

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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>I. IDPH Facility ID Number: <u>0014290</u></p> <p>Facility Name: <u>The Clayberg</u></p> <hr/> <p>Address: <u>625 East Monroe Street, PO Box 200</u> <u>Cuba</u> <u>61427</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Fulton</u></p> <p>Telephone Number: <u>(309) 785-5012</u> Fax # <u>(309) 785-5376</u></p> <p>HFS ID Number: <u>370914241001</u></p> <p>Date of Initial License for Current Owners: <u>7/6/69</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Bonnie Breese</u> Telephone Number: <u>(309) 785-5012</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p align="center"> I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/05</u> to <u>11/30/06</u> and certify to the best of my knowledge and belief that the said content 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 align="center"> 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:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Bonnie Breese</u> (Title) <u>Administrator</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>Helen Barrick Partner</u> (Firm Name & Address) <u>Clifton Gunderson, LLP 301 SW Adams, Ste 900, PO Box 1835, Peoria, IL 61656-1835</u> (Telephone) <u>(309) 671-4500</u> Fax # <u>(309) 671-4508</u> </td> </tr> </table> <p align="center"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Bonnie Breese</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Helen Barrick Partner</u> (Firm Name & Address) <u>Clifton Gunderson, LLP 301 SW Adams, Ste 900, PO Box 1835, Peoria, IL 61656-1835</u> (Telephone) <u>(309) 671-4500</u> Fax # <u>(309) 671-4508</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Bonnie Breese</u> (Title) <u>Administrator</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Helen Barrick Partner</u> (Firm Name & Address) <u>Clifton Gunderson, LLP 301 SW Adams, Ste 900, PO Box 1835, Peoria, IL 61656-1835</u> (Telephone) <u>(309) 671-4500</u> Fax # <u>(309) 671-4508</u>							

Facility Name & ID Number The Clayberg

0014290 Report Period Beginning: 12/1/05 Ending: 11/30/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	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			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	10,571	5,989		16,560
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	10,571	5,989		16,560

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.59%

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

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

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

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

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

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/06 Fiscal Year: 11/30/06

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/05 Ending: 11/30/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	170,150	7,124	2,816	180,090		180,090		180,090		
2	Food Purchase		91,298		91,298		91,298	(2,225)	89,073		
3	Housekeeping	147,866	7,782		155,648		155,648		155,648		
4	Laundry		7,982		7,982		7,982		7,982		
5	Heat and Other Utilities			61,909	61,909		61,909	(2,011)	59,898		
6	Maintenance	51,147	27,270	18,765	97,182		97,182		97,182		
7	Other (specify):*										
8	TOTAL General Services	369,163	141,456	83,490	594,109		594,109	(4,236)	589,873		
B. Health Care and Programs											
9	Medical Director										
10	Nursing and Medical Records	759,564	32,622	4,079	796,265		796,265		796,265		
10a	Therapy	43,389		4,205	47,594		47,594		47,594		
11	Activities	62,513	11,418	1,592	75,523		75,523		75,523		
12	Social Services	31,839		1,592	33,431		33,431		33,431		
13	CNA Training										
14	Program Transportation										
15	Other (specify):*										
16	TOTAL Health Care and Programs	897,305	44,040	11,468	952,813		952,813		952,813		
C. General Administration											
17	Administrative	70,899		1,529	72,428		72,428		72,428		
18	Directors Fees										
19	Professional Services			5,850	5,850		5,850		5,850		
20	Dues, Fees, Subscriptions & Promotions			10,107	10,107		10,107	(4,308)	5,799		
21	Clerical & General Office Expenses	39,867	5,767	3,686	49,320		49,320	5,364	54,684		
22	Employee Benefits & Payroll Taxes			490,465	490,465		490,465		490,465		
23	Inservice Training & Education			1,511	1,511		1,511		1,511		
24	Travel and Seminar			724	724		724		724		
25	Other Admin. Staff Transportation			1,061	1,061		1,061		1,061		
26	Insurance-Prop.Liab.Malpractice			29,584	29,584		29,584		29,584		
27	Other (specify):* fines and County assessment			83,515	83,515		83,515	(20,525)	62,990		
28	TOTAL General Administration	110,766	5,767	628,032	744,565		744,565	(19,469)	725,096		
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,377,234	191,263	722,990	2,291,487		2,291,487	(23,705)	2,267,782		

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

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

Facility Name & ID Number **The Clayberg**

#0014290

Report Period Beginning:

12/1/05

Ending:

11/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			43,969	43,969		43,969		43,969			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,758	1,758		1,758		1,758			35
36	Other (specify):*											36
37	TOTAL Ownership			45,727	45,727		45,727		45,727			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,815		5,815		5,815		5,815			39
40	Barber and Beauty Shops			828	828		828		828			40
41	Coffee and Gift Shops		4,491		4,491		4,491	(4,491)				41
42	Provider Participation Fee			26,828	26,828		26,828		26,828			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		10,306	27,656	37,962		37,962	(4,491)	33,471			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,377,234	201,569	796,373	2,375,176		2,375,176	(28,196)	2,346,980			45

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/05

Ending: 11/30/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,225)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,011)	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	(20,525)	27		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	(3,479)	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	(5,320)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,560)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	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)	5,364	sch VII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 5,364		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (28,196)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

The Clayberg

ID# 0014290
 Report Period Beginning: 12/1/05
 Ending: 11/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	lobbying portion of dues	\$ (829)	20	1
2	vending machine costs	(4,491)	41	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,320)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Clayberg

0014290 Report Period Beginning:

12/1/05

Ending:

11/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,225)	0	0	0	0	0	0	0	0	0	0	(2,225)	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	(2,011)	0	0	0	0	0	0	0	0	0	0	(2,011)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,236)	0	0	0	0	0	0	0	0	0	0	(4,236)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,308)	0	0	0	0	0	0	0	0	0	0	(4,308)	20
21	Clerical & General Office Expenses	0	(225,269)	0	0	0	0	0	0	0	0	0	(225,269)	21
22	Employee Benefits & Payroll Taxes	0	230,633	0	0	0	0	0	0	0	0	0	230,633	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):*	(20,525)	0	0	0	0	0	0	0	0	0	0	(20,525)	27
28	TOTAL General Administration	(24,833)	5,364	0	(19,469)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,069)	5,364	0	(23,705)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/05

Ending:

11/30/06

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(4,491)	0	0	0	0	0	0	0	0	0	0	(4,491) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(4,491)	0	0	0	0	0	0	0	0	0	0	(4,491) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(33,560)	5,364	0	0	0	0	0	0	0	0	0	(28,196) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Fulton County	100	none		Fulton County	Lewistown	county govt

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	21 payroll and accounts payable	\$ 230,633	Fulton County	100.00%	\$ 5,364	\$ (225,269)	1
2	V	22 health insurance	116,069	Fulton County	100.00%	230,633	114,564	2
3	V	22 IMRF	96,865	Fulton County	100.00%	116,069	19,204	3
4	V	22 FICA		Fulton County	100.00%	96,865	96,865	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		\$ 443,567			\$ 448,931	\$ * 5,364	14

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

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.

Facility Name & ID Number The Clayberg

0014290 Report Period Beginning: 12/1/05

Ending: 11/30/06

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/05

Ending:

11/30/06

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

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2005 report.		\$ <u>none</u>	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <u>none</u>	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>none</u>	3																								
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>none</u>	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ <u>none</u>	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ <u>none</u>	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		\$ <u>none</u>	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION\$</td><td>16</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION\$	16
2001	8																										
2002	9																										
2003	10																										
2004	11																										
2005	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION\$	16																									

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

12/1/05 Ending:

11/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,920 B. General Construction Type: Exterior brick Frame concrete block & steel Number of Stories one

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None.

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number The Clayberg

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 6,783	40	\$ 6,783		\$ 251,337	4
5			1978		8,009		20			8,009	5
6			1979		76,467	1,737	10 to 30	1,737		72,994	6
7											7
8											8
		Improvement Type**									
9		windows and plaster repair	1981		17,092		3 to 10			17,092	9
10		fire alarm and sprinkler system, front porch and patio	1982		8,432		5 to 20			8,432	10
11		office remodeling	1983		3,272		5 to 10			3,272	11
12		roof	1984		2,005		10			2,005	12
13		canvas, floors, sewer, box, sign, door	1985		17,304	322	15 to 25	322		16,217	13
14		roof and shutters	1986		3,066	16	15 to 25	16		3,002	14
15		shed, roof and floor tile	1987		17,275	259	15 to 25	259		16,903	15
16		heating and cooling system	1988		9,166	458	20	458		8,326	16
17		IDPA adjustment	1989		1,806	91	20	91		903	17
18		new shed	1990		8,284		15			8,284	18
19		new shed	1991		10,876	302	15	302		10,876	19
20		drain	1992		743	49	15	49		726	20
21		roof and greenhouse	1993		62,282	4,152	15	4,152		57,790	21
22		road repair	1994		13,496		5			13,496	22
23		storage building addition	1994		4,265	214	20	214		2,364	23
24		storage building addition	1996		12,141	607	20	607		6,458	24
25		laundry facility	1997		15,274	764	20	764		7,351	25
26		carpet, H/C system	2000		6,298	401	10 to 20	401		2,592	26
27		walk path	2001		4,177	279	15	279		1,439	27
28		walk path	2002		1,357	90	15	90		399	28
29		aviary	2002		4,740	316	15	316		1,396	29
30		flooring	2004		635	64	10	64		175	30
31		two A/C units	2004		4,583	458	10	458		1,070	31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	floor tile	2005	\$ 289	\$ 12	25	\$ 12		\$ 21	37
38	electrical box	2005	141	5	25	5		10	38
39	seal parking lot	2005	1,260	315	4	315		551	39
40	two metal doors	2005	1,166	39	30	39		68	40
41	wall coverings	2005	697	139	5	139		244	41
42	egress lights	2005	423	28	15	28		49	42
43	smoke detectors	2005	2,915	291	10	291		510	43
44	new corridor wall	2005	367	15	25	15		26	44
45	paint walls	2005	112	37	3	37		62	45
46	kitchen fire system	2005	2,877	82	35	82		130	46
47	sidewalk	2005	802	53	15	53		80	47
48	labor for bldg improvements	2005	5,904	393	15	393		590	48
49	heating and cooling units	2005	2,729	273	10	273		341	49
50	harbor in garden	2005	868	35	25	35		41	50
51	base board heaters	2006	278	17	15	17		17	51
52	wall board and glue	2006	168	28	5	28		28	52
53	floor tile	2006	640	19	25	19		19	53
54	East egress	2006	1,701	66	15	66		66	54
55	East egress soil	2006	390	8	30	8		8	55
56	door and frame	2006	614	12	30	12		12	56
57	water main	2006	9,291	77	40	77		77	57
58	water main walkway	2006	1,031	23	15	23		23	58
59	door locks	2006	474	5	15	5		5	59
60	labor for bldg improvements	2006	4,098	137	15	137		137	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)		\$ 623,616	\$ 19,471		\$ 19,471	\$	\$ 526,023	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 217,305	\$ 20,119	\$ 20,119	\$	5 to 20	\$ 129,781	71
72	Current Year Purchases	13,163	725	725		5 to 15	725	72
73	Fully Depreciated Assets	161,588	1,272	1,272		5 to 15	161,588	73
74								74
75	TOTALS	\$ 392,056	\$ 22,116	\$ 22,116	\$		\$ 292,094	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	patient transportation	2000 Chevy bus	2000	\$ 42,641	\$	\$	\$	5	\$ 42,641	76
77	pickup, delivery & plowing	2001 Ford truck with plow	2001	23,817	2,386	2,386		5	23,821	77
78										78
79										79
80	TOTALS			\$ 66,458	\$ 2,386	\$ 2,386	\$		\$ 66,462	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)	\$ 1,087,130	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,973	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,973	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)	\$ 884,579	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	sprinkler system	\$ 59,040	92
93			93
94			94
95		\$ 59,040	95

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

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/05

Ending: 11/30/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

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

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

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: \$ 1,758

Description: copier 146.48/month

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. /2007 \$ _____

13. /2008 \$ _____

14. /2009 \$ _____

* 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.

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>No nurses aides were trained during this report period because the facility hired only aides who were already certified.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	8	\$ 270	\$	8	\$ 270	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		9	335		9	335	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		36	3,600		36	3,600	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	Exceptional Care Program									12
13	Other (specify): <u>prescription drugs</u>	39-2					5,815		5,815	13
14	TOTAL			\$	53	\$ 4,205	\$ 5,815	53	\$ 10,020	14

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/05

Ending:

11/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/06

(last day of reporting year)

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

	1	2	
	Operating	After	
		Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 683,256	\$ 1
2	Cash-Patient Deposits	875	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	231,035	3
4	Supply Inventory (priced at cost)	3,713	4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	500	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 919,379	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	150,000	12
13	Land	5,000	13
14	Buildings, at Historical Cost	682,657	14
15	Leasehold Improvements, at Historical Cos		15
16	Equipment, at Historical Cost	458,513	16
17	Accumulated Depreciation (book methods)	(884,575)	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):		22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 411,595	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,330,974	\$ 25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 76,995	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	875	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	131,676	30
31	Accrued Taxes Payable (excluding real estate taxes)		31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	<u>Due to State of Illinois</u>	128,470	36
37	<u>accrued compensated absences</u>	95,865	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 433,881	\$ 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	60,131	39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43	<u>accrued compensated absences</u>	16,679	43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 76,810	\$ 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 510,691	\$ 46
47	TOTAL EQUITY (page 18, line 24)	\$ 820,280	\$ 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,330,971	\$ 48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 926,319	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 926,319	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(530,004)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (530,004)	17
	B. Transfers (Itemize):		
18	<u>transfer in from county IMRF fund</u>	116,069	18
19	<u>transfer in from county FICA fund</u>	96,865	19
20	<u>transfer in from county general fund</u>	136,786	20
21	<u>transfer in from county insurance fund</u>	71,851	21
22	<u>transfer in from county unemployment insurance fund</u>	2,394	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 423,965	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 820,280	24 *

* This must agree with page 17, line 47.

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

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

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,768,328	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,768,328	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	1,142	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,797	12
13	Barber and Beauty Care	954	13
14	Non-Patient Meals	2,225	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,118	23
D. Non-Operating Revenue			
24	Contributions	40,466	24
25	Interest and Other Investment Income***	27,260	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 67,726	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,845,172	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	594,109	31
32	Health Care	952,813	32
33	General Administration	744,565	33
B. Capital Expense			
34	Ownership	45,727	34
C. Ancillary Expense			
35	Special Cost Centers	11,134	35
36	Provider Participation Fee	26,828	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,375,176	40
41	Income before Income Taxes (line 30 minus line 40)**	(530,004)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (530,004)	43

* 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.

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

0014290

Report Period Beginning:

12/1/05

Ending:

11/30/06

(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	1,848	2,067	\$ 53,366	\$ 25.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,123	3,504	88,396	25.23	3
4	Licensed Practical Nurses	9,508	10,246	174,200	17.00	4
5	CNAs & Orderlies	32,774	37,440	399,631	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,192	3,623	43,389	11.98	8
9	Activity Director	1,140	1,633	26,070	15.96	9
10	Activity Assistants	2,954	3,492	36,443	10.44	10
11	Social Service Workers	1,483	1,902	31,839	16.74	11
12	Dietician					12
13	Food Service Supervisor	1,755	2,005	38,781	19.34	13
14	Head Cook	7,529	9,280	79,346	8.55	14
15	Cook Helpers/Assistants	3,402	3,844	52,023	13.53	15
16	Dishwashers					16
17	Maintenance Workers	2,913	3,550	51,147	14.41	17
18	Housekeepers	13,745	15,108	147,866	9.79	18
19	Laundry					19
20	Administrator	1,668	2,033	70,899	34.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,947	2,256	39,867	17.67	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 Plan Coordinators	1,487	1,884	43,971	23.34	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,468	103,867	\$ 1,377,234 *	\$ 13.26	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	96	\$ 2,816	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	3,649	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,592	11-3	44
45	Social Service Consultant	36	1,592	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	216	\$ 9,649		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

Facility Name & ID Number The Clayberg

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number The Clayberg# 0014290Report Period Beginning: 12/1/05Ending: 11/30/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IHCA 2705, CNHA 460, INHA 100
- (3) Did the nursing home make political contributions or payments to a political 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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,052 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 _____ NO X
- (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. \$ 26,828
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 2,862
- (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: Clifton Gunderson LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. report will be issued in April
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of service performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.