

Facility Name & ID Number CLEARBROOK CENTER

0030023 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	85	Intermediate (ICF)	85	31,025	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	85	TOTALS	85	31,025	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	28,325			28,325	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,325			28,325	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.30%

D. How many bed reserve days during this year were paid by the Department?
132 (Do not include bed reserve 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 NONE

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30 Fiscal Year: 6/30

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

Facility Name & ID Number **CLEARBROOK CENTER** # **0030023** Report Period Beginning: **07/01/2016** Ending: **06/30/2017**

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	159,962		102,000	261,962		261,962		261,962		1
2	Food Purchase		279,235		279,235		279,235		279,235		2
3	Housekeeping	35,710	19,481		55,191		55,191		55,191		3
4	Laundry		92,874		92,874		92,874		92,874		4
5	Heat and Other Utilities			108,595	108,595		108,595		108,595		5
6	Maintenance	94,031	27,845	219,690	341,566		341,566	26,626	368,192		6
7	Other (specify):*										7
8	TOTAL General Services	289,703	419,435	430,285	1,139,423		1,139,423	26,626	1,166,049		8
	B. Health Care and Programs										
9	Medical Director	9,018	112,504		121,522		121,522		121,522		9
10	Nursing and Medical Records	2,498,796			2,498,796		2,498,796		2,498,796		10
10a	Therapy										10a
11	Activities		741		741		741		741		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*			731,541	731,541		731,541		731,541		15
16	TOTAL Health Care and Programs	2,507,814	113,245	731,541	3,352,600		3,352,600		3,352,600		16
	C. General Administration										
17	Administrative	125,685			125,685		125,685	223,410	349,095		17
18	Directors Fees										18
19	Professional Services							22,115	22,115		19
20	Dues, Fees, Subscriptions & Promotions							4,531	4,531		20
21	Clerical & General Office Expenses	31,784	4,273		36,057		36,057	6,700	42,757		21
22	Employee Benefits & Payroll Taxes			630,704	630,704		630,704	51,154	681,858		22
23	Inservice Training & Education			1,297	1,297		1,297	7,752	9,049		23
24	Travel and Seminar			523	523		523		523		24
25	Other Admin. Staff Transportation			29	29		29	27,479	27,508		25
26	Insurance-Prop.Liab.Malpractice			23,380	23,380		23,380	2,322	25,702		26
27	Other (specify):*			10,732	10,732		10,732		10,732		27
28	TOTAL General Administration	157,469	4,273	666,665	828,407		828,407	345,463	1,173,870		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,954,986	536,953	1,828,491	5,320,430		5,320,430	372,089	5,692,519		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			264,645	264,645		264,645	3,386	268,031		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							8,806	8,806		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			264,645	264,645		264,645	12,192	276,837		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		295,644		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			295,644	295,644		295,644		295,644		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,954,986	536,953	2,388,780	5,880,719		5,880,719	384,281	6,265,000		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:

07/01/2016

Ending:

06/30/2017

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				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

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))	\$		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

CLEARBROOK CENTER

ID# 0030023

Report Period Beginning: 07/01/2016

Ending: 06/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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:

07/01/2016

Ending:

06/30/2017

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: 07/01/2016 Ending: 06/30/2017

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)	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.

Facility Name & ID Number

CLEARBROOK CENTER

0030023

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

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

Facility Name & ID Number CLEARBROOK CENTER # 0030023 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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:

07/01/2016

Ending: 6/30/2017

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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	27,561,966	\$ 248,343	\$	2,954,991	\$ 26,626	1
2	17	ADMIN SALARIES	SALARIES	27,561,966	2,083,801	2,083,801	2,954,991	223,410	2
3	19	PROFESSIONAL SVCS	SALARIES	27,561,966	206,276		2,954,991	22,115	3
4	20	DUES, FEES SUBSCRIPTIONS	SALARIES	27,561,966	42,261		2,954,991	4,531	4
5	21	CLERICAL, GEN OFFICE	SALARIES	27,561,966	62,495		2,954,991	6,700	5
6	22	EMP BENEFITS, TAXES	SALARIES	27,561,966	477,130		2,954,991	51,154	6
7	23	IN SVC TRAINING	SALARIES	27,561,966	72,304		2,954,991	7,752	7
8	25	OTHER ADMIN, TRAINING	SALARIES	27,561,966	256,306		2,954,991	27,479	8
9	26	INSURNACE	SALARIES	27,561,966	21,657		2,954,991	2,322	9
10	32	INTEREST	SALARIES	27,561,966	82,134		2,954,991	8,806	10
11	30	DEPRECIATION	SALARIES	27,561,966	31,583		2,954,991	3,386	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				\$ 3,584,290	\$ 2,083,801		\$ 384,281	25

Facility Name & ID Number **CLEARBROOK CENTER**

0030023

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
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.)

2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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:

A. Land. Table with columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, 5. Rows 1, 2, 3 TOTALS

Facility Name & ID Number CLEARBROOK CENTER

0030023

Report Period Beginning:

07/01/2016 Ending:

06/30/2017

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		1985	1985	\$ 4,357,440	\$ 108,825	40	\$ 108,825	\$	\$ 3,432,420
5									
6									
7									
8									
	Improvement Type**								
9	Improvements Prior to 2000			269,206	9,962		9,962		210,693
10	Boiler Valves		2000	1,444		10			1,444
11	Installation of Pella Windows		2000	6,704	268	25	268		4,693
12	Installation of Sprinkler System		2000	8,873	444	20	444		7,764
13	Installation of Pella Windows		2001	6,704	268	25	268		4,425
14	Equipment Survey		2001	2,000	100	20	100		1,650
15	Replace Brick wall		2001	700	35	25	35		578
16	Install New Gas Line		2001	3,018	101	30	101		1,660
17	Kohler 35RZ Gas Generator		2001	12,159	608	20	608		10,031
18	Simplex Fire Alarm System		2001	1,952	98	20	98		1,610
19	Replace Fuel Tank		2001	2,922	146	20	146		2,411
20	Install New Tile Flooring		2001	1,420	71	20	71		1,172
21	New AC Compressor		2001	15,223	762	20	762		12,567
22	Concrete Repair in the office		2001	1,200	60	20	60		990
23	HVAC Repairs		2001	14,767	713	20	713		12,183
24	Pool Chemical Controller		2001	2,886		10			286
25	HVAC Repairs		2001	20,763	1,038	20	1,038		17,129
26	Demolish and Remodel Entire kitchen, drywall, tiles, cabinets, sink, hardw		2001	61,420	2,457	25	2,457		40,393
27	Install New Tile Flooring in client bedroom		2001	1,555	75	20	75		1,283
28	Install Korogard Wall Protectors		2001	5,379	268	20	268		4,169
29	HVAC Upgrade		2002	25,761	1,288	20	1,288		19,964
30	Kitchen remodeling		2002	5,300	265	20	265		4,107
31	Replace AC Compressor		2002	2,500	125	20	125		1,990
32	HVAC Repairs		2002	23,430	1,171	20	1,171		18,158
33	Installation of Fire Alarm		2002	1,576		10			1,576
34	Wall Paper		2002	1,800		10			1,800
35	Install New Tile Flooring in client bedroom		2003	3,100		10			3,100
36	Install Security Equipment		2003	3,800		5			3,800

*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:

07/01/2016 Ending: 06/30/2017

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	Installation of New Tile Flooring in Client Bedroom	2003	\$ 3,100	\$	5	\$	\$	\$ 3,100	37
38	Repairs to Pool	2003	8,260		7			8,260	38
39	Repairs to Plumbing	2003	8,562		7			8,562	39
40	Install New Steel Door	2003	976		5			976	40
41	Installation of New Tile Flooring in Client Bedroom	2003	3,100		5			3,100	41
42	Repair to Elevator	2003	2,813		5			2,813	42
43	Demolish bathroom and remodel. New toilet, shower and sink	2004	18,970		10			18,970	43
44	Repair roof	2004	5,100		10			5,100	44
45	Elevator Motor Replacement	2004	6,913		10			6,913	45
46	Install Infra Red Door	2005	1,881		3			1,881	46
47	Install Alarm System	2005	13,800		10			13,800	47
48	Bathroom Remodeling	2006	66,523	4,435	15	4,435		67,136	48
49	Bathroom Remodeling	2006	8,892		5			8,892	49
50	Bathroom Remodeling	2006	20,641		10			20,641	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	Install 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	2007	656		3			656	59
60	Demolish bathroom and remodel. New toilet, shower and sink	2008	43,007	4,300	10	4,300		40,314	60
61	Bathroom Remodeling plans	2008	5,821		5			5,821	61
62	Engineer for Lighting Project	2009	4,991		7			4,991	62
63	Installation of new ceramic Tile	2009	3,177		5			3,177	63
64	Installation fo Linoleum Flooring	2009	1,850		3			1,850	64
65	Duct Cleaning Service	2009	7,230		7			7,230	65
66	Replace All Lighting in building	2009	21,000	2,100	10	2,100		17,850	66
67	Front Door Repairs	2009	1,300		3			1,300	67
68	Painting of 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	\$ 139,983		\$ 139,983	\$	\$ 4,106,177	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:

07/01/2016 Ending: 06/30/2017

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	\$ 139,983		\$ 139,983	\$	\$ 4,106,177	1
2	Wall Repairs and Painting	2009	1,190		5			1,190	2
3	Wall Repairs and Painting	2009	1,360		5			1,360	3
4	Install New Tile Flooring	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	Lighting Replacements	2009	4,114		7			4,114	7
8	Install Washer and Dryer	2009	1,229		3			1,229	8
9	Repair drywall, remove damaged laundry vent and install new ven	2009	3,258		3			3,258	9
10	Door and Hardware material for installation	2009	1,117		2			1,117	10
11	Repair 350 SF of water damage/leaks in office and gutter replacen	2009	1,645		2			1,645	11
12	Remove and replace lighting in building	2009	27,350	2,760	10	2,760		21,600	12
13	27 - 8Wx36H Hazelwood Door protectors	2009	1,901		2			1,901	13
14	Dismantle corroded 2.5" Pipe. Install Hangers to support Pipe. Ins	2010	1,351		5			1,351	14
15	Patch & Paint complete hallway area	2010	1,450		2			1,450	15
16	Installation of Fire Alarm System	2010	14,467	970	15	970		7,031	16
17	Remove and replace lighting in building	2010	3,525		5			3,525	17
18	Remove existing floor and Install Linoleum Flooring	2010	110		3			110	18
19	Remove and replace lighting in building	2010	710		5			710	19
20	Remove and replace lighting in building	2010	27,350	1,373	25	1,373		10,183	20
21	Remove and replace lighting in building	2010	3,300	165	20	165		1,229	21
22	Furnish & Install 250 SF of vinyl tecno flooring	2010	1,896		5			1,896	22
23	Furnish & Install 250 SF of vinyl tecno flooring	2010	1,221		2			1,221	23
24	16 - 74"x 64" windows removed & replaced & 4 Side windows.	2010	5,000	500	10	500		3,458	24
25	Furnish & Install 250 SF of vinyl tecno flooring	2010	1,290		2			1,290	25
26	Furnish & Install 250 SF of vinyl tecno flooring	2010	2,102		2			2,102	26
27	Air Testing complete for mold/water damage areas	2010	4,500		3			4,500	27
28	Bidding Documents for Roof replacement	2010	7,600	760	10	760		5,130	28
29	4 - 48"x64" double casement windows/4- 74"x64" opening window	2010	11,560	771	15	771		5,138	29
30	Remove drywall & reinstall new drywall/Tape joint and install tile	2010	3,863		5			3,860	30
31	Hydraulic Lift/Adult Glider	2010	4,999		5			4,999	31
32	Repair/Rewire Nurse Call System	2010	12,160	1,216	10	1,216		8,005	32
33	Motorized Wheel Chairs	2011	13,110	1,311	10	1,311		8,522	33
34	TOTAL (lines 1 thru 33)		\$ 5,325,160	\$ 149,809		\$ 149,809	\$	\$ 4,227,369	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:

07/01/2016 Ending: 06/30/2017

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	\$ 149,809		\$ 149,809	\$	\$ 4,227,369	1
2	Field Survey for HVAC, Plumbing & Electrical Engineering Balar	2011	2,700		2			2,700	2
3	24 hour water level reading/Geotechnical Engineering Services	2011	3,400		2			3,400	3
4	Hydraulic Lift Seat	2011	2,876		5			2,876	4
5	Patching of Roof	2011	533		2			533	5
6	Structural Design & Construction Documents	2011	2,900		2			2,900	6
7	Field Survey for HVAC, Plumbing & Electrical Engineering Balar	2011	2,700		5			2,700	7
8	Installation of New roof on Building	2011	112,000	5,600	20	5,600		37,333	8
9	Install Washer and Dryer	2011	1,355		5			1,355	9
10	Install Industrial Washer	2011	1,218		5			1,218	10
11	Installation of Electric Dryer	2012	1,002		3			1,002	11
12	Install New Ice Maker & water filtration system, single configurati	2012	3,169		5			3,169	12
13	Remove & Replace Approx. 150 SF of 5" P.C.C. Handicap Ramp	2011	5,250	525	10	525		2,756	13
14	Install Glass & Aluminum Double Door w/ Von Duprin 33 Panic D	2011	8,000	800	10	800		4,533	14
15	Site Survey & Soil Investigation Fees for Pool Removal	2012	3,323		5			3,323	15
16	Bid & Construction Documents to replace fire sprinkler piping	2012	6,578	439	15	439		2,412	16
17	Replace piping and install Laundry Station	2012	3,062		5			3,062	17
18	Fire Sprinkler System Replacement	2012	45,000	2,250	20	2,250		12,000	18
19	Fire Sprinkler System Replacement	2012	6,578	657	10	657		3,067	19
20	Remove Drywall & Install new durock, tile base board & install til	2012	8,462	847	10	847		4,301	20
21	Fire Sprinkler System Replacement	2012	1,950		2			1,950	21
22	Install new Washer & Dryer	2012	4,268		5			4,268	22
23	24 new Dining Room Chairs	2012	7,204	480	15	480		2,441	23
24	Remove existing & replace 4 HVAC roof top units	2011	24,000	1,600	15	1,600		9,333	24
25	Replace Lift Station Pump & Controls	2011	8,986	899	10	899		4,867	25
26	Replace 3 sets of Outside Doors	2012	16,800	840	10	840		4,480	26
27	Installation of New Green House	2012	15,950	1,063	15	1,063		5,405	27
28	Install Industrial Washing Machine	2012	1,425		3			1,425	28
29	Install Industrial Washing Machine	2012	1,413		3			1,413	29
30	Architectural Drawings for window replacement	2012	6,750		5			6,750	30
31	Replace Fire Alarm System	2012	5,310	759	7	759		3,793	31
32	Install 2 Gas Fryers & Casters	2012	3,721		3			3,721	32
33	Permit Fee for the Green House	2012	311		2			311	33
34	TOTAL (lines 1 thru 33)		\$ 5,643,354	\$ 166,568		\$ 166,568	\$	\$ 4,372,167	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:

07/01/2016 Ending: 06/30/2017

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	\$ 166,568		\$ 166,568	\$	\$ 4,372,167	1
2	Permit Fees for Windows	2012	1,723		2			1,723	2
3	Remove Old and Install New Windows for entire building	2012	175,000	8,750	20	8,750		40,833	3
4	Fill in pool to create new living space	2012	47,764	1,592	30	1,592		7,297	4
5	Engineer for Pool Project	2012	834		2			834	5
6	Install Digital Video Surveillance	2012	5,155		2			5,155	6
7	Design Drawings for Building Floor Replacement	2013	7,500	1,500	5	1,500		6,750	7
8	Fill in pool to create new living space	2013	119,610	3,987	30	3,987		17,942	8
9	Remove old piping & system. Install New Fire Sprinkler	2013	88,901	4,445	20	4,445		20,003	9
10	Fill in pool to create new living space	2013	145,483	4,849	30	4,849		21,418	10
11	Install Energy Efficient Equipment to reduce electric usage	2013	6,150	615	10	615		2,715	11
12	Fill in pool to create new living space	2013	53,126	1,771	30	1,771		7,674	12
13	Commons Pool Removal	2013	80,899	2,696	30	2,696		11,461	13
14	Floor Replacement in Pool Area	2013	41,127	2,742	15	2,742		11,424	14
15	Fill in pool to create new living space	2013	13,023	434	30	434		1,809	15
16	54" S/S exterior glass slide door refrigerator	2013	3,500		2			3,500	16
17	Architectural Work for New Living Space	2013	136,005	4,534	30	4,534		18,512	17
18	Floor Replacement in Pool Area	2013	30,436	2,029	15	2,029		8,116	18
19	Remove existing cabinets, repair drywall, install new kitchen cabin	2013	4,850	970	5	970		3,799	19
20	Sawcut & demo 414 SF concrete ramps. Install stone back fill and	2013	14,174	1,181	10	1,181		5,433	20
21	Install 2 Dry Chrome Pendant Sprinklers	2013	1,864	311	5	311		1,429	21
22	Install Comercial Washer and Dryer	2013	20,000	1,500	10	1,500		7,500	22
23	Remove existing cabinets, repair drywall, install new kitchen cabin	2013	4,985		3			4,985	23
24	Remove existing floor, install base board, install tile for all of the H	2013	30,436	1,521	15	1,521		7,609	24
25	Remove existing flooring and Replace with tile Floor in all 92 Bedr	2013	171,500	5,717	20	5,717		31,442	25
26	Sawcut & demo 414 SF concrete ramps. Install stone back fill and	2013	26,174	5,235	5	5,235		18,758	26
27	Sewer Replacement	2014	11,500	1,642	7	1,642		5,339	27
28	Sewer Replacement	2014	3,927		3			3,927	28
29	Remove tile from shower base on 6 showers. Replace tile base on s	2014	7,120	1,424	5	1,424		4,272	29
30	Paint Hallway & 8 Bedrooms	2014	3,220	894	3	894		3,041	30
31	Clean out Gutters/Guard and Tree Trim	2014	2,973	825	3	825		2,808	31
32	Paint Hallway & 8 Bedrooms	2014	3,220	894	3	894		3,041	32
33	Remove existing cabinets, repair drywall, install new kitchen cabin	2014	9,400	1,119	7	1,119		3,804	33
34	TOTAL (lines 1 thru 33)		\$ 6,914,933	\$ 229,745		\$ 229,745	\$	\$ 4,666,519	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:

07/01/2016 Ending: 06/30/2017

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	\$ 229,745		\$ 229,745		\$ 4,666,519	1
2	Remove damaged drywall & repair existing drywall in Taupe and	2014	1,150	287	3	287		1,054	2
3	Paint Peach Hallway & Family room	2014	4,000	1,333	3	1,333		3,667	3
4	Paint Green Hallway & Bedrooms	2014	3,220	804	3	804		2,952	4
5	Paint Red Hallway, 8 Bedrooms and Family Room	2014	4,000	1,333	3	1,333		3,667	5
6	Floor Replacemnt in 2 Isolation Rooms, remove damaged drywall,	2014	3,144	1,048	3	1,048		2,795	6
7	Remove existing sink & replace with new kitchen sink & Faucet R	2014	1,150	164	7	164		438	7
8	Add on To Sewer Replacement	2015	944	135	7	135		326	8
9	Vulcan Gas Range - 6 Burners & 2 Ovens	2015	4,397	440	10	440		989	9
10	Completion of flooring & painting in new living area	2015	3,887	777	5	777		1,620	10
11	Boilerless Convection Steamer	2015	5,120	1,024	5	1,024		2,133	11
12	Bulb & Ballaster Replacement	2015	53,521	5,352	10	5,352		11,150	12
13	Remove Existing Lift Station pump & piping. Install new slicing p	2015	100,000	5,000	20	5,000		9,167	13
14	Workstation installed in Plum Hall	2015	12,430	1,243	10	1,243		2,279	14
15	Add on To Sewer Replacement	2015	1,725	173	10	173		316	15
16	Install New concrete Sidewalk, replace damaged pavers.	2015	4,967	497	10	497		786	16
17	Over time labor for Sewer Project/Electrician	2015	8,314	416	20	416		624	17
18	Permit Fee For Sewer Project	2016	490	25	20	25		37	18
19	Upgrade of pump for sewer project	2016	1,800	90	20	90		135	19
20	Public Area Window Replacement	2016	3,292	658	5	658		878	20
21	Remove existing cabinets, repair drywall, install new kitchen cabin	2016	11,600	1,160	10	1,160		1,547	21
22	Remove existing cabinets, repair drywall, install new kitchen cabin	2016	11,400	1,140	10	1,140		1,330	22
23	Remove existing cabinets, repair drywall, install new kitchen cabin	2016	11,400	1,045	10	1,045		1,045	23
24	Replace windows in public area	2016	5,341	445	10	445		445	24
25	Furnish and Install Custom Fence	2016	2,000	300	5	300		300	25
26	Remove old and install new store front windows	2016	46,750	1,558	20	1,558		1,558	26
27	Remove existing cabinets, repair drywall, install new kitchen cabin	2016	11,600	773	10	773		773	27
28	Additional balance for kitchen remodel	2016	185	62	2	62		62	28
29	Floor Replacemnt in 2 bedrooms remove damaged drywall, patch	2016	4,886	651	5	651		651	29
30	Remove old and install new store front windows	2017	38,250	159	20	159		159	30
31	Remove existing cabinets, repair drywall, install new kitchen cabin	2017	11,400	570	10	570		570	31
32	Additional balance for kitchen remodel	2017	340	57	2	57		57	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,287,636	\$ 258,463		\$ 258,463		\$ 4,720,027	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:

07/01/2016

Ending:

06/30/2017

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)	\$ 7,287,636	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 258,463	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 258,463	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)	\$ 4,720,027	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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/2017**

(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	\$	\$ 972,484	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		419,341	5
6	Prepaid Insurance		350,971	6
7	Other Prepaid Expenses		440,933	7
8	Accounts Receivable (owners or related parties)		4,501,489	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 6,685,218	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,342,048	13
14	Buildings, at Historical Cost		25,061,130	14
15	Leasehold Improvements, at Historical Cost		458,039	15
16	Equipment, at Historical Cost		2,609,519	16
17	Accumulated Depreciation (book methods)		(14,172,905)	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)	\$	\$ 18,303,749	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 24,988,967	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 932,980	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		406,746	29
30	Accrued Salaries Payable		1,063,284	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		55,011	32
33	Accrued Interest Payable			33
34	Deferred Compensation		87,991	34
35	Federal and State Income Taxes		94,044	35
	Other Current Liabilities(specify):			
36	ACCRUED EMP BENEFITS		1,466,595	36
37	DUE TO OTHER MISC		163,698	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 4,270,349	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,680,000	40
41	Bonds Payable		3,897,802	41
42	Deferred Compensation		195,795	42
	Other Long-Term Liabilities(specify):			
43	DUE TO HUD		96,371	43
44	DUE TO TEMP RESTRICTED		100,254	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,970,222	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 12,240,571	46
47	TOTAL EQUITY(page 18, line 24)	\$	\$ 12,748,396	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	\$ 12,748,396	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,665,986	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 12,665,986	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,568,687)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) CLEARBROOK NET OF COMMONS	1,651,097	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 82,410	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)	\$ 12,748,396	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	\$ 4,631,466	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,631,466	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	26,071	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)	\$ 26,071	23
D. Non-Operating Revenue			
24	Contributions	29,318	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,318	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRAINING REVENUE	9,458	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,458	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,696,313	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,166,049	31
32	Health Care	3,352,600	32
33	General Administration	1,173,870	33
B. Capital Expense			
34	Ownership	276,837	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)*	\$ 6,265,000	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,568,687)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,568,687)	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? _____ 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: 07/01/2016

Ending: 06/30/2017

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	11,855	11,855	358,146	30.21	3
4	Licensed Practical Nurses	12,020	12,020	327,007	27.21	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,550	14,550	159,962	10.99	15
16	Dishwashers					16
17	Maintenance Workers	5,075	5,075	94,031	18.53	17
18	Housekeepers	3,000	3,000	35,710	11.90	18
19	Laundry			113,926		19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,400	2,400	40,382	16.83	22
23	Office Manager	2,080	2,080	31,784	15.28	23
24	Clerical	1,040	1,040	11,759	11.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	180	180	9,013	50.07	27
28	Qualified MR Prof. (QMRP)	11,250	11,250	163,994	14.58	28
29	Resident Services Coordinator	3,600	3,600	65,436	18.18	29
30	Habilitation Aides (DD Homes)	121,422	121,422	1,543,836	12.71	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	188,472	188,472	\$ 2,954,986 *	\$ 15.68	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	24,000	15	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	862	15	43
44	Activity Consultant			44
45	Social Service Consultant	21,870	15	45
46	Other(specify)			46
47	BEHAVIORAL	20,978	15	47
48				48
49	TOTAL (lines 35 - 48)	\$ 67,710		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		\$ 85,000	Workers' Compensation Insurance	\$ 95,524	IDPH License Fee	\$	
BRENDA DEVITO	VP PROGRAMS		28,926	Unemployment Compensation Insurance	15,900	Advertising: Employee Recruitment		
STACEY BELLOMO	QA ADMIN		11,759	FICA Taxes	217,241	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	231,427	Patient Background Checks		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				403B	70,612			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,685					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
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)			\$					
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	523
							Seminar Expense	
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 523	

* Attach copy of IMRF notifications

**See instructions.

