FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0014290

Facility Name: The Clayberg

Address: 625 E Monroe St (Number) Cuba (City) 61427 (Zip Code)

County: Fulton

Telephone Number: (309) 785-0512 **Fax #** (309) 785-5376

HFS ID Number:

Date of Initial License for Current Owners: 7/6/1969

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Diane Keime **Telephone Number:** (309) 785-5012
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2019 to 11/30/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Tammie Denning
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Jeff McPherson, Partner
(Firm Name & Address) Gray Hunter Stenn LLP, 500 Maine Street, Quincy, IL 62301
(Telephone) (217) 222-0304 Fax # (217) 222-1691

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,934	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,359	1,359	8
9	SNF/PED					9
10	ICF	11,977	2,433		14,410	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,977	2,433	1,359	15,769	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.93%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
Meal Delivery

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/6/1969

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 1,359

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/2020 Fiscal Year: 11/30/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	261,957	10,179	3,306	275,442		275,442		275,442			1
2	Food Purchase		101,347		101,347		101,347	(13,393)	87,954			2
3	Housekeeping	180,552	13,423		193,975		193,975		193,975			3
4	Laundry		15,248		15,248		15,248		15,248			4
5	Heat and Other Utilities			70,977	70,977		70,977	(4,877)	66,100			5
6	Maintenance	63,504	4,691	94,607	162,802		162,802		162,802			6
7	Other (specify):*											7
8	**TOTAL General Services**	506,013	144,888	168,890	819,791		819,791	(18,270)	801,521			8
	B. Health Care and Programs											
9	Medical Director			125	125		125		125			9
10	Nursing and Medical Records	1,206,178	71,827	31,739	1,309,744		1,309,744		1,309,744			10
10a	Therapy											10a
11	Activities	109,337	3,555	3,992	116,884		116,884		116,884			11
12	Social Services	48,486			48,486		48,486		48,486			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,364,001	75,382	35,856	1,475,239		1,475,239		1,475,239			16
	C. General Administration											
17	Administrative	77,451		1,588	79,039		79,039		79,039			17
18	Directors Fees											18
19	Professional Services			46,306	46,306		46,306		46,306			19
20	Dues, Fees, Subscriptions & Promotions			30,716	30,716		30,716	(19,954)	10,762			20
21	Clerical & General Office Expenses	71,829	8,727	9,595	90,151		90,151	(366)	89,785			21
22	Employee Benefits & Payroll Taxes			810,161	810,161		810,161		810,161			22
23	Inservice Training & Education			875	875		875		875			23
24	Travel and Seminar			4,029	4,029		4,029		4,029			24
25	Other Admin. Staff Transportation			1,430	1,430		1,430		1,430			25
26	Insurance-Prop.Liab.Malpractice			56,770	56,770		56,770		56,770			26
27	Other (specify):* See pg 23			61,262	61,262		61,262	(2,000)	59,262			27
28	**TOTAL General Administration**	149,280	8,727	1,022,732	1,180,739		1,180,739	(22,320)	1,158,419			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,019,294	228,997	1,227,478	3,475,769		3,475,769	(40,590)	3,435,179			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number The Clayberg #0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			117,704	117,704		117,704		117,704			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,419	28,419		28,419		28,419			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,934	26,934		26,934		26,934			35
36	Other (specify):*											36
37	**TOTAL Ownership**			173,057	173,057		173,057		173,057			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,145	1,145		1,145		1,145			38
39	Ancillary Service Centers	129,053	7,906	194,321	331,280		331,280		331,280			39
40	Barber and Beauty Shops		82		82		82		82			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			105,343	105,343		105,343		105,343			42
43	Other (specify):*			3,941	3,941		3,941		3,941			43
44	**TOTAL Special Cost Centers**	129,053	7,988	304,750	441,791		441,791		441,791			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,148,347	236,985	1,705,285	4,090,617		4,090,617	(40,590)	4,050,027			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,393)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,877)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(366)	21		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	(2,000)	27		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	(19,954)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,590)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (40,590)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		IMRF	$ 183,416	Fulton County	100.00%	$ 183,416	$	1
2	V		FICA	158,683	Fulton County	100.00%	158,683		2
3	V		Workers' Comp Insurance	60,141	Fulton County	100.00%	60,141		3
4	V		Property & Liability Insurance	56,770	Fulton County	100.00%	56,770		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			$ 459,010			$ 459,010	$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 1/30/2020

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRST MIDSTATE INC.		X	CAPITAL IMPROVEMENTS	$6,238.54	11/30/16	$ 1,000,000	$ 870,000	12/1/2036	4.5000	$ 28,419	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$6,238.54		$ 1,000,000	$ 870,000			$ 28,419	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,000,000	$ 870,000			$ 28,419	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

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13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Clayberg COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0014290

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,850 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building Site	217,800	1969	$ 5,000	1
2					2
3	TOTALS	217,800		$ 5,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1969		$ 271,336	$	40	$	$	$ 271,336	4
5			1978		8,009		20			8,009	5
6			1979		52,096		30			52,096	6
7											7
8											8
	Improvement Type**										
9	OFFICE REMODEL			1983	2,546		10			2,546	9
10	SHED, ROOF AND FLOOR TILE			1987	5,429		20 TO 25			5,429	10
11	IDPA ADJUSTMENT			1989	1,806		20			1,806	11
12	ROAD REPAIR			1994	13,496		5			13,496	12
13	STORAGE BUILDING ADDITION			1995	4,265		20			4,265	13
14	STORAGE BUILDING ADDITION			1996	12,141		20			12,141	14
15	LAUNDRY FACILITY			1997	15,274		20			15,242	15
16	H/C SYSTEM			2000	4,564	190	20	190		4,564	16
17	WALK, PATH			2001	4,177		15			4,177	17
18	WALK, PATH			2002	1,357		15			1,357	18
19	AVIARY			2002	4,740		15			4,740	19
20	TWO A/C UNITS			2004	4,583		10			4,583	20
21	TWO METAL DOORS			2005	1,166	39	30	39		612	21
22	WALL COVERINGS			2005	697		5			697	22
23	SMOKE DETECTORS			2005	2,915		10			2,915	23
24	KITCHEN FIRE SYSTEM			2005	2,877	82	35	82		1,281	24
25	SIDEWALK			2005	802	27	15	27		802	25
26	WALL H.C UNITS			2005	2,729		10			2,729	26
27	HARBOR IN GARDEN			2005	868	35	25	35		527	27
28	WATER MAIN			2006	9,291	232	40	232		3,329	28
29	SPRINKLER SYSTEM/CEILING UPGRADE			2007	138,564	9,238	15	9,238		123,168	29
30	PACKAGED UNIT AND DUCT WORK			2008	6,105	407	15	407		4,918	30
31	FIRE PROTECTION - SPRINKLER SYSTEM			2009	14,700	980	15	980		10,780	31
32	DINING DOOR			2012	3,092	104	30	104		902	32
33	HEAT/COOL WALL AIR CONDITIONER			2012	1,912	191	10	191		1,673	33
34	3 HEAT/COOL WALL AIR CONDITIONERS			2012	2,166	217	10	217		1,823	34
35	4 THROUGH WALL H/C UNITS			2013	4,607	459	10	459		3,400	35
36	DOOR ALARM AND OPENERS			2013	31,838	1,591	20	1,591		11,541	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ENTRANCE REPLACEMENT	2013	$ 122,450	$ 4,084	30	$ 4,084	$	$ 29,250	37
38	FLOOR - DINING ROOM	2013	11,222	748	15	748		3,741	38
39	AMANA AIR CONDITIONER	2015	2,709	181	15	181		903	39
40	FIRE WALL PROTECTION BARRIERS	2015	10,000	400	15	400		1,900	40
41	UNIVERSAL GAS WATER HEATER	2016	6,228	415	15	415		1,972	41
42	SILENT KNIGHT 10 ZONE ALARM	2016	2,560	171	15	171		755	42
43	PARKING LOT EXTENSION	2016	54,387	3,626	15	3,626		12,086	43
44	ROOF REPLACEMENT	2017	257,439	17,163	15	17,163		54,348	44
45	WINDOW REPLACEMENT	2017	144,487	7,224	20	7,224		18,061	45
46	HVAC MODIFICATION	2018	43,947	2,930	15	2,930		7,324	46
47	NEW CIRCUITS INSTALLED FOR GENERATOR	2018	2,525	126	20	126		347	47
48	LIGHTING	2018	31,175	2,078	15	2,078		3,118	48
49	FLOORING	2019	59,641	3,976	15	3,976		4,639	49
50	CLAYBERG REMODEL/ADDITION (ALZHEIMERS UNIT)	2019	644,909	32,245	15	32,245		40,307	50
51	WALK-IN FREEZER	2020	27,242		15				51
52	ROOF REPLACEMENT	2020	35,339	196	15	196		196	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,086,408	$ 89,355		$ 89,355	$	$ 755,831	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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	$ 167,484	$ 19,108	$ 19,108	$	3 to 20	$ 101,721	71
72	Current Year Purchases					5 to 10		72
73	Fully Depreciated Assets	241,916				3 to 20	241,916	73
74								74
75	TOTALS	$ 409,400	$ 19,108	$ 19,108	$		$ 343,637	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2000 Chevrolet Bus	2000	$ 42,641	$	$	$	5	$ 42,641	76
77	Patient Transportation	2019 Ford Transit Wagon	2019	46,205	9,241	9,241		5	13,862	77
78	Pickup, delivery, & plowing	2020 Ford truck	2020	38,780				5		78
79										79
80	TOTALS			$ 127,626	$ 9,241	$ 9,241	$		$ 56,503	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)	$ 2,628,434	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 117,704	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 117,704	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)	$ 1,155,971	85	

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 26,934 Description: See attachment, page 23
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$	1,048	$ 85,070	$	1,048	$ 85,070	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		150	28,125		150	28,125	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		1,162	76,922		1,162	76,922	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts		4,894	4,204		4,894	4,204	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): STOCK DRUGS	39-2					7,906		7,906	12
13	Other (specify): RADIOLOGY	39-3				2,035			2,035	13
14	TOTAL			$	7,254	$ 196,356	$ 7,906	7,254	$ 204,262	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,027,125	$	1
2	Cash-Patient Deposits	8,494		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 146,464)	707,976		3
4	Supply Inventory (priced at COST)	4,267		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): PROPERTY TAXES	540,750		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,288,612	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	2,086,408		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	537,026		16
17	Accumulated Depreciation (book methods)	(1,155,971)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,472,463	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,761,075	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 17,568	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,494		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,961		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	138,636		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED PROPERTY TAXES	540,750		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 741,409	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	870,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 870,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,611,409	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,149,666	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,761,075	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,262,741	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,262,741	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	427,915	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 427,915	17
	B. Transfers (Itemize):		
18	**Transfer in from County IMRF Fund**	183,416	18
19	**Transfer in from County FICA Fund**	158,683	19
20	**Transfer in from County Insurance Fund**	116,911	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 459,010	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,149,666	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,608,126	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,608,126	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	342,529	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	13,393	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)**	$ 355,922	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Property Taxes**	514,165	28
28a	**Miscellaneous Income**	40,319	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 554,484	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,518,532	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	819,791	31
32	Health Care	1,475,239	32
33	General Administration	1,180,739	33
	B. Capital Expense		
34	Ownership	173,057	34
	C. Ancillary Expense		
35	Special Cost Centers	336,448	35
36	Provider Participation Fee	105,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,090,617	40
41	**Income before Income Taxes (line 30 minus line 40)****	427,915	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 427,915	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,639,967	44
45	Private Pay - Net Inpatient Revenue	274,364	45
46	Medicare - Net Inpatient Revenue	693,795	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,608,126	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,142	$ 72,154	$ 33.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,276	9,526	273,290	28.69	3
4	Licensed Practical Nurses	10,183	11,505	286,064	24.86	4
5	CNAs & Orderlies	29,930	34,148	511,590	14.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,586	7,825	129,053	16.49	8
9	Activity Director	1,573	1,995	38,053	19.07	9
10	Activity Assistants	4,831	5,488	71,284	12.99	10
11	Social Service Workers	1,858	2,193	48,486	22.11	11
12	Dietician					12
13	Food Service Supervisor	1,725	1,597	43,870	27.47	13
14	Head Cook	8,845	10,449	141,792	13.57	14
15	Cook Helpers/Assistants	5,546	6,472	76,295	11.79	15
16	Dishwashers					16
17	Maintenance Workers	2,628	3,074	63,504	20.66	17
18	Housekeepers	12,503	14,442	180,552	12.50	18
19	Laundry					19
20	Administrator	2,080	2,007	77,451	38.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,107	71,829	34.09	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coordin	2,037	2,410	63,080	26.17	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,761	117,380	$ 2,148,347 *	$ 18.30	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 3,306	1-3	35
36	Medical Director		125	9-3	36
37	Medical Records Consultant		2,849	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,204	39-3	39
40	Physical Therapy Consultant	1,162	76,922	39-3	40
41	Occupational Therapy Consultant	1,048	85,070	39-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	150	28,125	39-3	43
44	Activity Consultant	40	3,992	11-3	44
45	Social Service Consultant				45
46	Other(specify) Radiology		2,035	43-3	46
47	Lab		1,906	43-3	47
48					48
49	TOTAL (lines 35 - 48)	2,496	$ 208,534		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tammie Denning	Administrator	0	$ 77,451
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,451

B. Administrative - Other

Description	Amount
Health Committee of County Board Expense	$ 1,588
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,588
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Chaney Technology	IT Support	$ 7,725
Templin Healthcare Accting	Accounting Consulting	2,945
Miller, Hall & Trigg	Legal services	1,494
Health Dimensions Revenue Prof	Contracted Health Director	26,800
Hesse Martone PC	Legal services	7,342
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 46,306

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,141
Unemployment Compensation Insurance	
FICA Taxes	158,683
Employee Health Insurance	405,340
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	183,416
Employee Physicals	2,280
Drug Testing	301
TOTAL (agree to Schedule V, line 22, col.8)	$ 810,161

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	918
Health Care Worker Background Check	
(Indicate # of checks performed 29)	
Patient Background Checks	500
Non allowable advertising	13,948
Dues and Subscriptions	5,264
Bonding	100
Less: Public Relations Expense	( )
Non-allowable advertising	(13,948)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,762

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Contracted Health Director Accomodations	4,029
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,029

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2019 Ending: 11/30/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,018**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,877** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **105,343**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **13,393**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Gray Hunter Stenn LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Page 3, line 27	IPRF Safety & ED Grant Expense	$	1,851
	COVID-19 Expense		57,411
	Fines and Penalties		2,000
		$	61,262
Page 4, line 43	Laboratory	$	1,906
	Radiology		2,035
		$	3,941
Page 14, line 16	Dishwasher $74/month	$	814
	1 Copier $418/month April 2020-Nov 2020		4,991
	Therapy Equipment $1,761/month		21,129
		$	26,934
Page 19, line 28	Property Taxes	$	514,165
Page 19, line 28A	Misc. Reimbursements	$	366
	Insurance Proceeds for Totaled Facility Truck		3,813
	Solar Revenue		36,140
		$	40,319

Page 21, part XIX, C., description of legal fees

Miller, Hall & Trigg	Solar Contract Negotiations	$	1,494
Hesse Martone	Union Contract Negotiations		7,155
Hesse Martone	Employment Issue		188