

Facility Name & ID Number CLEARBROOK CENTER

0030023 Report Period Beginning: 7/1/08 Ending: 6/30/09

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 92

	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>92</u>	Intermediate (ICF)	<u>92</u>	<u>33,580</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>32,557</u>			<u>32,557</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,557</u>			<u>32,557</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.95%

D. How many bed-hold days during this year were paid by the Department? 994 (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 11/1/85

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1/85 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: 7/1/08 Fiscal Year: 6/30/09

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

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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
	A. General Services										
1	Dietary	142,661		104,000	246,661		246,661		246,661		1
2	Food Purchase		234,965		234,965		234,965		234,965		2
3	Housekeeping	169,498	110,439		279,937		279,937		279,937		3
4	Laundry										4
5	Heat and Other Utilities			112,569	112,569		112,569		112,569		5
6	Maintenance	87,460	30,291	145,131	262,882		262,882	40,766	303,648		6
7	Other (specify):*										7
8	TOTAL General Services	399,619	375,695	361,700	1,137,014		1,137,014	40,766	1,177,780		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,347,998	92,025		2,440,023		2,440,023		2,440,023		10
10a	Therapy										10a
11	Activities	29,931	2,051		31,982		31,982		31,982		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation			3,269	3,269		3,269		3,269		14
15	Other (specify):*			659,188	659,188		659,188		659,188		15
16	TOTAL Health Care and Programs	2,377,929	94,076	662,457	3,134,462		3,134,462		3,134,462		16
	C. General Administration										
17	Administrative	104,653			104,653		104,653	204,596	309,249		17
18	Directors Fees										18
19	Professional Services			88,346	88,346		88,346	31,628	119,974		19
20	Dues, Fees, Subscriptions & Promotions			560	560		560	5,455	6,015		20
21	Clerical & General Office Expenses	38,405	4,598		43,003		43,003	33,573	76,576		21
22	Employee Benefits & Payroll Taxes			612,647	612,647		612,647	40,905	653,552		22
23	Inservice Training & Education							6,910	6,910		23
24	Travel and Seminar			2,198	2,198		2,198		2,198		24
25	Other Admin. Staff Transportation							6,527	6,527		25
26	Insurance-Prop.Liab.Malpractice			38,722	38,722		38,722	4,055	42,777		26
27	Other (specify):*			181,739	181,739		181,739		181,739		27
28	TOTAL General Administration	143,058	4,598	924,212	1,071,868		1,071,868	333,649	1,405,517		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,920,606	474,369	1,948,369	5,343,344		5,343,344	374,415	5,717,759		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			202,470	202,470		202,470		202,470		30
31	Amortization of Pre-Op. & Org.			46,835	46,835		46,835		46,835		31
32	Interest			28,765	28,765		28,765	11,528	40,293		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			21,326	21,326		21,326		21,326		35
36	Other (specify):*										36
37	TOTAL Ownership			299,396	299,396		299,396	11,528	310,924		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			273,402	273,402		273,402		273,402		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			273,402	273,402		273,402		273,402		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,920,606	474,369	2,521,167	5,916,142		5,916,142	385,943	6,302,085		45

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

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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		0	49

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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
none	0	clearbrook east	rolling meadows	CRH Inc	Rolling Meadows	non profit
none	0	clearbrook west	rolling meadows	CRH Inc	Rolling Meadows	non profit
none	0	clearbrook wright	gurnee	Augustana Group Hon	Gurnee	non profit

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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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	6	MAINTENANCE	SALARIES	16,510,255	\$ 230,451	\$	2,920,603	\$ 40,766	1
2	17	ADMIN SALARIES	SALARIES	16,510,255	1,156,587	1,156,587	2,920,603	204,596	2
3	19	PROFESS SVCS	SALARIES	16,510,255	178,796		2,920,603	31,628	3
4	20	DUES, FEE & SUBSCRIPTIONS	SALARIES	16,510,255	30,840		2,920,603	5,455	4
5	21	CLERICAL & GEN OFFICE	SALARIES	16,510,255	189,791		2,920,603	33,573	5
6	22	EMP BENEFITS & PR TAXES	SALARIES	16,510,255	231,239		2,920,603	40,905	6
7	23	INSVC TRAINING	SALARIES	16,510,255	39,063		2,920,603	6,910	7
8	25	OTHER ADMIN & TRANS	SALARIES	16,510,255	36,900		2,920,603	6,527	8
9	26	INSURANCE	SALARIES	16,510,255	22,921		2,920,603	4,055	9
10	32	INTEREST	SALARIES	16,510,255	65,166		2,920,603	11,528	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				\$ 2,181,754	\$ 1,156,587		\$ 385,943	25

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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										
										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			
A. Directly Facility Related																			
Long-Term																			
1	IRB	x	construct building	variable	10/15/2008	\$ 5,400,000	\$ 5,400,000	10/14/2033	variable	\$ 28,765	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related					\$ 5,400,000	\$ 5,400,000			\$ 28,765	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 5,400,000	\$ 5,400,000			\$ 28,765	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,765 Line # 32

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	_____	8
	2005	_____	9
	2006	_____	10
	2007	_____	11
	2008	_____	12
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	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.

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,000 B. General Construction Type: Exterior brick Frame steel Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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: bond fees to finance debt on building
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>building donated</u>	<u>50,000</u>	<u>1985</u>	\$	<u>1</u>
2					<u>2</u>
3	TOTALS	50,000		\$	3

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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	92		1985	1985	\$ 4,357,440	\$ 129,845	40	\$ 129,845	\$	\$ 2,645,891	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Improvements Prior to 2002			269,206	9,962		9,962		140,959	9
10		Boiler Valves	2000		1,444	144	10	144		1,369	10
11		Windows	2000		6,704	268	25	268		2,303	11
12		Sprinkler System	2000		8,873	444	20	444		4,217	12
13		Windows	2001		6,704	268	25	268		2,278	13
14		Equipment Survey	2001		2,000	100	20	100		850	14
15		Brick Wall	2001		700	35	20	35		298	15
16		Gas Line	2001		3,018	101	30	101		857	16
17		Generator	2001		12,159	608	20	608		5,168	17
18		Fire Alarm	2001		1,952	98	20	98		833	18
19		Fuel Tank	2001		2,922	146	20	146		1,241	19
20		Floor Tile	2001		1,420	71	20	71		603	20
21		Pool Chemical Controller	2001		2,886	289	10	289		2,457	21
22		HVAC Repairs	2001		20,763	1,038	20	1,038		8,823	22
23		Kitchen Remodeling	2001		61,419	2,457	25	2,457		21,301	23
24		Floor Tile	2001		1,555	78	20	78		663	24
25		AC Compressor	2001		15,223	762	20	762		6,477	25
26		Tile	2001		14,760	738	20	738		6,273	26
27		Concrete Repair	2001		1,200	120	10	120		1,020	27
28		AC Repairs	2001		14,267	713	20	713		6,060	28
29		Wall Protector	2001		14,777	739	10	739		5,912	29
30		HVAC Repairs	2002		25,761	2,576	10	2,576		19,320	30
31		Kitchen Remodeling	2002		5,300	530	10	530		3,975	31
32		AC Compressor	2002		2,500	250	10	250		1,875	32
33		HVAC Repairs	2002		23,430	2,343	10	2,343		17,573	33
34		Fire Alarm System	2002		1,576	158	10	158		1,186	34
35		Wall Paper	2002		1,800	180	10	180		1,350	35
36											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

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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	Flooring	2003	\$ 3,100	\$ 310	10	\$ 310	\$	\$ 2,015	37
38	Security Equipment	2003	3,800		5			3,800	38
39	Tile	2003	3,100		5			3,100	39
40	Roof Repair	2003	8,260	1,180	7	1,180		7,139	40
41	Plumbing	2003	8,562	1,223	7	1,223		6,176	41
42	Doors	2003	976	49	5	49		976	42
43	Tile	2003	3,100	155	5	155		3,100	43
44	Elevator Repairs	2003	2,813		5			2,813	44
45	Bathroom Remodeling	2004	18,970	1,897	10	1,897		10,433	45
46	Roof Repair	2004	5,100	510	10	510		2,805	46
47	Elevator Repairs	2004	6,913	691	10	691		3,801	47
48	Infra Red Door	2005	1,881		3			1,881	48
49	Alarm System	2005	13,800	1,380	10	1,380		6,900	49
50	Bathroom Remodeling	2005	66,523	4,435	15	4,435		31,656	50
51	Bathroom Remodeling	2006	8,892	1,778	5	1,778		5,513	51
52	Bathroom Remodeling	2006	20,641	2,064	10	2,064		6,536	52
53	Elevator Repairs	2006	3,250	542	5	542		1,788	53
54	Temperature Equipment	2006	7,116	1,423	5	1,423		4,525	54
55	Fire Protection Pipe	2007	1,587	317	5	317		846	55
56	Carpet	2007	1,935	387	5	387		935	56
57	Carpet	2007	930	310	3	310		801	57
58	Toilet System	2007	1,055	352	3	352		968	58
59	Carpet	2007	2,147	429	5	429		1,037	59
60	Glass Door	2007	656	219	3	219		456	60
61	Glass Door	2008	656	219	3	219		383	61
62	Bathroom Remodeling	2008	43,007	4,300	10	4,300		5,914	62
63	Bathroom Remodeling Plans	2008	5,821	1,164	5	1,164		1,940	63
64	Lighting Engineer	2009	4,991	654	7	654		654	64
65	Ceramic Tile	2009	3,177	477	5	477		477	65
66	Install Linoleum Floor	2009	1,850	463	3	463		463	66
67	Duct Service	2009	7,230	516	7	516		516	67
68	Lighting Replacement	2009	42,000	2,100	10	2,100		2,100	68
69	Repair Front Door	2009	1,300	144	3	144		144	69
70	TOTAL (lines 4 thru 69)		\$ 5,186,898	\$ 184,749		\$ 184,749	\$	\$ 3,033,723	70

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

Facility Name & ID Number CLEARBROOK CENTER

0030023

Report Period Beginning:

7/1/08

Ending:

6/30/09

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		
1	Totals from Page 12A, Carried Forward	\$ 5,186,898	\$ 184,749		\$ 184,749	\$	\$ 3,033,723	1	
2	Painting	2009 7,125	369	5	369		369	2	
3	Weil Pump	2009 2,998	150	5	150		150	3	
4	Painting	2009 1,190	60	5	60		60	4	
5	Painting	2009 1,360	67	5	67		67	5	
6	Tile	2009 1,670	56	5	56		56	6	
7	Door Protectors	2009 1,898		3				7	
8	Install Furnace	2009 4,500	250	3	250		250	8	
9	Lighting Replacement	2009 4,114	654	7	654		654	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	TOTAL (lines 1 thru 33)	\$ 5,211,753	\$ 186,355		\$ 186,355	\$	\$ 3,035,329	34	

**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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,211,753	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 186,355	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 186,355	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)	\$ 3,035,329	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

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" 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		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/09** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 2,236,374	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>139,703</u>)		3,867,910	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		114,467	6
7	Other Prepaid Expenses		285,356	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 6,504,107	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,248,088	13
14	Buildings, at Historical Cost		20,131,675	14
15	Leasehold Improvements, at Historical Cost		448,281	15
16	Equipment, at Historical Cost		3,448,073	16
17	Accumulated Depreciation (book methods)		(10,331,444)	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):		5,919	22
23	Other(specify):		(296,441)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 16,654,151	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 23,158,258	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 1,649,937	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		56,250	28
29	Short-Term Notes Payable		313,287	29
30	Accrued Salaries Payable		1,433,195	30
31	Accrued Taxes Payable (excluding real estate taxes)		51,203	31
32	Accrued Real Estate Taxes(Sch.IX-B)		20,480	32
33	Accrued Interest Payable		13,623	33
34	Deferred Compensation		91,630	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>due to temp and perm restricted</u>		617,383	36
37	<u>deferred rev</u>		87,671	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 4,334,659	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,889,031	40
41	Bonds Payable		5,400,000	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>due to govt agencies</u>		186,266	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,475,297	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 12,809,956	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,348,302	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,348,302	\$ 12,809,956	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,538,105	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,538,105	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(725,809)	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) Clearbrook net income net of commons	2,536,006	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,810,197	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,348,302	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,364,140	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,364,140	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	680,224	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 680,224	23
D. Non-Operating Revenue			
24	Contributions	71,845	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 71,845	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		74,124	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 74,124	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,190,333	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,137,014	31
32	Health Care	3,134,462	32
33	General Administration	1,071,868	33
B. Capital Expense			
34	Ownership	299,396	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	273,402	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,916,142	40
41	Income before Income Taxes (line 30 minus line 40)**	(725,809)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (725,809)	43

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

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

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

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

Facility Name & ID Number **CLEARBROOK CENTER**

0030023

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	18,652	377,897	20.26	3
4	Licensed Practical Nurses	12,386	238,423	19.25	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	2,684	29,931	11.15	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	15,456	142,661	9.23	15
16	Dishwashers				16
17	Maintenance Workers	9,569	87,460	9.14	17
18	Housekeepers	19,305	169,498	8.78	18
19	Laundry				19
20	Administrator	3,633	104,653	28.81	20
21	Assistant Administrator				21
22	Other Administrative	3,050	38,405	12.59	22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director	240	13,622	56.76	27
28	Qualified MR Prof. (QMRP)	13,578	204,724	15.08	28
29	Resident Services Coordinator	3,001	62,359	20.78	29
30	Habilitation Aides (DD Homes)	145,532	1,450,973	9.97	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	247,086	\$ 2,920,606 *	\$ 11.82	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	120	24,000	Part line V 15 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	174	21,679	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Psych</u>	275	43,237	46
47	<u>Neurological</u>	120	9,720	47
48	<u>Sign</u>	75	4,241	48
49	TOTAL (lines 35 - 48)	764	\$ 102,877	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joe Lawler	Admin		\$ 65,068	Workers' Compensation Insurance	\$ 73,192	IDPH License Fee	\$	
Jean Adaskavich	Admin		22,392	Unemployment Compensation Insurance	20,994	Advertising: Employee Recruitment		
Stacey Bellomo	Other Admin		17,193	FICA Taxes	228,392	Health Care Worker Background Check		
				Employee Health Insurance	245,722	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		dues & subscriptions	560	
				403b	44,347			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 104,653					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	2,198
							Seminar Expense	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL				
(Attach a copy of any management service agreement)			\$				(agree to Sch. V,	
							line 24, col. 8)	\$ 2,198
TOTAL (agree to Schedule V, line 19, column 3)			\$ 88,346					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CLEARBROOK CENTER

0030023

Report Period Beginning: 7/1/08

Ending: 6/30/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,012 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? _____
If YES, give effective date of lease. no
- (9) Are you presently operating under a sublease agreement? _____ YES no NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO 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. \$ 273,402
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? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 95
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? na
g. Does the facility transport residents to and from day training? yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: Blackman Kallick LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? na
- (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? yes
Attach invoices and a summary of services for all architect and appraisal fees.