



Facility Name & ID Number The Clayberg# 0014290 Report Period Beginning: 12/1/06 Ending: 11/30/07

## 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	<u>49</u>	Intermediate (ICF)	<u>49</u>	<u>17,885</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>49</u>	TOTALS	<u>49</u>	<u>17,885</u>	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	<u>8,044</u>	<u>5,797</u>		<u>13,841</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>8,044</u>	<u>5,797</u>		<u>13,841</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.39%

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)

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

G. Do pages 3 &amp; 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

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 11/30/07 Fiscal Year: 11/30/07

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

Facility Name & ID Number      The Clayberg      #      0014290      Report Period Beginning:      12/1/06      Ending:      11/30/07

**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	179,461	6,794	2,816	189,071		189,071		189,071		1
2	Food Purchase		76,674		76,674		76,674	(1,585)	75,089		2
3	Housekeeping	143,025	5,983		149,008		149,008		149,008		3
4	Laundry		8,963		8,963		8,963		8,963		4
5	Heat and Other Utilities			76,586	76,586		76,586	(2,081)	74,505		5
6	Maintenance	59,435	5,371	29,563	94,369		94,369		94,369		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>381,921</b>	<b>103,785</b>	<b>108,965</b>	<b>594,671</b>		<b>594,671</b>	<b>(3,666)</b>	<b>591,005</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	759,794	33,494	3,743	797,031		797,031		797,031		10
10a	Therapy	23,214		4,203	27,417		27,417		27,417		10a
11	Activities	60,553	2,945	825	64,323		64,323		64,323		11
12	Social Services	33,691		825	34,516		34,516		34,516		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>877,252</b>	<b>36,439</b>	<b>9,596</b>	<b>923,287</b>		<b>923,287</b>		<b>923,287</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	40,378		2,884	43,262		43,262		43,262		17
18	Directors Fees										18
19	Professional Services			4,000	4,000		4,000		4,000		19
20	Dues, Fees, Subscriptions & Promotions			7,540	7,540		7,540	(3,627)	3,913		20
21	Clerical & General Office Expenses	42,751	6,008	3,589	52,348		52,348	5,456	57,804		21
22	Employee Benefits & Payroll Taxes			458,482	458,482		458,482		458,482		22
23	Inservice Training & Education			1,387	1,387		1,387		1,387		23
24	Travel and Seminar			1,146	1,146		1,146		1,146		24
25	Other Admin. Staff Transportation			1,131	1,131		1,131		1,131		25
26	Insurance-Prop.Liab.Malpractice			25,637	25,637		25,637		25,637		26
27	Other (specify):* <b> fines and County assessment</b>			504,314	504,314		504,314	(19,875)	484,439		27
28	<b>TOTAL General Administration</b>	<b>83,129</b>	<b>6,008</b>	<b>1,010,110</b>	<b>1,099,247</b>		<b>1,099,247</b>	<b>(18,046)</b>	<b>1,081,201</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,342,302</b>	<b>146,232</b>	<b>1,128,671</b>	<b>2,617,205</b>		<b>2,617,205</b>	<b>(21,712)</b>	<b>2,595,493</b>		<b>29</b>

\*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: 12/1/06 Ending: 11/30/07

## 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			44,831	44,831	44,831		44,831			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):* <b>loss on disposal</b>			501	501	501		501			36
37	<b>TOTAL Ownership</b>			47,090	47,090	47,090		47,090			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		3,821		3,821	3,821		3,821			39
40	Barber and Beauty Shops			144	144	144		144			40
41	Coffee and Gift Shops		5,655		5,655	5,655	(4,336)	1,319			41
42	Provider Participation Fee			25,863	25,863	25,863		25,863			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		9,476	26,007	35,483	35,483	(4,336)	31,147			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,342,302	155,708	1,201,768	2,699,778	2,699,778	(26,048)	2,673,730			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: 12/1/06

Ending: 11/30/07

**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	(1,585)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,081)	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	(19,875)	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	(3,558)	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	(4,405)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (31,504)</b>		<b>\$</b>	<b>30</b>

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)	5,456	sch VII	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 5,456</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (26,048)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY					
48		49		50	51
					52

The Clayberg

ID# 0014290  
 Report Period Beginning: 12/1/06  
 Ending: 11/30/07

Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	lobbying portion of dues	\$ (69)	20	1
2	vending machine costs	(4,336)	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	<b>Total</b>	(4,405)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number The Clayberg

# 0014290

Report Period Beginning:

12/1/06

Ending:

11/30/07

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,585)	0	0	0	0	0	0	0	0	0	0	(1,585)	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	(2,081)	0	0	0	0	0	0	0	0	0	0	(2,081)	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>(3,666)</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>(3,666)</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	(3,627)	0	0	0	0	0	0	0	0	0	0	(3,627)	20
21	Clerical & General Office Expenses	0	5,456	0	0	0	0	0	0	0	0	0	5,456	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):*	(19,875)	0	0	0	0	0	0	0	0	0	0	(19,875)	27
28	<b>TOTAL General Administration</b>	<b>(23,502)</b>	<b>5,456</b>	<b>0</b>	<b>(18,046)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(27,168)</b>	<b>5,456</b>	<b>0</b>	<b>(21,712)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number The Clayberg

# 0014290 Report Period Beginning:

12/1/06 Ending:

Summary B

11/30/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</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>37</b>
	<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	(4,336)	0	0	0	0	0	0	0	0	0	0	(4,336)	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>	<b>(4,336)</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>(4,336)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(31,504)</b>	<b>5,456</b>	<b>0</b>	<b>(26,048)</b>	<b>45</b>								

**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	\$	Fulton County	100.00%	\$ 5,456	\$	5,456
2	V	22 health insurance	95,807	Fulton County	100.00%	95,807		
3	V	22 IMRF	117,732	Fulton County	100.00%	117,732		
4	V	22 FICA	102,686	Fulton County	100.00%	102,686		
5	V	22 Workers comp ins	39,923	Fulton County	100.00%	39,923		
6	V	22 Unemployment ins	3,711	Fulton County	100.00%	3,711		
7	V	17 Committee per diem exp	2,884	Fulton County	100.00%	2,884		
8	V	26 Property and liab ins	25,537	Fulton County	100.00%	25,537		
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 388,280			\$ 393,736	\$ *	5,456

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/06 Ending: 11/30/07

## 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:

12/1/06

Ending: 11/30/07

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

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

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

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

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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	none									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>					\$	\$		\$	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>					\$	\$		\$	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><b>Important</b>, 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 2006 report.		\$ none	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.)		\$ none	2																																			
3. Under or (over) accrual (line 2 minus line 1).		\$ none	3																																			
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ none	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ none	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$ none	6																																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ none	7																																			
Real Estate Tax History:																																						
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2002</td><td>_____</td><td>8</td></tr> <tr><td>2003</td><td>_____</td><td>9</td></tr> <tr><td>2004</td><td>_____</td><td>10</td></tr> <tr><td>2005</td><td>_____</td><td>11</td></tr> <tr><td>2006</td><td>_____</td><td>12</td></tr> </table>	2002	_____	8	2003	_____	9	2004	_____	10	2005	_____	11	2006	_____	12	<table border="1"> <tr><td colspan="4"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>		<b>FOR BHF USE ONLY</b>				13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2002	_____	8																																				
2003	_____	9																																				
2004	_____	10																																				
2005	_____	11																																				
2006	_____	12																																				
<b>FOR BHF USE ONLY</b>																																						
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

**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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

12/1/06 Ending:

11/30/07

**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:**

A. Land.

	1	2	3	4	
	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	<b>TOTALS</b>	<b>217,800</b>		<b>\$ 5,000</b>	<b>3</b>

Facility Name &amp; ID Number The Clayberg

# 0014290

Report Period Beginning:

12/1/06

Ending:

11/30/07

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1969		\$ 271,336	\$ 6,783	40	\$ 6,783		\$ 258,121	4
5			1978		8,009		20			8,009	5
6			1979		52,592	1,737	30	1,737		50,856	6
7											7
8											8
		<b>Improvement Type**</b>									
9		windows and plaster repair		1981	17,092		3 to 10			17,092	9
10		front porch and patio		1982	6,110		5 to 20			6,110	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		16,539	13
14		shutters		1986	1,591	16	15 to 25	16		1,543	14
15		shed, roof and floor tile		1987	17,275	137	15 to 25	137		17,040	15
16		heating and cooling system		1988	9,166	458	20	458		8,784	16
17		IDPA adjustment		1989	1,806	90	20	90		993	17
18		new shed		1990	8,284		15			8,284	18
19		new shed		1991	10,876		15			10,876	19
20		drain		1992	743	17	15	17		743	20
21		roof and greenhouse		1993	62,282	4,151	15	4,151		61,942	21
22		road repair		1994	13,496		5			13,496	22
23		storage building addition		1994	4,265	213	20	213		2,576	23
24		storage building addition		1996	12,141	606	20	606		7,066	24
25		laundry facility		1997	15,274	764	20	764		8,114	25
26		carpet, H/C system		2000	6,298	402	10 to 20	402		2,993	26
27		walk path		2001	4,177	278	15	278		1,717	27
28		walk path		2002	1,357	90	15	90		490	28
29		aviary		2002	4,740	316	15	316		1,711	29
30		flooring		2004	635	64	10	64		238	30
31		two A/C units		2004	4,583	458	10	458		1,528	31
32		floor tile		2005	289	12	25	12		33	32
33		electrical box		2005	141	6	25	6		16	33
34		seal parking lot		2005	1,260	315	4	315		867	34
35		two metal doors		2005	1,166	39	30	39		107	35
36		wall coverings		2005	697	139	5	139		384	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Clayberg

# 0014290

Report Period Beginning:

12/1/06

Ending:

11/30/07

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	egress lights	2005	\$ 423	\$ 28	15	\$ 28	\$	\$ 77	37
38	smoke detectors	2005	2,915	292	10	292		802	38
39	new corridor wall	2005	367	15	25	15		40	39
40	paint walls	2005	112	37	3	37		100	40
41	kitchen fire system	2005	2,877	82	35	82		212	41
42	sidewalk	2005	802	53	15	53		134	42
43	labor for bldg improvements	2005	5,904	394	15	394		984	43
44	heating and cooling units	2005	2,729	273	10	273		614	44
45	harbor in garden	2005	868	35	25	35		75	45
46	base board heaters	2006	278	19	15	19		36	46
47	wall board and glue	2006	168	34	5	34		62	47
48	floor tile	2006	640	26	25	26		45	48
49	East egress	2006	1,701	113	15	113		180	49
50	East egress soil	2006	390	13	30	13		21	50
51	door and frame	2006	614	20	30	20		32	51
52	water main	2006	9,291	232	40	232		310	52
53	water main walkway	2006	1,031	69	15	69		92	53
54	door locks	2006	474	32	15	32		37	54
55	labor for bldg improvements	2006	4,098	273	15	273		410	55
56	steel door	2007	630	12	30	12		12	56
57	sprinkler system/ceiling upgrade	2007	151,553	3,368	15	3,368		3,368	57
58	wiring/electrical outlets	2007	635	8	20	8		8	58
59	4 A/C units	2007	1,668	42	10	42		42	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)		\$ 750,430	\$ 22,883		\$ 22,883	\$	\$ 521,238	70

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/06 Ending: 11/30/07

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	\$ 210,583	\$ 19,892	\$ 19,892	\$	5 to 20	\$ 132,085	71
72	Current Year Purchases	16,063	982	982		5 to 15	982	72
73	Fully Depreciated Assets	154,718	1,074	1,074		5 to 15	154,718	73
74								74
75	TOTALS	\$ 381,364	\$ 21,948	\$ 21,948	\$		\$ 287,785	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				5	23,817	77
78										78
79										79
80	TOTALS			\$ 66,458	\$	\$	\$		\$ 66,458	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,203,252	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,831	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,831	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)	\$ 875,481	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number The Clayberg

# 0014290

Report Period Beginning:

12/1/06

Ending: 11/30/07

**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

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	<b>TOTAL</b>		\$ _____	\$ _____	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. \_\_\_\_\_/2008 \$ \_\_\_\_\_

13. \_\_\_\_\_/2009 \$ \_\_\_\_\_

14. \_\_\_\_\_/2010 \$ \_\_\_\_\_

\* 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>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><u>No nurses aides were trained during this report period because the facility hired only aides who were already certified.</u></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		3	4
		1	2		
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		12	603		12	603	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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-2					3,821		3,821	13
14	<b>TOTAL</b>			\$	48	\$ 4,203	\$ 3,821	48	\$ 8,024	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# 0014290Report Period Beginning: 12/1/06

Ending:

11/30/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 255,028	\$	1
2	Cash-Patient Deposits	1,038		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	192,694		3
4	Supply Inventory (priced at <u>cost</u> )	3,186		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 451,946	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	151,110		12
13	Land	5,000		13
14	Buildings, at Historical Cost	750,430		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	447,822		16
17	Accumulated Depreciation (book methods)	(875,481)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 478,881	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 930,827	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 21,293	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,038		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,740		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to State of Illinois</u>	5,380		36
37	<u>Due to city gen fund and accr comp abs</u>	95,813		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 150,264	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	60,131		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>accrued compensated absences</u>	16,379		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 76,510	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 226,774	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 704,053	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 930,827	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 820,280	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 820,280	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(504,507)	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)	\$ (504,507)	17
	<b>B. Transfers (Itemize):</b>		
18	transfer in from county IMRF fund	117,732	18
19	transfer in from county FICA fund	102,686	19
20	transfer in from county general fund	98,691	20
21	transfer in from county insurance fund	65,460	21
22	transfer in from county unemployment insurance fund	3,711	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 388,280	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 704,053	24 *

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

Facility Name & ID Number The Clayberg# 0014290Report Period Beginning: 12/1/06Ending: 11/30/07**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,166,423	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,166,423	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,336	12
13	Barber and Beauty Care	612	13
14	Non-Patient Meals	1,585	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	1,145	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,678	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,948	24
25	Interest and Other Investment Income***	19,222	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 21,170	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,195,271	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	594,671	31
32	Health Care	923,287	32
33	General Administration	1,099,247	33
<b>B. Capital Expense</b>			
34	Ownership	47,090	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	9,620	35
36	Provider Participation Fee	25,863	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,699,778	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(504,507)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (504,507)	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.

Facility Name & ID Number The Clayberg

# 0014290

Report Period Beginning:

12/1/06

Ending:

11/30/07

**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	1,880	2,358	\$ 58,741	\$ 24.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,266	4,608	106,813	23.18	3
4	Licensed Practical Nurses	8,796	9,946	168,285	16.92	4
5	CNAs & Orderlies	37,435	41,985	386,685	9.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,808	2,159	23,214	10.75	8
9	Activity Director	1,868	2,199	28,371	12.90	9
10	Activity Assistants	3,102	3,818	32,182	8.43	10
11	Social Service Workers	2,255	2,537	33,691	13.28	11
12	Dietician					12
13	Food Service Supervisor	1,885	2,229	37,068	16.63	13
14	Head Cook	9,667	10,790	110,274	10.22	14
15	Cook Helpers/Assistants	3,469	3,922	32,119	8.19	15
16	Dishwashers					16
17	Maintenance Workers	3,700	4,285	59,435	13.87	17
18	Housekeepers	10,672	12,192	143,025	11.73	18
19	Laundry					19
20	Administrator	1,440	1,520	40,378	26.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,101	2,443	42,751	17.50	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 Care Plan Coordinators	1,683	2,000	39,270	19.64	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,027	108,991	\$ 1,342,302 *	\$ 12.32	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	3,240	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	603	10a-3	43
44	Activity Consultant	42	825	11-3	44
45	Social Service Consultant	42	825	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	240	\$ 8,309		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

# 0014290

Report Period Beginning: 12/1/06

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**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	
Bonnie Beese	administrator	0	\$ 40,378	Workers' Compensation Insurance	\$ 39,923	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,711	Advertising: Employee Recruitment	1,297	
				FICA Taxes	102,686	Health Care Worker Background Check		
				Employee Health Insurance	191,654	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	65	
				Illinois Municipal Retirement Fund (IMRF)*	117,732	Dues and subscriptions	2,035	
				employee physicals	2,776	less lobbying portion	(69)	
						non-allowable advertising	3,558	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 40,378					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Health committee of County Board expenses			\$ 2,884				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							mileage	619
							meals	107
							seminars	420
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,884				(agree to Sch. V,	
(Attach a copy of any management service agreement)							line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount					
Clifton Gunderson, LLP	CPA		\$ 4,000					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 4,000					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



**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 225, CNHA 450, INHA 100
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,339 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 25,863  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 1,585
- (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 June
- (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 services performed been attached to this cost report? n/a  
Attach invoices and a summary of services for all architect and appraisal fees.