

		FOR BHF USE				

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**2017  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2017)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0033035</u></p> <p><b>Facility Name:</b> <u>CLEARBROOK WEST</u></p> <p><b>Address:</b> <u>3980 FAIRFAX</u> <u>ROLLING MEADOWS</u> <u>60008</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>847-870-7711</u> <b>Fax #</b> <u>847-870-9926</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1/31/89</u></p> <p><b>Type of Ownership:</b></p> <table border="0" style="width:100%;"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td>    <input checked="" type="checkbox"/> Charitable Corp.</td> <td>    <input type="checkbox"/> Individual</td> <td>    <input type="checkbox"/> State</td> </tr> <tr> <td>    <input type="checkbox"/> Trust</td> <td>    <input type="checkbox"/> Partnership</td> <td>    <input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501C3</u></td> <td>    <input type="checkbox"/> Corporation</td> <td>    <input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td>    <input type="checkbox"/> "Sub-S" Corp.</td> <td>    <input type="checkbox"/> Limited Liability Co. _____</td> </tr> <tr> <td></td> <td>    <input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td>    <input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>EMMA HERSHEY</u> <b>Telephone Number:</b> <u>847-870-7711X5004</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> Limited Liability Co. _____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2016</u> to <u>06/30/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%; vertical-align: top; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>TONY DI VITTORIO</u> (Title) <u>PRESIDENT</u></td> </tr> <tr> <td style="width:25%; vertical-align: top; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"><b>9/30/2017</b> (Date)</p> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</b> Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>TONY DI VITTORIO</u> (Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																								
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																								
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Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____																									

Facility Name & ID Number CLEARBROOK WEST

# 0033035 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

**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	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,620			5,620	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,620			5,620	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.23%**

**D. How many bed reserve days during this year were paid by the Department?**  
6 (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)**  
none

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

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

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

**I. On what date did you start providing long term care at this location?**  
Date started 1/31/1989

**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 \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary none

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30 Fiscal Year: 6/30

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

Facility Name & ID Number **CLEARBROOK WEST** # **0033035** Report Period Beginning: **07/01/2016** Ending: **06/30/2017**

**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	31,099	32,938	3,185	67,222		67,222	67,222			1
2	Food Purchase										2
3	Housekeeping		8,709		8,709		8,709	8,709			3
4	Laundry										4
5	Heat and Other Utilities			16,236	16,236		16,236	16,236			5
6	Maintenance	673	6,384	59,361	66,418		66,418	4,506	70,924		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	31,772	48,031	78,782	158,585		158,585	4,506	163,091		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	2,254	24,259	29,820	56,333		56,333	56,333	56,333		9
10	Nursing and Medical Records	432,529			432,529		432,529	432,529	432,529		10
10a	Therapy										10a
11	Activities		181		181		181	181	181		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*				96,468		96,468	96,468	96,468		15
16	<b>TOTAL Health Care and Programs</b>	434,783	24,440	29,820	585,511		585,511		585,511		16
	<b>C. General Administration</b>										
17	Administrative	33,483			33,483		33,483	37,805	71,288		17
18	Directors Fees										18
19	Professional Services			8,962	8,962		8,962	3,742	12,704		19
20	Dues, Fees, Subscriptions & Promotions			33	33		33	767	800		20
21	Clerical & General Office Expenses			820	820		820	1,134	1,954		21
22	Employee Benefits & Payroll Taxes			113,316	113,316		113,316	8,656	121,972		22
23	Inservice Training & Education			814	814		814	1,312	2,126		23
24	Travel and Seminar			1,635	1,635		1,635		1,635		24
25	Other Admin. Staff Transportation							4,650	4,650		25
26	Insurance-Prop.Liab.Malpractice			7,367	7,367		7,367	393	7,760		26
27	Other (specify):*			5,560	5,560		5,560		5,560		27
28	<b>TOTAL General Administration</b>	33,483		138,507	171,990		171,990	58,459	230,449		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	500,038	72,471	247,109	916,086		916,086	62,965	979,051		29

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

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

Facility Name & ID Number **CLEARBROOK WEST**

#0033035

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

## 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			36,561	36,561		36,561	573	37,134			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,754	31,754		31,754	1,490	33,244			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			68,315	68,315		68,315	2,063	70,378			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,292	47,292		47,292		47,292			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			47,292	47,292		47,292		47,292			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	500,038	72,471	362,716	1,031,693		1,031,693	65,028	1,096,721			45

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

Facility Name & ID Number CLEARBROOK WEST

# 0033035

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

**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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	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>	\$		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
							52

CLEARBROOK WEST

ID# 0033035

Report Period Beginning: 07/01/2016

Ending: 06/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
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31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number CLEARBROOK WEST

# 0033035

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLEARBROOK WEST

# 0033035

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	0	0	0	0	0	0	0	0	0	0	0	0	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45



**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number

CLEARBROOK WEST

# 0033035

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

**VII. RELATED PARTIES**

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

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

Facility Name & ID Number CLEARBROOK WEST # 0033035 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number CLEARBROOK WEST

# 0033035

Report Period Beginning:

07/01/2016

Ending: 6/30/2017

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 clearbrook  
 Street Address 1835 w central rd  
 City / State / Zip Code arlington heights, il 60005  
 Phone Number ( 847-870-7711  
 Fax Number ( 847-870-9926

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	6	MAINTENANCE	SALARIES	27,561,966	\$ 248,343	\$	500,036	\$ 4,506	1
2	17	ADMIN SALAREIS	SALARIES	27,561,966	2,083,801		500,036	37,805	2
3	19	PROFESSIONAL SVCS	SALARIES	27,561,966	206,276		500,036	3,742	3
4	20	DUES, FEES, SUBSCRIPTIONS	SALARIES	27,561,966	42,261		500,036	767	4
5	21	CLERICAL, GEN OFFICE	SALARIES	27,561,966	62,495		500,036	1,134	5
6	22	EMP BENEFITS, TAXES	SALARIES	27,561,966	477,130		500,036	8,656	6
7	23	IN SVC TRAINING	SALARIES	27,561,966	72,304		500,036	1,312	7
8	25	OTHER ADMIN, TRNG	SALARIES	27,561,966	256,306		500,036	4,650	8
9	26	INSURANCE	SALARIES	27,561,966	21,657		500,036	393	9
10	32	INTEREST	SALARIES	27,561,966	82,134		500,036	1,490	10
11	30	DEPRECIATION	SALARIES	27,561,966	31,583		500,036	573	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,584,290	\$		\$ 65,028	25

Facility Name & ID Number CLEARBROOK WEST

# 0033035

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

**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			x	construct building	\$3,839.00	1/1/89	\$ 497,600	\$ 344,969	11/1/2028	9.0000	\$ 31,754	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>				\$3,839.00		\$ 497,600	\$ 344,969			\$ 31,754	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>						\$ 497,600	\$ 344,969			\$ 31,754	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,754 Line # 32

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 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 2017 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:	<b>2012</b>	<u>                    </u>	<b>8</b>
	<b>2013</b>	<u>                    </u>	<b>9</b>
	<b>2014</b>	<u>                    </u>	<b>10</b>
	<b>2015</b>	<u>                    </u>	<b>11</b>
	<b>2016</b>	<u>                    </u>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$ <u>                    </u>	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$ <u>                    </u>	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$ <u>                    </u>	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$ <u>                    </u>	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME CLEARBROOK WEST COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0033035

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 CLEARBROOK WEST

# 0033035 Report Period Beginning:

07/01/2016 Ending:

06/30/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,216 B. General Construction Type: Exterior aluminum Frame 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).

Blank lines for listing other business entities.

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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers. Row 1: land, 40,704, 1986, \$ 87,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 40,704, (blank), \$ 87,000, 3.



Facility Name &amp; ID Number CLEARBROOK WEST

# 0033035

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

**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				1989	\$ 495,998	\$ 13,302	40	\$ 13,302	\$	\$ 369,631	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Sprinkler System		1989	7,797	211	37	211		5,795	9
10		Sprinkler System		1990	1,729	47	37	47		1,285	10
11		Protective Wall Coverings		1993	2,480	71	35	71		1,736	11
12		Garage Addition		1994	5,740	168	34	168		3,967	12
13		Bathroom Remodeling		1998	7,726		10			7,726	13
14		Installation of New Carpet		2000	4,876		10			4,876	14
15		New Roof		2000	9,240		15			9,240	15
16		Kitchen Remodeling		2000	10,717	429	25	429		7,502	16
17		Bathroom Improvements		2000	9,043		15			9,043	17
18		Bathroom Improvements		2000	2,319		15			2,319	18
19		Handpunch Terminal Installation		2002	3,430		10			3,430	19
20		Installation of New Tile		2003	845		5			845	20
21		Installation of New Tile		2003	4,500		5			4,500	21
22		Installation of New Carpeting		2003	2,917		3			2,917	22
23		Installation of New Tile		2004	4,724		5			4,724	23
24		Repair of Air Conditioner		2006	1,822		3			1,822	24
25		Seal Coat Driveway		2007	2,675		3			2,675	25
26		Ceramic Tile Installation		2007	1,822		3			1,822	26
27		Rim Panic Device		2007	831		3			831	27
28		Ceiling Lifts		2009	17,025	1,716	10	1,716		13,446	28
29		Panacea 7200 Bed With Safety Locks		2010	1,770		5			1,770	29
30		CCTV System		2009	8,835	883	10	883		6,479	30
31		Fire Protection System		2009	2,200		3			2,200	31
32		Backflow Labor & Maintenance		2009	6,065		5			6,065	32
33		Install 15 New Window Panels		2010	1,492		1			1,492	33
34		Built in Refridgerator		2006	6,659		10			6,659	34
35		Sofa & Loveseat		2008	1,700		5			1,700	35
36		Steel Door & Life Master		2010	1,316		2			1,316	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fire Alarm System	2010	\$ 8,400	\$ 560	15	\$ 560	\$	\$ 3,873	37
38	Fire Alarm System	2010	8,400	840	10	840		5,670	38
39	Replace Drum & Pressure Switch	2010	2,150		3			2,150	39
40	Replace Lighting in Hallways	2011	5,900	590	10	590		3,589	40
41	Create Two New Office Spaces	2011	5,862	589	10	589		3,584	41
42	Installation of New Tile for Common Area	2011	2,417		3			2,417	42
43	Ceramic Tile Installation	2011	1,822		3			1,822	43
44	Replace Parking Lot & Sidewalks	2012	20,000	1,000	20	1,000		5,250	44
45	Replace Parking Lot & Sidewalks	2012	294		2			294	45
46	Installation of New HVAC System	2011	13,073	654	20	654		3,813	46
47	Installation of New Generator	2011	19,638	982	20	982		5,646	47
48	Installation of New Generator	2011	6,438	322	20	322		1,824	48
49	Replace Fire Sprinkler System	2013	44,723	4,472	10	4,472		18,635	49
50	Ford Starcraft 2014	2014	63,000	6,300	10	6,300		19,950	50
51	Installation of New Driveway and door replacements	2016	15,982	599	20	599		599	51
52	Fire Protection System for Building	2017	10,500	525	10	525		525	52
53	Addition to driveway and door replacement (line 51)	2017	532	89	2	89		89	53
54	Extending dining and living rooms - Addition to building	2017	16,300	136	10	136		136	54
55	Extending dining and living rooms - Addition to building	2017	16,700	139	10	139		139	55
56	Extending dining and living rooms - Addition to building	2017	2,400	20	10	20		20	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)		\$ 892,824	\$ 34,644		\$ 34,644	\$	\$ 567,837	70

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

**XI. OWNERSHIP COSTS (continued)**

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

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

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 979,824	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,644	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,644	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)	\$ 567,837	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
 (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input 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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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.

**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	4					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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.**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **06/30/2017**

(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	\$	\$ <b>972,484</b>	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )			3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		<b>419,341</b>	5
6	Prepaid Insurance		<b>350,971</b>	6
7	Other Prepaid Expenses		<b>440,933</b>	7
8	Accounts Receivable (owners or related parties)		<b>4,501,489</b>	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ <b>6,685,218</b>	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		<b>4,342,048</b>	13
14	Buildings, at Historical Cost		<b>25,061,130</b>	14
15	Leasehold Improvements, at Historical Cost		<b>458,039</b>	15
16	Equipment, at Historical Cost		<b>2,609,519</b>	16
17	Accumulated Depreciation (book methods)		<b>(14,172,905)</b>	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		<b>5,918</b>	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ <b>18,303,749</b>	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ <b>24,988,967</b>	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ <b>932,980</b>	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		<b>406,746</b>	29
30	Accrued Salaries Payable		<b>1,063,284</b>	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		<b>55,011</b>	32
33	Accrued Interest Payable			33
34	Deferred Compensation		<b>87,991</b>	34
35	Federal and State Income Taxes		<b>94,044</b>	35
	<b>Other Current Liabilities(specify):</b>			
36	<b>ACCRED EMP BEBENITS</b>		<b>1,466,595</b>	36
37	<b>DUE TO OTHER MISC</b>		<b>163,698</b>	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ <b>4,270,349</b>	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		<b>3,680,000</b>	40
41	Bonds Payable		<b>3,897,802</b>	41
42	Deferred Compensation		<b>195,795</b>	42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>DUE TO HUD</b>		<b>96,371</b>	43
44	<b>DUE TO TEMP RESTRICTED</b>		<b>100,254</b>	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ <b>7,970,222</b>	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ <b>12,240,571</b>	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$	\$ <b>12,748,396</b>	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$	\$ <b>12,748,396</b>	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>12,665,986</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>12,665,986</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(144,138)	<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>clearbrook net of clearbrook west</b>	226,548	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>82,410</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>12,748,396</b>	<b>24</b> *

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



**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

**classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 865,084	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 865,084	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	72,372	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 72,372	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	14,605	24
25	Interest and Other Investment Income***	32	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,637	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>training income</b>	490	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 490	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 952,583	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	163,091	31
32	Health Care	585,511	32
33	General Administration	230,449	33
<b>B. Capital Expense</b>			
34	Ownership	70,378	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	47,292	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,096,721	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(144,138)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (144,138)	43

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

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

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

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

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

Facility Name & ID Number **CLEARBROOK WEST**

# **0033035**

Report Period Beginning: **07/01/2016**

Ending:

**06/30/2017**

**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				1	
2	Assistant Director of Nursing				2	
3	Registered Nurses		22,288		3	
4	Licensed Practical Nurses				4	
5	CNAs & Orderlies				5	
6	CNA Trainees				6	
7	Licensed Therapist				7	
8	Rehab/Therapy Aides				8	
9	Activity Director				9	
10	Activity Assistants				10	
11	Social Service Workers				11	
12	Dietician				12	
13	Food Service Supervisor				13	
14	Head Cook		31,099		14	
15	Cook Helpers/Assistants				15	
16	Dishwashers				16	
17	Maintenance Workers		673		17	
18	Housekeepers				18	
19	Laundry				19	
20	Administrator		20,677		20	
21	Assistant Administrator				21	
22	Other Administrative	540	540	6,343	11.75	22
23	Office Manager	1,040	1,040	12,505	12.02	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	42	42	2,254	53.67	27
28	Qualified MR Prof. (QMRP)	2,080	2,080	34,922	16.79	28
29	Resident Services Coordinator			16,410		29
30	Habilitation Aides (DD Homes)			352,867		30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	3,702	3,702	\$ 500,038 *	\$ 135.07	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			35
36	Medical Director		24,000	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant		862	43
44	Activity Consultant			44
45	Social Service Consultant		21,870	45
46	Other(specify)			46
47	behaviorist		20,978	47
48				48
49	TOTAL (lines 35 - 48)		\$ 67,710	49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Jones	Administrator		\$ 33,483	Workers' Compensation Insurance	\$ 11,905	IDPH License Fee	\$	
				Unemployment Compensation Insurance	2,818	Advertising: Employee Recruitment	33	
				FICA Taxes	36,966	Health Care Worker Background Check		
				Employee Health Insurance	49,956	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
				403b	11,671			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 33,483					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 113,316	Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
plante moran	audit		\$ 4,900			\$	Out-of-State Travel	\$
laner muchin	legal		4,062					
							In-State Travel	1,635
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 8,962	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 1,635	

\* Attach copy of IMRF notifications

\*\*See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? no  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,130 Line 9
- (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 no NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO no 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. \$ \_\_\_\_\_  
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. \$ na Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 95%
  - d. Have vehicle usage logs been maintained? yes
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
  - g. Does the facility transport residents to and from day training? yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: plante moran
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. na  
Attach invoices and a summary of services for all architect and appraisal fees