licensed Practical Nurses	9,320	10,704	227,569	21.26	4
5	CNAs & Orderlies	38,131	42,632	449,951	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,084	8,777	119,608	13.63	8
9	Activity Director	1,881	2,169	34,382	15.85	9
10	Activity Assistants	3,963	4,946	55,550	11.23	10
11	Social Service Workers	1,873	2,276	43,180	18.97	11
12	Dietician					12
13	Food Service Supervisor	2,005	2,424	47,393	19.55	13
14	Head Cook	6,838	8,215	104,124	12.67	14
15	Cook Helpers/Assistants	7,544	8,897	90,988	10.23	15
16	Dishwashers					16
17	Maintenance Workers	3,791	4,464	68,563	15.36	17
18	Housekeepers	14,299	16,620	180,881	10.88	18
19	Laundry					19
20	Administrator	2,080	2,080	82,808	39.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	57,822	27.80	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 Care <u>Care Plan Coordin</u>	1,983	2,259	59,096	26.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,367	132,471	\$ 1,998,147 *	\$ 15.08	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	96	\$ 4,059	1-3	35
36	Medical Director		500	9-3	36
37	Medical Records Consultant		607	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,241	39-3	39
40	Physical Therapy Consultant	1,127	69,738	39-3	40
41	Occupational Therapy Consultant	1,520	68,612	39-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	243	16,763	39-3	43
44	Activity Consultant	28	2,720	11-3	44
45	Social Service Consultant				45
46	Other(specify) <u>Radiology</u>		1,070	43-3	46
47	<u>Lab</u>		2,835	43-3	47
48					48
49	TOTAL (lines 35 - 48)	3,014	\$ 171,145		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' PREPARATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Marcos Perez	Administrator	0	\$ 82,808	Workers' Compensation Insurance	\$ 101,083	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	3,689	
				FICA Taxes	150,912	Health Care Worker Background Check	850	
				Employee Health Insurance	269,812	(Indicate # of checks performed <u>12</u> )		
				Employee Meals		Patient Background Checks	400	
				Illinois Municipal Retirement Fund (IMRF)*	211,754	Non allowable advertising	9,769	
				Employee Physicals	2,660	Dues and Subscriptions	6,648	
				Drug Testing	322			
				Bonding	100			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,808	TOTAL (agree to Schedule V, line 22, col.8)		\$ 11,587		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Entertainment Expense	( )
C. Professional Services							TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount				\$	
Chaney Technologies	IT Support		\$ 7,012					
Templin Healthcare Acctg	Accounting Consulting		2,191					
Terrill Consulting	Reimbursement Consulting		15,194					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 24,397					

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name & ID Number The Clayberg# 0014290Report Period Beginning: 12/1/2016Ending: 11/30/2017**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 \$4,029
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,901 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 124,741  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,670
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Gray Hunter Stenn LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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

**SEE ACCOUNTANTS' PREPARATION REPORT**



<b>Page 4, line 43</b>	Radiology	\$	1,070
	Laboratory		2,835
<b>Page 19, line 28</b>	Property Taxes	\$	454,595
<b>Page 19, line 28A</b>	Misc. Reimbursements	\$	6,745