

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0033035</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>CLEARBROOK WEST</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2010</u> to <u>6/30/11</u> 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.	
Address: <u>3980 FAIRFAX</u> <u>ROLLING MEADOWS</u> <u>60008</u>			
Number City Zip Code			
County: <u>COOK</u>			
Telephone Number: <u>847-870-7711</u> Fax # <u>847-870-9926</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>1/31/89</u>			
Type of Ownership:			
☒ VOLUNTARY,NON-PROFIT			
☒ Charitable Corp.			
☐ Trust			
IRS Exemption Code <u>501 C 3</u>			
☐ PROPRIETARY			
☐ Individual			
☐ Partnership			
☐ Corporation			
☐ "Sub-S" Corp.			
☐ Limited Liability Co.			
☐ Trust			
☐ Other _____			
☐ GOVERNMENTAL			
☐ State			
☐ County			
☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>JOAN KEARNEY</u>			
Telephone Number: <u>847-385-5065</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ <u>9/28/2011</u> (Date)	
		(Type or Print Name) <u>CARL M LAMELL</u>	
		(Title) <u>PRESIDENT</u>	
		Paid Preparer	
		(Signed) _____ (Date)	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) <u>()</u> Fax # <u>()</u>	
		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	

Facility Name & ID Number CLEARBROOK WEST

0033035 Report Period Beginning: 7/1/2010 Ending: 6/30/11

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		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					11
12	SC					12
13	DD 16 OR LESS	5,784			5,784	13
14	TOTALS	5,784			5,784	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.04%

D. How many bed-hold days during this year were paid by the Department? ALL (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ S

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒ S

I. On what date did you start providing long term care at this location? Date started 1/1/89

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date 1/1/89 NO ☐

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 7/1/2010 Fiscal Year: 6/30/11

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

Facility Name & ID Number		CLEARBROOK WEST				STATE OF ILLINOIS		# 0033035		Report Period Beginning:		7/1/2010		Ending:		Page 3 6/30/11	
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	2	3	4	5	6	7	8	9	10						
1	Dietary	28,504			28,504		28,504		28,504			1					
2	Food Purchase		32,751		32,751		32,751		32,751			2					
3	Housekeeping		6,707		6,707		6,707		6,707			3					
4	Laundry											4					
5	Heat and Other Utilities			19,400	19,400		19,400		19,400			5					
6	Maintenance	19,607	9,998	43,225	72,830		72,830		72,830			6					
7	Other (specify):*											7					
8	TOTAL General Services	48,111	49,456	62,625	160,192		160,192		160,192			8					
	B. Health Care and Programs																
9	Medical Director											9					
10	Nursing and Medical Records	440,000	7,317		447,317		447,317		447,317			10					
10a	Therapy		4,149	1,278	5,427		5,427		5,427			10a					
11	Activities											11					
12	Social Services											12					
13	CNA Training											13					
14	Program Transportation											14					
15	Other (specify):*			146,756	146,756		146,756		146,756			15					
16	TOTAL Health Care and Programs	440,000	11,466	148,034	599,500		599,500		599,500			16					
	C. General Administration																
17	Administrative	27,290			27,290		27,290		27,290			17					
18	Directors Fees											18					
19	Professional Services											19					
20	Dues, Fees, Subscriptions & Promotions			170	170		170		170			20					
21	Clerical & General Office Expenses		381		381		381		381			21					
22	Employee Benefits & Payroll Taxes			122,177	122,177		122,177		122,177			22					
23	Inservice Training & Education											23					
24	Travel and Seminar			228	228		228		228			24					
25	Other Admin. Staff Transportation											25					
26	Insurance-Prop.Liab.Malpractice			18,597	18,597		18,597		18,597			26					
27	Other (specify):*			45,677	45,677		45,677		45,677			27					
28	TOTAL General Administration	27,290	381	186,849	214,520		214,520		214,520			28					
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	515,401	61,303	397,508	974,212		974,212		974,212			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			29,733	29,733		29,733		29,733			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,706	37,706		37,706		37,706			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			67,439	67,439		67,439		67,439			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			41,319	41,319		41,319		41,319			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			41,319	41,319		41,319		41,319			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	515,401	61,303	506,266	1,082,970		1,082,970		1,082,970			45

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

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				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 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	(sum of SUBTOTALS 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 Yes	2 No	3 Amount	4 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

Report Period Beginning:

Ending:

ID#0033035

7/1/2010

6/30/11

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

Summary A

6/30/11

[illegible]

Summary B

6/30/11

[illegible]

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
NONE		CLEARBROOK COMMONS	ROLLING MEADOWS	CLEARBROOK	ARLINGTON HTS	NON PROFIT
NONE		CLEARBROOK EAST	ROLLING MEADOWS	CRH, INC	ROLLING MEADOWS	HUD
NONE		CLEARBROOK WRIGHT	GURNEE	AUGUSTANA	ROLLING MEADOWS	HUD

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number CLEARBROOK WEST # 0033035 Report Period Beginning: 7/1/2010 Ending: 6/30/11

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	MAINTENANCE	salaries	18,302,468		\$ 262,560	\$	515,401	\$ 7,394	1
2	17	ADMIN SALARIES	salaries	18,302,468		1,266,237	1,266,237	515,401	35,657	2
3	19	PROFESSIONAL SVCS	salaries	18,302,468		170,387		515,401	4,798	3
4	20	DUES, FEES & SUBSCRIPTION	salaries	18,302,468		26,641		515,401	750	4
5	21	CLERICAL AND GEN OFFICE	salaries	18,302,468		290,209		515,401	8,172	5
6	22	EMP BENEFITS & PR TAXES	salaries	18,302,468		253,905		515,401	7,150	6
7	23	IN SVC TRAINING	salaries	18,302,468		27,439		515,401	773	7
8	25	OTHER ADMIN & TRANS	salaries	18,302,468		30,690		515,401	864	8
9	26	INSURANCE	salaries	18,302,468		19,666		515,401	554	9
10	32	INTEREST	salaries	18,302,468		23,220		515,401	654	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,370,954	\$ 1,266,237		\$ 66,766	25

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	HUD		X	CONSTRUCT BUILDING	\$3,839.00	1/1/89	\$ 497,600	\$ 414,366	11/1/28	9.0000	\$ 41,319	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$3,839.00		\$ 497,600	\$ 414,366			\$ 41,319	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 497,600	\$ 414,366			\$ 41,319	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,319 Line # 32

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:	2006		8		
	2007		9		
	2008		10		
	2009		11		
	2010		12		

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,216

B. General Construction Type: Exterior ALUMINUM Frame _____ Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>LAND</u>	<u>40,704</u>	<u>1986</u>	<u>\$ 87,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	40,704		\$ 87,000	3

Facility Name & ID Number CLEARBROOK WEST

0033035

Report Period Beginning:

7/1/2010

Ending:

6/30/11

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	16		1989	1989	\$ 495,998	\$ 13,302	40	\$ 13,302	\$	\$ 298,821	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System			1989	7,797	211	37	211		4,531	9
10	Sprinkler System			1990	1,729	47	37	47		1,005	10
11	Protective Wall Covering			1993	2,480	71	35	71		1,311	11
12	Garage Addition			1994	5,740	161	34	161		2,955	12
13	Bathroom Remodeling			1998	7,726		10			7,726	13
14	Carpet installation			2000	4,876		10			4,876	14
15	Installation of new roof			2000	9,240	616	15	616		7,084	15
16	Kitchen Remodeling			2000	10,717	429	25	429		4,929	16
17	Bathroom Improvements			2000	9,043	624	15	624		7,484	17
18	Bathroom Improvements			2000	2,319	155	15	155		1,777	18
19	Ceramic Tile installation, cement and grout			2003	845		5			845	19
20	Ceramic Tile installation, cement and grout			2003	4,500		5			4,500	20
21	Carpet installation			2003	2,917		3			2,917	21
22	Ceramic Tile installation, cement and grout			2004	4,724		5			4,724	22
23	Air Conditioning			2006	1,822		3			1,822	23
24	Seal Coat Driveway			2007	2,675	445	3	445		2,140	24
25	Ceramic Tile installation, cement and grout			2007	1,822	364	5	364		1,092	25
26	Rim Panic Devices for Exit door			2008	831		3			831	26
27	2 Horcher PC-2 Heavy Duty portable ceiling munted lifts w/hand controls			2009	17,025	1,419	10	1,419		3,137	27
28	Panacea 7200 Bed with safety lock, end panels and side rails			2010	1,770	206	5	206		567	28
29	Installation of CCTV System and cable for system			2010	8,835	295	10	295		1,178	29
30	Replace corroded piping in fire protection system			2009	2,200	672	3	672		1,406	30
31	Piped 3 new sprinkler heads inot Fire protection system			2009	6,065	910	5	910		2,147	31
32	Install 15 Window panels in dining room			2010	1,492	497	1	497		1,178	32
33	Handpunch Terminal			2002	3,430	355	10	355		2,927	33
34	Bulit in Refridgerator			2006	6,659	676	10	676		3,617	34
35	Sofa & Loveseat			2008	1,700	340	5	340		1,020	35
36	Steel Raised Panel Door, track, springs & Hdwr. Liftmaster w/cha			2010	1,316	658	2	658		658	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number CLEARBROOK WEST

0033035

Report Period Beginning:

7/1/2010

Ending:

6/30/11

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

1	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 Fire Alarm system	2010	\$ 8,400	\$ 560	15	\$ 560	\$	\$ 513	37
38 Installation of Fire Alarm system	2010	8,400	840	10	840		630	38
39 Replace Drum Drip & Pressure Switch	2010	2,150	717	3	717		418	39
40 Fluorescent recessed can lights for Hallways, Dining and family ro	2011	5,900	590	10	590		49	40
41 Drywall & Tape, Metal Framing, Paint, Vinyl Base, Doors, Electri	2011	5,892	589	10	589		49	41
42 Ceramice Tile, Cement, Grout and installation	2011	2,417	806	3	806		67	42
43 Ceramice Tile, Cement, Grout and installation	2011	1,822	607	3	607		51	43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								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)		\$ 663,274	\$ 27,162		\$ 27,162	\$	\$ 380,981	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$750,274	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$27,162	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$27,162	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)	\$380,981	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	_____/2012	\$ _____
13.	_____/2013	\$ _____
14.	_____/2014	\$ _____

* 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.

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
☐ 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.

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 2,679,196	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,250)		4,538,169	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		230,361	6
7	Other Prepaid Expenses		241,157	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 7,688,883	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,962,440	13
14	Buildings, at Historical Cost		20,815,149	14
15	Leasehold Improvements, at Historical Cost		210,425	15
16	Equipment, at Historical Cost		1,564,068	16
17	Accumulated Depreciation (book methods)		(8,904,923)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		5,919	22
23	Other(specify):		(319,888)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 17,333,190	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 25,022,073	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 1,011,245	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		224,441	28
29	Short-Term Notes Payable		370,621	29
30	Accrued Salaries Payable		1,795,023	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,801	32
33	Accrued Interest Payable		13,622	33
34	Deferred Compensation		145,564	34
35	Federal and State Income Taxes		58,816	35
	Other Current Liabilities(specify):			
36	due to temp restricted		836,796	36
37	deferred revenue		587,661	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 5,067,590	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,564,993	40
41	Bonds Payable		4,970,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	due to HUD		163,153	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,698,146	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 13,765,736	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,256,337	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,256,337	\$ 13,765,736	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,915,124	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,915,124	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(75,403)	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) net of Clearbrook West	416,616	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 341,213	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)	\$ 11,256,337	24 *

* This must agree with page 17, line 47.

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 781,328	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 781,328	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	72,372	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)	\$ 72,372	23
	D. Non-Operating Revenue		
24	Contributions	6,809	24
25	Interest and Other Investment Income***	132	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,941	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 860,641	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	160,192	31
32	Health Care	452,744	32
33	General Administration	214,350	33
	B. Capital Expense		
34	Ownership	67,439	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	41,319	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 936,044	40
41	Income before Income Taxes (line 30 minus line 40)**	(75,403)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (75,403)	43

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

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

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

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

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		1,510	32,292	21.39	3
4	Licensed Practical Nurses					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		3,115	28,504	9.15	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers		1,400	19,607	14.01	17
18	Housekeepers					18
19	Laundry					19
20	Administrator		1,040	24,220	23.29	20
21	Assistant Administrator					21
22	Other Administrative		1,820	23,174	12.73	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		1,820	26,173	14.38	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)		39,270	359,069	9.14	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) medical director		50	2,362	47.24	33
34	TOTAL (lines 1 - 33)		50,025	\$ 515,401 *	\$ 10.30	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	120	24,000	15	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	41	3,079	15	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	350	26,949	15	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psych	95	13,815	15	46
47	Neurological	55	9,720	15	47
48					48
49	TOTAL (lines 35 - 48)	661	\$ 77,563		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberCLEARBROOK WEST# 0033035Report Period Beginning: 7/1/2010Ending: 6/30/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jean Adaskevich	admin		\$ 23,595
Stacey Bellomo	other admin		3,695
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 27,290

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		\$
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 12,289
Unemployment Compensation Insurance	3,681
FICA Taxes	38,061
Employee Health Insurance	56,650
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	11,496
TOTAL (agree to Schedule V, line 22, col.8)	

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	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	228
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 228

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

yes
- (2)

Are there any dues to nursing home associations included on the cost report?

no

If YES, give association name and amount.
- (3)

Did the nursing home make political contributions or payments to a political action organization?

no

If YES, have these costs been properly adjusted out of the cost report?
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

yes

What was the average life used for new equipment added during this period?

5 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 735

Line 20
- (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.

\$ 41,319

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

no

If YES, attach an explanation of the allocation.
- (13)

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

yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

no

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ na

Has any meal income been offset against related costs?

Indicate the amount. \$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

no

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

98

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

na

g. Does the facility transport residents to and from day training?

yes

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ none
- (17)

Has an audit been performed by an independent certified public accounting firm?

Firm Name:

blackman kallick llc
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

na

Attach invoices and a summary of services for all architect and appraisal fees.