

Facility Name & ID Number THE CLAYBERG

0014290 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,307	1,307	8
9	SNF/PED					9
10	ICF	6,091	9,173		15,264	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,091	9,173	1,307	16,571	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.65%

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 7/6/1969

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 49 and days of care provided 1,307

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2015 Fiscal Year: 11/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	211,205	8,422	4,594	224,221		224,221	224,221		1	
2	Food Purchase		106,673		106,673		106,673	(6,757)	99,916	2	
3	Housekeeping	165,271	10,258		175,529		175,529		175,529	3	
4	Laundry		6,284		6,284		6,284		6,284	4	
5	Heat and Other Utilities			75,242	75,242		75,242	(3,903)	71,339	5	
6	Maintenance	70,901	7,970	42,368	121,239		121,239		121,239	6	
7	Other (specify):*									7	
8	TOTAL General Services	447,377	139,607	122,204	709,188		709,188	(10,660)	698,528	8	
	B. Health Care and Programs										
9	Medical Director			375	375		375		375	9	
10	Nursing and Medical Records	1,039,118	118,569		1,157,687		1,157,687		1,157,687	10	
10a	Therapy									10a	
11	Activities	64,940	3,255	1,854	70,049		70,049		70,049	11	
12	Social Services	44,239			44,239		44,239		44,239	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,148,297	121,824	2,229	1,272,350		1,272,350		1,272,350	16	
	C. General Administration										
17	Administrative	72,061		1,471	73,532		73,532		73,532	17	
18	Directors Fees									18	
19	Professional Services			50,336	50,336		50,336		50,336	19	
20	Dues, Fees, Subscriptions & Promotions			12,691	12,691		12,691	(7,724)	4,967	20	
21	Clerical & General Office Expenses	59,092	13,384	8,299	80,775		80,775		80,775	21	
22	Employee Benefits & Payroll Taxes			751,001	751,001		751,001		751,001	22	
23	Inservice Training & Education			2,351	2,351		2,351		2,351	23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation			362	362		362		362	25	
26	Insurance-Prop.Liab.Malpractice			28,522	28,522		28,522		28,522	26	
27	Other (specify):*									27	
28	TOTAL General Administration	131,153	13,384	855,033	999,570		999,570	(7,724)	991,846	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,726,827	274,815	979,466	2,981,108		2,981,108	(18,384)	2,962,724	29	

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

12/1/2014

Ending:

11/30/2015

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			46,933	46,933		46,933		46,933			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			3,087	3,087		3,087		3,087			35
36	Other (specify):*											36
37	TOTAL Ownership			50,020	50,020		50,020		50,020			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,130	3,130		3,130		3,130			38
39	Ancillary Service Centers	68,295	7,125	201,198	276,618		276,618		276,618			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,797	112,797		112,797		112,797			42
43	Other (specify):* Lab & Radiology			3,292	3,292		3,292		3,292			43
44	TOTAL Special Cost Centers	68,295	7,125	320,417	395,837		395,837		395,837			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,795,122	281,940	1,349,903	3,426,965		3,426,965	(18,384)	3,408,581			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number THE CLAYBERG

0014290

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

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	(6,757)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,903)	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	(7,724)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (18,384)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (18,384)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

THE CLAYBERG

ID# 0014290

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE CLAYBERG# 0014290

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,757)	0	0	0	0	0	0	0	0	0	0	(6,757)	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	(3,903)	0	0	0	0	0	0	0	0	0	0	(3,903)	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	(10,660)	0	(10,660)	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	(7,724)	0	0	0	0	0	0	0	0	0	0	(7,724)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(7,724)	0	(7,724)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(18,384)	0	(18,384)	29									

STATE OF ILLINOIS

Facility Name & ID Number THE CLAYBERG# 0014290

Report Period Beginning:

12/1/2014 Ending:

Summary B

11/30/2015

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	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(18,384)	0	0	0	0	0	0	0	0	0	0	(18,384)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
FULTON COUNTY	100					

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	22 IMRF	\$ 200,942	FULTON COUNTY	100.00%	\$ 200,942	\$
2	V	22 FICA	133,927	FULTON COUNTY	100.00%	133,927	
3	V	22 WORKERS' COMP INSURANCE	106,977	FULTON COUNTY	100.00%	106,977	
4	V	22 UNEMPLOYMENT INSURANCE	2,126	FULTON COUNTY	100.00%	2,126	
5	V	17 COMMITTEE PER DIEM EXPENSE	1,471	FULTON COUNTY	100.00%	1,471	
6	V	26 PROPERTY & LIABILITY INSURAN	28,522	FULTON COUNTY	100.00%	28,522	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 473,965			\$ 473,965	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

THE CLAYBERG

#

0014290

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number THE CLAYBERG

0014290 Report Period Beginning: 12/1/2014

Ending: 1/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

THE CLAYBERG

0014290

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	NONE						\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6	NONE															
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10	NONE															
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2014 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 2015 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:	2010	_____	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	_____	9																
	2012	_____	10																
	2013	_____	11																
	2014	_____	12																

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE CLAYBERG COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0014290

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,920 B. General Construction Type: Exterior BRICK Frame CONCRETE & STEE 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).

NONE

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number THE CLAYBERG

0014290

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49	1969		\$ 271,336	\$	40	\$	\$	\$ 271,336	4
5		1978		8,009		20			8,009	5
6		1979		52,096		30			52,096	6
7										7
8										8
	Improvement Type**									
9	PATIO	1982		2,437		5			2,437	9
10	OFFICE REMODEL	1983		2,546		10			2,546	10
11	DRAIN	1985		1,261		25			1,261	11
12	ROOF	1986		1,200		15			1,200	12
13	SHED, ROOF AND FLOOR TILE	1987		5,429		20 TO 25			5,429	13
14	IDPA ADJUSTMENT	1989		1,806	90	20	90		1,625	14
15	ROOF	1993		61,283		15			61,283	15
16	ROAD REPAIR	1994		13,496		5			13,496	16
17	STORAGE BUILDING ADDITION	1994		4,265	213	20	213		4,265	17
18	STORAGE BUILDING ADDITION	1996		12,141	607	20	607		11,922	18
19	LAUNDRY FACILITY	1997		15,274	764	20	764		14,224	19
20	H/C SYSTEM	2000		4,564	228	20	228		3,461	20
21	WALK, PATH	2001		4,177	278	15	278		3,945	21
22	WALK, PATH	2002		1,357	90	15	90		1,214	22
23	AVIARY	2002		4,740	316	15	316		4,240	23
24	FLOORING	2004		634		10			634	24
25	TWO A/C UNITS	2004		4,583		10			4,583	25
26	FLOOR TILE	2005		290	11	25	11		125	26
27	ELECTRICAL BOX	2005		141	6	25	6		61	27
28	TWO METAL DOORS	2005		1,166	39	30	39		418	28
29	WALL COVERINGS	2005		697		5			697	29
30	EGRESS LIGHTS	2005		423	28	15	28		303	30
31	SMOKE DETECTORS	2005		2,915	73	10	73		2,915	31
32	NEW CORRIDOR WALL	2005		367	15	25	15		158	32
33	KITCHEN FIRE SYSTEM	2005		2,877	82	35	82		870	33
34	SIDEWALK	2005		802	53	15	53		561	34
35	LABOR FOR BLDG IMPROVEMENT	2005		5,904	394	15	394		4,133	35
36	WALL H/C UNITS	2005		2,729	205	10	205		2,729	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number THE CLAYBERG

0014290

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HARBOR IN GARDEN	2005	\$ 868	\$ 35	25	\$ 35	\$	\$ 353	37
38	BASE BOARD HEATERS	2006	278	18	15	18		184	38
39	FLOOR TILE	2006	640	26	25	26		250	39
40	EAST EGRESS	2006	1,701	113	15	113		1,087	40
41	EAST EGRESS SOIL	2006	390	13	30	13		125	41
42	DOOR AND FRAME	2006	614	20	30	20		196	42
43	WATER MAIN	2006	9,291	232	40	232		2,168	43
44	WATER MAIN WALKWAY	2006	1,031	69	15	69		641	44
45	DOOR LOCKS	2006	474	32	15	32		289	45
46	LABOR FOR BLDG IMPROVEMENT	2006	4,098	273	15	273		2,595	46
47	STEEL DOOR	2007	630	21	30	21		180	47
48	SPRINKLER SYSTEM/CEILING UPGRADE	2007	151,553	10,103	15	10,103		84,196	48
49	WIRING/ELECTRICAL OUTLETS	2007	635	32	20	32		262	49
50	4 A/C UNITS	2007	1,668	167	10	167		1,376	50
51	SENTRICON BAITING SYSTEM	2008	1,272	85	15	85		678	51
52	PACKAGED UNIT AND DUCT WORK	2008	6,105	407	15	407		2,883	52
53	ROOF WORK	2008	28,174	1,878	15	1,878		13,148	53
54	GENERATOR REPAIR	2009	2,170	145	15	145		892	54
55	FIRE PROTECTION - SPRINKLER SYSTEM	2009	25,825	1,722	15	1,722		10,330	55
56	WALL PAPER	2010	6,294	420	15	420		2,413	56
57	GARAGE DOOR	2012	848	85	10	85		318	57
58	DINING DOOR	2012	3,092	103	30	103		387	58
59	HEAT/COOL WALL AIR CONDITIONER	2012	1,912	191	10	191		717	59
60	3 HEAT/COOL WALL AIR CONDITIONERS	2012	2,166	217	10	217		740	60
61	FLOOR FINISH	2012	599	24	25	24		74	61
62	OFFICE CARPET	2012	1,601	160	10	160		480	62
63	LINEN CLOSET DOORS	2013	2,072	104	20	104		276	63
64	JUICE BAR FOR DINING ROOM	2013	550	27	20	27		71	64
65	4 THROUGH WALL H/C UNITS	2013	4,607	461	10	461		1,099	65
66	DOOR ALARM AND OPENERS	2013	31,838	1,592	20	1,592		3,582	66
67	ENTRANCE REPLACEMENT	2013	123,864	4,129	30	4,129		8,946	67
68	FLOWER BOXES AND LANDSCAPING	2013	4,281	285	15	285		595	68
69	WALL KIOSK	2014	8,254	825	10	825		1,307	69
70	TOTAL (lines 4 thru 69)		\$ 920,340	\$ 27,506		\$ 27,506	\$	\$ 625,014	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 920,340	\$ 27,506		\$ 27,506	\$	\$ 625,014	1
2	FLOOR - DINING ROOM	2015	11,222		15				2
3	AMANA AIR CONDITIONER	2015	2,709		15				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	TOTAL (lines 1 thru 33)		\$ 934,271	\$ 27,506		\$ 27,506	\$	\$ 625,014	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 170,193	\$ 18,451	\$ 18,451	\$	5 to 20	\$ 112,331	71
72	Current Year Purchases	21,355	976	976		3 to 10	976	72
73	Fully Depreciated Assets	180,389					180,389	73
74								74
75	TOTALS	\$ 371,937	\$ 19,427	\$ 19,427	\$		\$ 293,696	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2000 Chevrolet Bus	2000	\$ 42,641	\$	\$	\$	5	\$ 42,641	76
77	Pickup, delivery, & plowing	2001 Ford truck w/ 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)	\$ 1,377,666	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,933	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,933	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 985,168	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ **3,087** Description: **Copier \$183.23 per month and dish washing machine \$74 per 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number THE CLAYBERG # 0014290 Report Period Beginning: 12/1/2014 Ending: 11/30/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	2	3	
		Drop-outs	Completed	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)	\$			

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$	1,595	\$ 87,335	\$	1,595	\$ 87,335	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs		522	31,280		522	31,280	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39-3	hrs		1,138	79,409		1,138	79,409	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39-3	# of prescripts		6,215	3,174		6,215	3,174	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): STOCK DRUGS	39-2					7,125		7,125	12	
13	Other (specify): RADIOLOGY	43-3				1,849			1,849	13	
14	TOTAL			\$	9,470	\$ 203,047	\$ 7,125	9,470	\$ 210,172	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **THE CLAYBERG**# **0014290**Report Period Beginning: **12/1/2014**Ending: **11/30/2015****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **11/30/2015** (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	\$ 1,024,092	\$	1
2	Cash-Patient Deposits	5,032		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	281,546		3
4	Supply Inventory (priced at <u>COST</u>)	3,675		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>PROPERTY TAX RECEIVABL</u>	435,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,749,345	\$	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	934,270		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	438,396		16
17	Accumulated Depreciation (book methods)	(985,168)		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)	\$ 392,498	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,141,843	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,426	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,032		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,205		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	93,236		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO GENERAL FUND</u>	62,500		36
37	<u>DEFERRED PROPERTY TAXES</u>	435,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 721,399	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 721,399	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,420,444	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,141,843	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,484,369	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,484,369	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(537,890)	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)	\$ (537,890)	17
B. Transfers (Itemize):			
18	Transfer in from County IMRF Fund	200,942	18
19	Transfer in from County FICA Fund	133,927	19
20	Transfer in from County Insurance Fund	135,499	20
21	Transfer in from County Unemployment Fund	2,126	21
22	Transfer in from County General Fund	1,471	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 473,965	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,420,444	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 2,457,600	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,457,600	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		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals	6,757	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	4,539	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)	\$ 11,296	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	1,957	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,957	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	PROPERTY TAXES	418,222	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 418,222	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,889,075	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	709,188	31	
32	Health Care	1,272,350	32	
33	General Administration	999,570	33	
B. Capital Expense				
34	Ownership	50,020	34	
C. Ancillary Expense				
35	Special Cost Centers	283,040	35	
36	Provider Participation Fee	112,797	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,426,965	40	
41	Income before Income Taxes (line 30 minus line 40)**	(537,890)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (537,890)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,356,810	44
45	Private Pay - Net Inpatient Revenue	597,683	45
46	Medicare - Net Inpatient Revenue	503,107	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,457,600	49

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **THE CLAYBERG**

0014290

Report Period Beginning: 12/1/2014

Ending:

11/30/2015

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	1,750	1,815	\$ 45,522	\$ 25.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,648	5,836	161,654	27.70	3
4	Licensed Practical Nurses	14,155	15,077	329,299	21.84	4
5	CNAs & Orderlies	40,058	42,989	457,883	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,768	5,148	68,295	13.27	8
9	Activity Director	1,481	1,486	24,429	16.44	9
10	Activity Assistants	3,160	3,515	40,511	11.53	10
11	Social Service Workers	1,870	2,133	44,239	20.74	11
12	Dietician					12
13	Food Service Supervisor	2,093	2,244	47,030	20.96	13
14	Head Cook	8,265	8,889	100,316	11.29	14
15	Cook Helpers/Assistants	6,023	6,523	63,859	9.79	15
16	Dishwashers					16
17	Maintenance Workers	4,246	4,661	70,901	15.21	17
18	Housekeepers	14,331	15,517	165,271	10.65	18
19	Laundry					19
20	Administrator	2,000	1,820	72,061	39.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,345	2,289	59,092	25.82	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 C: CARE PLAN COO	1,632	1,837	44,760	24.37	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,825	121,779	\$ 1,795,122 *	\$ 14.74	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	64	\$ 4,594	35
36	Medical Director	3	375	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant		3,174	39
40	Physical Therapy Consultant	1,138	79,409	40
41	Occupational Therapy Consultant	1,595	87,335	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	522	31,280	43
44	Activity Consultant	16	1,766	44
45	Social Service Consultant			45
46	Other(specify) RADIOLOGY		1,849	46
47	LAB		1,443	47
48				48
49	TOTAL (lines 35 - 48)	3,338	\$ 211,225	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number THE CLAYBERG

0014290

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

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? Yes
If YES, give association name and amount. IHCA \$3,391
- (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? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,770 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. \$ 112,797
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,757
- (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: Gray Hunter Stenn LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Page 4, line 43	Radiology	\$ 1,849
	Laboratory	1,443

Page 19, line 28	Property Taxes	\$ 418,222
------------------	----------------	------------

Page 21, XIX, C.

Vendor/Payee	Type	Amount
Chaney Technology	IT Services	\$ 962
Diana Kieme	Accounting Consulting	300
Pathway Health Services	Accounting Consulting	10,489