

Facility Name & ID Number CLEARBROOK CENTER

0030023 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 10/27/2014

	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		Intermediate (ICF)			3
4	92	Intermediate/DD	77	29,531	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	77	29,531	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	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	29,456			29,456	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,456			29,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.75%

D. How many bed-hold days during this year were paid by the Department? 75 (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 7/7/92

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

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

Medicare Intermediary no

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30 Fiscal Year: 2015

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

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	149,556		102,000	251,556		251,556		251,556		1
2	Food Purchase		288,680		288,680		288,680		288,680		2
3	Housekeeping	69,026	33,105		102,131		102,131		102,131		3
4	Laundry		82,286		82,286		82,286		82,286		4
5	Heat and Other Utilities			93,288	93,288		93,288		93,288		5
6	Maintenance	89,531	19,934		109,465		109,465	7,481	116,946		6
7	Other (specify):*			124,402	124,402		124,402		124,402		7
8	TOTAL General Services	308,113	424,005	319,690	1,051,808		1,051,808	7,481	1,059,289		8
	B. Health Care and Programs										
9	Medical Director	13,583			13,583		13,583		13,583		9
10	Nursing and Medical Records	729,385	85,011	293,812	1,108,208		1,108,208		1,108,208		10
10a	Therapy										10a
11	Activities		2,083	3,561	5,644		5,644		5,644		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*	1,992,084		49,283	2,041,367		2,041,367		2,041,367		15
16	TOTAL Health Care and Programs	2,735,052	87,094	346,656	3,168,802		3,168,802		3,168,802		16
	C. General Administration										
17	Administrative	118,359			118,359		118,359	198,618	316,977		17
18	Directors Fees										18
19	Professional Services							29,214	29,214		19
20	Dues, Fees, Subscriptions & Promotions			2,072	2,072		2,072	4,334	6,406		20
21	Clerical & General Office Expenses	32,214		4,898	37,112		37,112	11,104	48,216		21
22	Employee Benefits & Payroll Taxes			635,436	635,436		635,436	45,966	681,402		22
23	Inservice Training & Education			791	791		791	5,735	6,526		23
24	Travel and Seminar			752	752		752		752		24
25	Other Admin. Staff Transportation							35,623	35,623		25
26	Insurance-Prop.Liab.Malpractice			20,878	20,878		20,878	2,962	23,840		26
27	Other (specify):*										27
28	TOTAL General Administration	150,573		664,827	815,400		815,400	333,556	1,148,956		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,193,738	511,099	1,331,173	5,036,010		5,036,010	341,037	5,377,047		29

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

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

Facility Name & ID Number CLEARBROOK CENTER

#0030023

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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			262,130	262,130	262,130	12,934	275,064				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						3,243	3,243				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			262,130	262,130	262,130	16,177	278,307				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				295,644	295,644		295,644				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers				295,644	295,644		295,644				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,193,738	511,099	1,593,303	5,593,784	5,593,784	357,214	5,950,998				45

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

Facility Name & ID Number **CLEARBROOK CENTER**

0030023

Report Period Beginning: **7/1/2014**

Ending: **6/30/2015**

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-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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				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)	\$		\$	30

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))	\$		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

CLEARBROOK CENTER

ID# 0030023

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLEARBROOK CENTER

0030023

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLEARBROOK CENTER

0030023

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	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

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.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

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

Facility Name & ID Number CLEARBROOK CENTER

0030023

Report Period Beginning:

7/1/2014

Ending: 7/30/2015

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 CLEARBROOK
 Street Address 1835 W CENTRAL ROAD
 City / State / Zip Code ARLINGTON HEIGHTS, IL 60005
 Phone Number (847-870-7711
 Fax Number (847-870-9926

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	24,795,342	\$ 58,072	\$ 3,194,238	3,194,238	\$ 7,481	1
2	17	ADMIN SALARIES	SALARIES	24,795,342	1,541,780	1,541,780	3,194,238	198,618	2
3	19	PROFESSIONAL SVCS	SALARIES	24,795,342	226,778		3,194,238	29,214	3
4	20	DUES,FEES, SUBSCRIPTIONS	SALARIES	24,795,342	33,641		3,194,238	4,334	4
5	21	CLERICAL, GEN OFFICE	SALARIES	24,795,342	86,197		3,194,238	11,104	5
6	22	EMP BENEFITS & TAXES	SALARIES	24,795,342	356,815		3,194,238	45,966	6
7	23	IN SVC TRAINING	SALARIES	24,795,342	44,515		3,194,238	5,735	7
8	25	OTHER ADMIN & TRAINING	SALARIES	24,795,342	276,527		3,194,238	35,623	8
9	26	INSURANCE	SALARIES	24,795,342	22,995		3,194,238	2,962	9
10	32	INTEREST	SALARIES	24,795,342	100,399		3,194,238	12,934	10
11	30	DEPRECIATION	SALARIES	24,795,342	25,175		3,194,238	3,243	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				\$ 2,772,894	\$ 1,541,780		\$ 357,214	25

Facility Name & ID Number

CLEARBROOK CENTER

0030023

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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**					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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10																	
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.)

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2014 report.		\$ tax exempt	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).		\$ #VALUE!	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.		\$ #VALUE!	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2010</td><td>_____</td><td>8</td></tr> <tr><td>2011</td><td>_____</td><td>9</td></tr> <tr><td>2012</td><td>_____</td><td>10</td></tr> <tr><td>2013</td><td>_____</td><td>11</td></tr> <tr><td>2014</td><td>_____</td><td>12</td></tr> </table>	2010	_____	8	2011	_____	9	2012	_____	10	2013	_____	11	2014	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2014 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 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
2010	_____	8																														
2011	_____	9																														
2012	_____	10																														
2013	_____	11																														
2014	_____	12																														
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																														

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CLEARBROOK CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0030023

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.**

Facility Name & ID Number CLEARBROOK CENTER

0030023 Report Period Beginning:

7/1/2014 Ending:

6/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,000 B. General Construction Type: Exterior brickk 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: _____
 (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>bldg donated</u>	<u>50,000</u>	<u>1985</u>	\$	1
2					2
3	TOTALS	<u>50,000</u>		\$	3

Facility Name & ID Number CLEARBROOK CENTER

0030023

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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	92	1985	1985	\$ 4,357,440	\$ 108,825	40	\$ 108,825	\$	\$ 3,214,768	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Improvements Prior to 2000			269,206	9,962		9,962		190,769	9
10	Boiler Valves		2000	1,444		10			1,440	10
11	Installation of Pella Windows		2000	6,704	268	25	268		4,157	11
12	Installation of Sprinkler System		2000	8,873	444	20	444		6,877	12
13	Installation of Pella Windows		2001	6,704	268	25	268		3,889	13
14	Equipment Survey		2001	2,000	100	20	100		1,450	14
15	Replace Brick Wall		2001	700	35	25	35		508	15
16	Install New Gas Link		2001	3,018	101	30	101		1,459	16
17	Kohler 35RZ Gas Generator		2001	12,159	608	20	608		8,815	17
18	Simplex Fire Alarm System		2001	1,952	98	20	98		1,417	18
19	Replace Fuel Tank		2001	2,922	146	20	146		2,119	19
20	Install new tile flooring		2001	1,420	71	20	71		1,030	20
21	New AC Compressor		2001	15,223	762	20	762		11,045	21
22	Concrete Repair		2001	1,200	60	20	60		870	22
23	AC Repairs		2001	14,767	713	20	713		10,605	23
24	Pool Chemical Controller		2001	2,886		10			2,886	24
25	HVAC Repairs		2001	20,763	1,038	20	1,038		15,052	25
26	Kitchen demolish and remodel entire		2001	61,420	2,457	25	2,457		35,378	26
27	Install new tile flooring		2001	1,555	75	20	75		1,125	27
28	Wall Protectors		2001	5,379	268	20	268		3,627	28
29	HVAC Upgrade		2002	25,761	1,288	20	1,288		17,388	29
30	Kitchen Remodeling		2002	5,300	265	20	265		3,577	30
31	AC Compressor		2002	2,500	125	20	125		1,740	31
32	HVAC Repairs		2002	23,430	1,171	20	1,171		15,813	32
33	Installation of fire alarm		2002	1,576		10			1,576	33
34	Wall Paper		2002	1,800		10			1,800	34
35	Install new flooring		2003	3,100		10			3,100	35
36	Security Equipment		2003	3,800		5			3,800	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number CLEARBROOK CENTER

0030023

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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	Install new tile flooring	2003	\$ 3,100	\$	5	\$	\$	\$ 3,100	37
38	Pool Repairs	2003	8,260		7			8,260	38
39	Plumbing Repairs	2003	8,562		7			8,562	39
40	Install New Door	2003	976		5			976	40
41	Install new tile flooring	2003	3,100		5			3,100	41
42	Elevator Repairs	2003	2,813		5			2,813	42
43	Bathroom Gut and Remodel	2004	18,970		10			18,970	43
44	Roof Repairs	2004	5,100		10			5,100	44
45	Elevator Repairs	2004	6,913		10			6,913	45
46	Infra Red Door	2005	1,881		3			1,881	46
47	Install Alarm systems	2005	13,800		10			13,800	47
48	Bathroom Remodeling	2006	66,523	4,435	15	4,435		58,266	48
49	Bathroom Remodeling	2006	8,892		5			8,892	49
50	Bathroom Remodeling	2006	20,641	2,064	10	2,064		18,920	50
51	Elevator Repairs	2006	3,250		5			3,250	51
52	Temperature Equipment	2006	7,116		5			7,116	52
53	Fire Protection Pipe	2007	1,587		5			1,587	53
54	Install New Carpeting	2007	1,935		5			1,935	54
55	Install New Carpeting	2007	930		5			930	55
56	New Toilet system	2007	1,055		3			1,055	56
57	Install New Carpeting	2007	2,147		5			2,147	57
58	Installation of new Glass Door	2007	656		3			656	58
59	Installation of new Glass Door	2008	656		3			656	59
60	Bathroom Remodeling	2008	43,007	4,300	10	4,300		31,714	60
61	Bathroom Remodeling Plans	2008	5,821		5			5,821	61
62	Engineer for Lighting	2009	4,991	654	7	654		4,578	62
63	Installation of new ceramic Tile	2009	3,177		5			3,177	63
64	Install Linoleum	2009	1,850		3			1,850	64
65	Duct Service	2009	7,230	1,033	7	1,033		6,714	65
66	Replace All Lighting in building	2009	21,000	2,100	10	2,100		13,650	66
67	Repair Front Door	2009	1,300		3			1,300	67
68	Painting Common Areas	2009	7,125		5			7,125	68
69	Well Pump replacement	2009	2,998		5			2,998	69
70	TOTAL (lines 4 thru 69)		\$ 5,152,364	\$ 143,733		\$ 143,733	\$	\$ 3,825,890	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:

7/1/2014

Ending:

6/30/2015

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	
1	Totals from Page 12A, Carried Forward		\$ 5,152,364	\$ 143,733		\$ 143,733	\$	\$ 3,825,890	1
2	Wall Repairs & Painting	2009	1,190		5			1,190	2
3	Wall Repairs & Painting	2009	1,360		5			1,360	3
4	Install New Floor Tile	2009	1,670		5			1,670	4
5	Door Protectors	2009	1,898		3			1,898	5
6	Install Lenox Furnace	2009	4,500		3			4,500	6
7	Light Replacements	2009	4,114		7			4,114	7
8	Washer & Dryer	2009	1,229		3			1,229	8
9	Install new laundry vents	2009	3,258		3			3,258	9
10	Buliding Materials	2009	1,117		2			1,117	10
11	Repair Water Leaks	2009	1,645		2			1,645	11
12	Light Replacements	2009	27,350	2,760	10	2,760		16,079	12
13	Door Protectors	2009	1,901		2			1,901	13
14	Repair Sprinkler	2010	1,351		5			1,351	14
15	Paint Hallways	2010	1,450		2			1,450	15
16	Fire Alarm System	2010	14,467	970	15	970		5,091	16
17	Replace Lighting	2010	3,525		5			3,525	17
18	Linoleum Flooring Installation'	2010	110		3			110	18
19	Light Replacements	2010	710		5			710	19
20	Light Replacements	2010	27,350	1,373	25	1,373		7,437	20
21	Light Replacements	2010	3,300	165	20	165		897	21
22	Teknoflor	2010	1,896		5			1,896	22
23	Install New carpeting	2010	1,221		2			1,221	23
24	Window Replacement	2010	5,000	500	10	500		2,458	24
25	Teknoflor	2010	1,290		2			1,290	25
26	Vinyl Tecno Floor	2010	2,102		2			2,102	26
27	Air Testing	2010	4,500		3			4,500	27
28	Roof Replacement	2010	7,600	760	10	760		3,610	28
29	Window Replacement	2010	11,560	771	15	771		3,596	29
30	Bathroom Remodeling	2010	3,863	773	5	773		3,605	30
31	Hydraulic Glider	2010	4,999	1,000	5	1,000		4,582	31
32	Repair Nurse Call System	2010	12,160	1,216	10	1,216		4,357	32
33	Motorized Wheel Chairs	2011	13,110	1,311	10	1,311		5,900	33
34	TOTAL (lines 1 thru 33)		\$ 5,325,160	\$ 155,332		\$ 155,332	\$	\$ 3,925,539	34

**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:

7/1/2014

Ending:

6/30/2015

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	
1	Totals from Page 12B, Carried Forward		\$ 5,325,160	\$ 155,332		\$ 155,332	\$	\$ 3,925,539	1
2	Field Survey	2011	2,700		2			2,700	2
3	Geotechnical Engineering	2011	3,400		2			3,400	3
4	Hydraulic Lift Seat	2011	2,876	575	5	575		2,492	4
5	Roof Repairs	2011	533		2			533	5
6	Construction Documents	2011	2,900		2			2,900	6
7	HVAC, Plumbing & Electrical repairs	2011	2,700	540	5	540		2,295	7
8	New Roof on building	2011	112,000	5,600	20	5,600		26,133	8
9	Washer & Dryer	2011	1,355	271	5	271		1,115	9
10	Industrial Washing Machine	2011	1,218	244	5	244		1,394	10
11	Electric Dryer	2012	1,002		3			1,002	11
12	Ice Maker	2012	3,169	634	5	634		2,060	12
13	Demolish and replace Handicap Ramp	2011	5,250	525	10	525		1,706	13
14	Replace outside door	2011	8,000	800	10	800		2,933	14
15	Pool Repairs	2012	3,323	665	5	665		2,381	15
16	Sprinkler Replacement	2012	6,578	439	15	439		1,535	16
17	Replace Laundry Station	2012	3,062	612	5	612		2,194	17
18	Fire Sprinkler System Repair	2012	45,000	2,250	20	2,250		7,500	18
19	Fire Sprinkler System Repair	2012	6,578	657	10	657		1,753	19
20	Tile Floor Installation for 6 Kitchens	2012	8,462	847	10	847		2,610	20
21	Building Sprinkler Replacement	2012	1,950		2			1,950	21
22	Washer & Dryer	2012	4,268	854	5	854		2,988	22
23	Dining room Chairs	2012	7,204	480	15	480		1,480	23
24	Replace 4 AC/Heat Roof Top Units	2011	24,000	1,600	15	1,600		6,400	24
25	Replace Lifet Station Pump & controls	2011	8,986	899	10	899		3,220	25
26	Replace 3 sets of Outside doors	2012	16,800	840	20	840		2,800	26
27	Installation of new green house	2012	15,950	1,063	15	1,063		3,278	27
28	Industrial Washing Machine	2012	1,425		3			1,425	28
29	Industrial Washing Machine	2012	1,413		3			1,413	29
30	Window Replacement	2012	6,750	1,350	5	1,350		4,050	30
31	Replace fire alarm system	2012	5,310	759	7	759		2,276	31
32	2 Gas Fryers & Casters	2012	3,721	1,240	3	1,240		3,721	32
33	Permit fee for green house	2012	311		2			311	33
34	TOTAL (lines 1 thru 33)		\$ 5,643,354	\$ 179,076		\$ 179,076	\$	\$ 4,029,488	34

**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:

7/1/2014

Ending:

6/30/2015

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	
1	Totals from Page 12C, Carried Forward		\$ 5,643,354	\$ 179,076		\$ 179,076	\$	\$ 4,029,488	1
2	Permit Fee for Windows	2012	1,723		2			1,723	2
3	New Windows for entire building	2012	175,000	8,750	20	8,750		23,333	3
4	Fill in pool & create living space	2012	47,764	1,592	30	1,592		4,113	4
5	Engineer for Pool project	2012	834		2			834	5
6	Install Digital Video Surveillance	2012	5,155		2			5,155	6
7	Building Floor Replacement	2013	7,500	1,500	5	1,500		3,750	7
8	Fill in pool & create living space	2013	119,610	3,987	30	3,987		9,968	8
9	Replace Fire Sprinkler	2013	88,901	4,445	20	4,445		11,113	9
10	Fill in pool & create living space	2013	145,483	4,849	30	4,849		11,719	10
11	Energy Efficient Equipment	2013	6,150	615	10	615		1,486	11
12	Fill in pool & create living space	2013	53,126	1,771	30	1,771		4,132	12
13	Commons Pool Removal	2013	80,899	2,696	30	2,696		6,067	13
14	Floor Replacement in pool area	2013	41,127	2,742	15	2,742		5,941	14
15	Fill in pool & create living space	2013	13,023	434	30	434		940	15
16	EME Restaurant Equipment	2013	3,500		2			3,500	16
17	Architectural Work for New Living Space	2013	136,005	4,534	30	4,534		9,445	17
18	Floor Replacement	2013	30,436	2,029	15	2,029		4,058	18
19	Kitchen Remodeling	2013	4,850	970	5	970		2,021	19
20	Remove & Replace Concrete Ramps	2013	14,174	1,181	10	1,181		2,362	20
21	Install 2 Dry Chrome Pendant Sprinklers	2013	1,864	311	5	311		622	21
22	Comercial Washer & Dryers	2013	20,000	1,500	10	1,500		3,000	22
23	Kitchen Remodeling	2013	4,985	1,523	3	1,523		3,046	23
24	Floor Replacement for hallways	2013	30,436	1,521	15	1,521		3,042	24
25	Replace Floor in All 92 Bedrooms	2013	171,500	5,717	20	5,717		11,434	25
26	Remove & Replace Concrete Ramps	2013	26,174	3,054	5	3,054		6,108	26
27	Sewer Replacement	2014	11,500	1,642	7	1,642		2,327	27
28	Sewer Replacement	2014	3,927	1,309	3	1,309		1,636	28
29	Remove & Replace Tile in 6 Showers	2014	7,120	1,424	5	1,424		1,424	29
30	Paint Hallway & 8 Bedrooms	2014	3,220	894	3	894		894	30
31	Gutters/Guard and Tree Trim	2014	2,973	825	3	825		825	31
32	Paint Hallway & 8 Bedrooms	2014	3,220	894	3	894		894	32
33	Kitchen Cabinets, Hardware and countertops	2014	9,400	1,119	7	1,119		1,119	33
34	TOTAL (lines 1 thru 33)		\$ 6,914,933	\$ 242,904		\$ 242,904	\$	\$ 4,177,519	34

**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	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 12D, Carried Forward		\$ 6,914,933	\$ 242,904		\$ 242,904	\$	\$ 4,177,519	1
2	Drywall repairs in Taupe & Red Halls	2014	1,150	287	3	287		287	2
3	Paint Peach Hallway and family room	2014	4,000	1,000	3	1,000		1,000	3
4	Paint Green Hallway & 8 Bedrooms	2014	2,236	804	3	804		804	4
5	Paint Red Hallway, 8 bedrooms and Family room	2014	4,000	1,000	3	1,000		1,000	5
6	Floor Replacement in 2 Isolation Rooms	2014	3,144	698	3	698		698	6
7	Kitchen Sink & Faucet replacement	2014	1,150	110	7	110		110	7
8	Add on to Sewer Replacement	2015	944	56	7	56		56	8
9	Vulcan Gas Range - 6 Burners - 2 Ovens	2015	4,397	110	10	110		110	9
10	Completion of Flooring & Painting in new living area	2015	3,887	65	5	65		65	10
11	Bolierless Convection Steamer	2015	5,120	85	5	85		85	11
12	Bulb & Ballaster Replacement	2015	53,521	446	10	446		446	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)		\$ 6,998,482	\$ 247,565		\$ 247,565	\$	\$ 4,182,179	34

**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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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				\$	\$	\$	\$		\$	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)	\$ 6,998,482	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 247,565	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 247,565	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)	\$ 4,182,179	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /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: \$ _____ 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

* 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.

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 7/1/2014 Ending: 6/30/2015
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?</p> <p><input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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		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 prescrpts							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.

Facility Name & ID Number **CLEARBROOK CENTER**# **0030023**Report Period Beginning: **7/1/2014**

Ending:

6/30/2015**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2015**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 1,900,488	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		394,190	5
6	Prepaid Insurance		355,514	6
7	Other Prepaid Expenses		292,758	7
8	Accounts Receivable (owners or related parties)		4,314,596	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 7,257,546	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,559,296	13
14	Buildings, at Historical Cost		24,908,516	14
15	Leasehold Improvements, at Historical Cost		274,756	15
16	Equipment, at Historical Cost		2,296,082	16
17	Accumulated Depreciation (book methods)		(12,975,890)	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):		5,918	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 19,068,678	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 26,326,224	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 1,070,937	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		415,823	29
30	Accrued Salaries Payable		914,510	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		100,547	32
33	Accrued Interest Payable			33
34	Deferred Compensation		201,518	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accrued emp benefits		1,313,987	36
37	due to other misc		151,196	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 4,168,518	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,728,363	40
41	Bonds Payable		4,110,000	41
42	Deferred Compensation		171,364	42
	Other Long-Term Liabilities(specify):			
43	due to HUD		119,483	43
44	due to temp restricted		1,359,839	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,489,049	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 13,657,567	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,668,657	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,668,657	\$ 13,657,567	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,041,262	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 12,041,262	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(227,349)	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) <u>clearbrook net of clearbrook commons</u>	854,744	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 627,395	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)	\$ 12,668,657	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,657,449	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,657,449	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	28,071	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)	\$ 28,071	23
D. Non-Operating Revenue			
24	Contributions	38,129	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,129	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,723,649	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,059,289	31
32	Health Care	3,168,802	32
33	General Administration	1,148,956	33
B. Capital Expense			
34	Ownership	278,307	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	295,644	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,950,998	40
41	Income before Income Taxes (line 30 minus line 40)**	(227,349)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (227,349)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? na 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: 7/1/2014

Ending: 6/30/2015

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
2	Assistant Director of Nursing				2
3	Registered Nurses	19,250	641,980	33.35	3
4	Licensed Practical Nurses	3,250	87,405	26.89	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,080	28,382	13.65	9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	13,650	149,556	10.96	15
16	Dishwashers				16
17	Maintenance Workers	5,040	89,531	17.76	17
18	Housekeepers	6,020	69,026	11.47	18
19	Laundry				19
20	Administrator	3,750	118,359	31.56	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	2,080	32,214	15.49	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director	240	13,583	56.60	27
28	Qualified MR Prof. (QMRP)	9,650	146,365	15.17	28
29	Resident Services Coordinator	3,100	66,605	21.49	29
30	Habilitation Aides (DD Homes)	145,600	1,750,732	12.02	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	213,710	\$ 3,193,738 *	\$ 14.94	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	15
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	5	210	15
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	85	2,582	15
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>behavioral</u>	325	32,317	15
47	<u>neurological</u>	60	5,400	15
48	<u>counseling</u>	180	16,110	15
49	TOTAL (lines 35 - 48)	775	\$ 80,619	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	
JESSICA SMART	ADMINISTRATOR		\$ 71,138	Workers' Compensation Insurance	\$ 85,502	IDPH License Fee	\$	
SUSAN KAUFMAN	VP PROGRAMS		30,059	Unemployment Compensation Insurance	22,658	Advertising: Employee Recruitment	29,214	
STACEY BELLOMO	PROGRAM DEV		17,162	FICA Taxes	235,645	Health Care Worker Background Check		
				Employee Health Insurance	287,671	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
				PENSION	49,926			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 118,359					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 681,402	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 29,214	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	752
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$	TOTAL		\$	TOTAL	\$ 752

* Attach copy of IMRF notifications

**See instructions.

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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. NO
- (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? YES If YES, what is the capacity? 77
- (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? 7 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,505 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. NA
- (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. \$ 295,644
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. \$ NONE Has any meal income been offset against related costs? NA 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? YES
 - 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? YES
Firm Name: PLANTE MORAN
- (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. NA
Attach invoices and a summary of services for all architect and appraisal fees.