

Facility Name & ID Number The Clayberg

0014290 Report Period Beginning: 12/1/07 Ending: 11/30/08

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	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF	9,166	4,441		13,607
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	9,166	4,441		13,607

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.87%

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: 11/30/08 Fiscal Year: 11/30/08

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

STATE OF ILLINOIS

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/07 Ending: 11/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
A. General Services											
1	Dietary	189,025	5,351	4,627	199,003		199,003		199,003		1
2	Food Purchase		88,261		88,261		88,261	(5,740)	82,521		2
3	Housekeeping	156,833	9,900		166,733		166,733		166,733		3
4	Laundry		6,360		6,360		6,360		6,360		4
5	Heat and Other Utilities			89,503	89,503		89,503	(2,120)	87,383		5
6	Maintenance	61,692	6,689	26,346	94,727		94,727		94,727		6
7	Other (specify):*										7
8	TOTAL General Services	407,550	116,561	120,476	644,587		644,587	(7,860)	636,727		8
B. Health Care and Programs											
9	Medical Director										9
10	Nursing and Medical Records	941,109	41,290	4,273	986,672		986,672		986,672		10
10a	Therapy	47,294		3,548	50,842		50,842		50,842		10a
11	Activities	67,245	3,599	375	71,219		71,219		71,219		11
12	Social Services	36,387		375	36,762		36,762		36,762		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,092,035	44,889	8,571	1,145,495		1,145,495		1,145,495		16
C. General Administration											
17	Administrative	47,500		2,106	49,606		49,606		49,606		17
18	Directors Fees										18
19	Professional Services			5,351	5,351		5,351		5,351		19
20	Dues, Fees, Subscriptions & Promotions			5,784	5,784		5,784	(3,527)	2,257		20
21	Clerical & General Office Expenses	43,938	7,021	3,221	54,180		54,180	5,652	59,832		21
22	Employee Benefits & Payroll Taxes			478,111	478,111		478,111		478,111		22
23	Inservice Training & Education			1,333	1,333		1,333		1,333		23
24	Travel and Seminar			693	693		693		693		24
25	Other Admin. Staff Transportation			1,416	1,416		1,416		1,416		25
26	Insurance-Prop.Liab.Malpractice			27,327	27,327		27,327		27,327		26
27	Other (specify):* county assessment			429,629	429,629		429,629	(429,629)			27
28	TOTAL General Administration	91,438	7,021	954,971	1,053,430		1,053,430	(427,504)	625,926		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,591,023	168,471	1,084,018	2,843,512		2,843,512	(435,364)	2,408,148		29

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

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

Facility Name & ID Number

The Clayberg

#0014290

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	
	D. Ownership											
30	Depreciation			46,513	46,513		46,513		46,513			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			48,271	48,271		48,271		48,271			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,751		5,751		5,751		5,751			39
40	Barber and Beauty Shops			106	106		106		106			40
41	Coffee and Gift Shops		5,048		5,048		5,048	(3,584)	1,464			41
42	Provider Participation Fee			26,873	26,873		26,873		26,873			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		10,799	26,979	37,778		37,778	(3,584)	34,194			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,591,023	179,270	1,159,268	2,929,561		2,929,561	(438,948)	2,490,613			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: 12/1/07

Ending: 11/30/08

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	(5,740)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,120)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,345)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	(433,395)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (444,600)		\$	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)	5,652	Sch VII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 5,652		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (438,948)		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: 12/1/07

Ending: 11/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Lobbying portion of dues	\$ (182)	20	1
2	Vending machine costs	(3,584)	41	2
3	County Contribution to State	(429,629)	27	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	(433,395)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	(5,740)	0	0	0	0	0	0	0	0	0	0	(5,740)	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	(2,120)	0	0	0	0	0	0	0	0	0	0	(2,120)	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	(7,860)	0	0	0	0	0	0	0	0	0	0	(7,860)	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	(3,527)	0	0	0	0	0	0	0	0	0	0	(3,527)	20
21	Clerical & General Office Expenses	0	5,652	0	0	0	0	0	0	0	0	0	5,652	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):*	(429,629)	0	0	0	0	0	0	0	0	0	0	(429,629)	27
28	TOTAL General Administration	(433,156)	5,652	0	(427,504)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(441,016)	5,652	0	(435,364)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	(3,584)	0	0	0	0	0	0	0	0	0	0	(3,584) 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	(3,584)	0	0	0	0	0	0	0	0	0	0	(3,584) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(444,600)	5,652	0	(438,948) 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
<u>Fulton County</u>	<u>100</u>	<u>None</u>		<u>Fulton County</u>	<u>Lewistown</u>	<u>County Gov't</u>

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	21	<u>Payroll</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>\$ 5,652</u>	<u>5,652</u>
2	V	22	<u>Health Insurance</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>91,038</u>	
3	V	22	<u>IMRF</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>129,562</u>	
4	V	22	<u>FICA</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>121,713</u>	
5	V	22	<u>Workers comp ins</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>38,388</u>	
6	V	22	<u>Unemployment ins</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>2,500</u>	
7	V	17	<u>Committee per diem exp</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>2,106</u>	
8	V	26	<u>Property and liab ins</u>	<u>Fulton County</u>	<u>100.00%</u>	<u>27,227</u>	
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 412,534			\$ 418,186	\$ * 5,652

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/07 Ending: 11/30/08

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

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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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/07 Ending: 11/30/08

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
						Original	Balance				
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									
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 2007 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 2008 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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ 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>2003</td><td>8</td></tr> <tr><td>2004</td><td>9</td></tr> <tr><td>2005</td><td>10</td></tr> <tr><td>2006</td><td>11</td></tr> <tr><td>2007</td><td>12</td></tr> </table>	2003	8	2004	9	2005	10	2006	11	2007	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 2007 \$</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 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2003	8																										
2004	9																										
2005	10																										
2006	11																										
2007	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2007 \$	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: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 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 Costs

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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 Allocation:

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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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:12/1/07 Ending:11/30/08**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 14,920 B. General Construction Type: Exterior Brick Frame concrete block & steel Number of Stories oneC. 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 ground (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)

noneF. 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>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>217,800</u>		<u>\$ 5,000</u>	<u>3</u>

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	\$	\$ 264,904	4
5		1978		8,009		20			8,009	5
6		1979		52,592	1,737	30	1,737		52,592	6
7										7
8										8
Improvement Type**										
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		16,861	13
14	shutters	1986		1,591	16	15 to 25	16		1,558	14
15	shed, roof and floor tile	1987		17,275	50	15 to 25	50		17,089	15
16	heating and cooling system	1988		9,166	382	20	382		9,166	16
17	IDPA adjustment	1989		1,806	90	20	90		1,083	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		15			743	20
21	roof and greenhouse	1993		62,282	340	15	340		62,282	21
22	road repair	1994		13,496		5			13,496	22
23	storage building addition	1994		4,265	213	20	213		2,790	23
24	storage building addition	1996		12,141	607	20	607		7,673	24
25	laundry facility	1997		15,274	764	20	764		8,878	25
26	carpet, H/C system	2000		6,298	402	10 to 20	402		3,396	26
27	walk path	2001		4,177	278	15	278		1,995	27
28	walk path	2002		1,357	90	15	90		581	28
29	aviary	2002		4,740	316	15	316		2,028	29
30	flooring	2004		635	64	10	64		302	30
31	two A/C units	2004		4,583	458	10	458		1,987	31
32	floor tile	2005		289	12	25	12		44	32
33	electrical box	2005		141	6	25	6		22	33
34	seal parking lot	2005		1,260	315	4	315		1,182	34
35	two metal doors	2005		1,166	39	30	39		146	35
36	wall coverings	2005		697	139	5	139		523	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 106	37
38	smoke detectors	2005	2,915	292	10	292		1,093	38
39	new corridor wall	2005	367	15	25	15		55	39
40	paint walls	2005	112	12	3	12		112	40
41	kitchen fire system	2005	2,877	82	35	82		295	41
42	sidewalk	2005	802	53	15	53		187	42
43	labor for bldg improvements	2005	5,904	394	15	394		1,378	43
44	heating and cooling units	2005	2,729	273	10	273		887	44
45	harbor in garden	2005	868	35	25	35		110	45
46	base board heaters	2006	278	19	15	19		54	46
47	wall board and glue	2006	168	34	5	34		95	47
48	floor tile	2006	640	26	25	26		70	48
49	East egress	2006	1,701	113	15	113		293	49
50	East egress soil	2006	390	13	30	13		34	50
51	door and frame	2006	614	20	30	20		53	51
52	water main	2006	9,291	232	40	232		542	52
53	water main walkway	2006	1,031	69	15	69		160	53
54	door locks	2006	474	32	15	32		68	54
55	labor for bldg improvements	2006	4,098	273	15	273		683	55
56	steel door	2007	630	21	30	21		33	56
57	sprinkler system/ceiling upgrade	2007	151,553	10,104	15	10,104		13,471	57
58	wiring/electrical outlets	2007	635	32	20	32		40	58
59	4 A/C units	2007	1,668	167	10	167		209	59
60	Sentricon Baiting system	2008	1,272	85	15	85		85	60
61	packaged unit and duct work	2008	6,105	34	15	34		34	61
62	Roof Work	2008	28,174		15				62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 785,981	\$ 25,881		\$ 25,881	\$	\$ 547,116	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	\$ 188,519	\$ 16,229	\$ 16,229	\$	5 to 20	\$ 114,126	71
72	Current Year Purchases	21,033	1,447	1,447		5 to 15	1,447	72
73	Fully Depreciated Assets	192,845	2,956	2,956		5 to 15	192,845	73
74								74
75	TOTALS	\$ 402,397	\$ 20,632	\$ 20,632	\$		\$ 308,418	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)	\$ 1,259,836	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,513	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,513	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)	\$ 921,992	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.

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

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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

* 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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist		hrs	\$									\$	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			9	428					9	428	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a-3	hrs			20	3,120					20	3,120	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Other (specify):													12
13	Other (specify):	39-2								5,751			5,751	13
14	TOTAL			\$		29	3,548	\$	5,751	\$	5,751	29	\$	9,299

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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/07

Ending:

11/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/08

(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	\$ 349,495	\$	1
2	Cash-Patient Deposits	1,617		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	286,499		3
4	Supply Inventory (priced at cost)	2,974		4
5	Short-Term Investments	208,775		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prop tax rec	372,810		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,222,170	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	785,981		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	468,855		16
17	Accumulated Depreciation (book methods)	(921,992)		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)	\$ 337,844	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,560,014	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 27,989	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,617		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,846		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	County Assessment and deferred property	378,176		36
37	Due to city gen fund and accr comp abs	226,616		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 682,244	\$	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	Accrued compensated absences	19,256		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 79,387	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 761,631	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 798,383	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,560,014	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 704,053	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 704,053	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(318,204)	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)	\$ (318,204)	17
B. Transfers (Itemize):			
18	Transfer in from county IMRF fund	129,562	18
19	Transfer in from County FICA fund	121,713	19
20	Transfer in from county general fund	93,144	20
21	transfer in from county insurance fund	65,615	21
22	transfer in from county unemployment ins. Fund	2,500	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 412,534	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 798,383	24 *

* This must agree with page 17, line 47.

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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	\$ 2,242,274	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,242,274	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,584	12
13	Barber and Beauty Care	800	13
14	Non-Patient Meals	5,740	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,124	23
D. Non-Operating Revenue			
24	Contributions	3,282	24
25	Interest and Other Investment Income***	20,872	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,154	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Property taxes collected	334,805	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 334,805	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,611,357	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	644,587	31
32	Health Care	1,145,495	32
33	General Administration	1,053,430	33
B. Capital Expense			
34	Ownership	48,271	34
C. Ancillary Expense			
35	Special Cost Centers	10,905	35
36	Provider Participation Fee	26,873	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,929,561	40
41	Income before Income Taxes (line 30 minus line 40)**	(318,204)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (318,204)	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.

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 57,232	\$ 27.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,571	7,998	172,586	21.58	3
4	Licensed Practical Nurses	10,254	11,082	211,761	19.11	4
5	CNAs & Orderlies	37,410	41,199	456,422	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,607	4,287	47,294	11.03	8
9	Activity Director	2,080	2,080	30,097	14.47	9
10	Activity Assistants	4,461	5,015	37,148	7.41	10
11	Social Service Workers	1,948	2,291	36,387	15.88	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,984	14.90	13
14	Head Cook	11,670	12,993	124,104	9.55	14
15	Cook Helpers/Assistants	3,414	4,044	33,937	8.39	15
16	Dishwashers					16
17	Maintenance Workers	3,385	4,135	61,692	14.92	17
18	Housekeepers	16,594	18,079	156,833	8.67	18
19	Laundry					19
20	Administrator	2,080	2,080	47,500	22.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,994	2,284	43,938	19.24	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	1,654	1,980	43,108	21.77	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,282	123,707	\$ 1,591,023 *	\$ 12.86	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	157	\$ 4,627	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,273	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	9	375	11-3	44
45	Social Service Consultant	9	375	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	175	\$ 9,650		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

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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	
Kevin Stoneking	administrator	0	\$ 47,500	Workers' Compensation Insurance	\$ 38,388	IDPH License Fee	\$ 149	
				Unemployment Compensation Insurance	2,500	Advertising: Employee Recruitment	149	
				FICA Taxes	121,713	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	183,564	Patient Background Checks	35	
				Employee Meals		Dues and subscriptions	1,940	
				Illinois Municipal Retirement Fund (IMRF)*	129,562	less lobbying portion	(182)	
				employee physicals	2,384	non-allowable advertising	3,345	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 47,500			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(3,345)	
Description			Amount			Yellow page advertising	()	
Health Committee of County Board expenses			\$ 2,106			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,257	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 2,106	TOTAL (agree to Schedule V, line 22, col.8)	\$ 478,111			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Clifton Gunderson	CPA		\$ 4,200				Out-of-State Travel	\$
Miller, Hall & Triggs	Legal		1,151				In-State Travel	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,351	TOTAL		\$	Seminar Expense	
							mileage	316
							meals	112
							seminars	265
							Entertainment Expense	()
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 693

* Attach copy of IMRF notifications

**See instructions.

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11/30/08**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 595, CNHA 490, 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. \$ 3,861 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. \$ 26,873
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. \$ 5,740
- (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.