

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0014290

Facility Name: The Clayberg

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

County: Fulton

Telephone Number: (309) 785-5012 Fax #: (309) 785-5376

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

X

GOVERNMENTAL

State

X

County

Other

In the event there are further questions about this report, please contact:

Name: Diana 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 12/1/2024 to 11/30/2024 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)

(Type or Print Name) Tammie Denning

(Title) Administrator

(Signed)

(Date)

Paid Preparer

(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 # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/2024 Ending: 11/30/2024

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	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>17,885</u>	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	<u>49</u>	TOTALS	<u>49</u>	<u>17,885</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						325		325	8
9	SNF/PED									9
10	ICF	6,399	4,006	3,435		2,399			16,239	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,399	4,006	3,435		2,399	325		16,564	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.61%

SEE ACCOUNTANTS' PREPARATION REPORT

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, Outpatient Therapy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 7/6/1969

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 49

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 11/30/2025 Fiscal Year: 11/30/2025

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

STATE OF ILLINOIS

Facility Name & ID NumberThe Clayberg#0014290Report Period Beginning:12/1/2024Ending:11/30/2024

Page 3

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	411,983	12,788	4,742	429,513		429,513		429,513			1
2	Food Purchase		245,154		245,154		245,154	(214,021)	31,133			2
3	Housekeeping	239,654	19,134		258,788		258,788		258,788			3
4	Laundry		12,591		12,591		12,591		12,591			4
5	Heat and Other Utilities			75,620	75,620		75,620	(7,111)	68,509			5
6	Maintenance	92,605	1,252	165,274	259,131		259,131		259,131			6
7	Other (specify):*											7
8	TOTAL General Services	744,242	290,919	245,636	1,280,797		1,280,797	(221,132)	1,059,665			8
	B. Health Care and Programs											
9	Medical Director			500	500		500		500			9
10	Nursing and Medical Records	1,962,495	87,611	266,256	2,316,362		2,316,362		2,316,362			10
10a	Therapy											10a
11	Activities	139,286	4,524	2,475	146,285		146,285		146,285			11
12	Social Services	56,785			56,785		56,785		56,785			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,158,566	92,135	269,231	2,519,932		2,519,932		2,519,932			16
	C. General Administration											
17	Administrative	101,480		1,484	102,964		102,964		102,964			17
18	Directors Fees											18
19	Professional Services			28,820	28,820		28,820		28,820			19
20	Dues, Fees, Subscriptions & Promotions			14,894	14,894		14,894	(4,380)	10,514			20
21	Clerical & General Office Expenses	73,125	4,759	27,285	105,169		105,169	(817)	104,352			21
22	Employee Benefits & Payroll Taxes			934,864	934,864		934,864		934,864			22
23	Inservice Training & Education			4,031	4,031		4,031		4,031			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			140	140		140		140			25
26	Insurance-Prop.Liab.Malpractice			114,000	114,000		114,000		114,000			26
27	Other (specify):*											27
28	TOTAL General Administration	174,605	4,759	1,125,518	1,304,882		1,304,882	(5,197)	1,299,685			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,077,413	387,813	1,640,385	5,105,611		5,105,611	(226,329)	4,879,282			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.

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			142,107	142,107		142,107		142,107			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,480	11,480		11,480		11,480			35
36	Other (specify):*											36
37	TOTAL Ownership			153,587	153,587		153,587		153,587			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,017	2,017		2,017		2,017			38
39	Ancillary Service Centers	121,357	22,108	184,174	327,639		327,639		327,639			39
40	Barber and Beauty Shops		134		134		134		134			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,091	77,091		77,091		77,091			42
43	Other (specify):* Lab and radiology			2,097	2,097		2,097		2,097			43
44	TOTAL Special Cost Centers	121,357	22,242	265,379	408,978		408,978		408,978			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,198,770	410,055	2,059,351	5,668,176		5,668,176	(226,329)	5,441,847			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

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	(214,021)			4
5	Telephone, TV & Radio in Resident Rooms	(7,111)			5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(817)			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	(4,380)			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)	\$ (226,329)		\$	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))	\$ (226,329)		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

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					
See Fulton County board member detail on "Ownership-1" tab						

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	22	IMRF	\$ 150,149	Fulton County	100.00%	\$ 150,149	\$	1
2	V	22	FICA	242,485	Fulton County	100.00%	242,485		2
3	V	22	Workers' Comp Insurance	50,000	Fulton County	100.00%	50,000		3
4	V	26	Property & Liability Insurance	50,000	Fulton County	100.00%	50,000		4
5	V	21	Administrative Costs	21,630	Fulton County	100.00%	21,630		5
6	V	19	Audit Fees	7,000	Fulton County	100.00%	7,000		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 521,264			\$ 521,264	\$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 1/30/2024

Fax Number**SEE ACCOUNTANTS' PREPARATION REPORT**

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	FIRST MIDSTATE INC.		X	CAPITAL IMPROVEMENTS	\$3,750.00	11/30/26	\$ 1,000,000	\$ 655,000	12/1/2036	4.5000	\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$3,750.00		\$ 1,000,000	\$ 655,000			\$	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	\$ 655,000			\$	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.)

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

SEE ACCOUNTANTS' PREPARATION REPORT

SEE ACCOUNTANTS' PREPARATION REPORT

2024 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 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' PREPARATION REPORT

SEE ACCOUNTANTS' PREPARATION REPORT

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	FIRE WALL PROTECTION BARRIERS	2016	\$ 10,000	\$ 400	15	\$ 400	\$	\$ 3,900	37
38	UNIVERSAL GAS WATER HEATER	2016	6,228	415	15	415		4,048	38
39	SILENT KNIGHT 10 ZONE ALARM	2016	2,560	171	15	171		1,610	39
40	PARKING LOT EXTENSION	2017	54,387	3,626	15	3,626		30,215	40
41	ROOF REPLACEMENT	2017	257,439	17,163	15	17,163		140,161	41
42	WINDOW REPLACEMENT	2018	144,487	7,224	20	7,224		54,182	42
43	HVAC MODIFICATION	2018	43,947	2,930	15	2,930		21,973	43
44	NEW CIRCUITS INSTALLED FOR GENERATOR	2018	2,525	126	20	126		978	44
45	Lighting	2019	31,175	2,078	15	2,078		13,509	45
46	Flooring	2019	59,641	3,976	15	3,976		24,519	46
47	Clayberg Remodel/Addition (Therapy Gym)	2019	644,909	32,245	15	32,245		201,534	47
48	Walkin Freezer	2020	27,242	1,816	15	1,816		9,080	48
49	Roof Replacement	2020	35,339	2,356	15	2,356		11,976	49
50	Kitchen Flooring	2022	21,656	2,166	10	2,166		6,858	50
51	100 Gallon Water Heater	2022	9,050	905	10	905		2,790	51
52	Steel Fire Rated Door	2024	3,896	260	15	260		390	52
53	100 Gallon Water Heater	2024	9,650	965	10	965		1,448	53
54	Venilation and Shower Rooms Renovation	2025	685,378	19,990	20	19,990		19,990	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)		\$ 2,812,073	\$ 105,905		\$ 105,905	\$	\$ 1,213,734	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 174,044	\$ 20,372	\$ 20,372	\$	3 to 20	\$ 104,556	71
72	Current Year Purchases	73,316	1,222	1,222		5 to 10	1,222	72
73	Fully Depreciated Assets	214,552				3 to 20	214,552	73
74								74
75	TOTALS	\$ 461,912	\$ 21,594	\$ 21,594	\$		\$ 320,330	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				5	46,205	77
78	Pickup, delivery, & plowing	2020 Ford Truck	2020	38,780	7,756	7,756		5	38,780	78
79	Patient Transportation	2019 Ford Starcraft	2025	82,223	6,852	6,852		5	6,852	79
80	TOTALS			\$ 209,849	\$ 14,608	\$ 14,608	\$		\$ 134,478	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)	\$ 3,488,834	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 142,107	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 142,107	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)	\$ 1,668,542	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: \$ 11,480 Description: See 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.

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
		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)	\$			

- (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.

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	

- (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.)

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	39-3	hrs	\$	1,027	\$ 78,993	\$	1,027	\$ 78,993	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		61	4,265		61	4,265	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		2,234	96,926		2,234	96,926	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		5,373	3,990		5,373	3,990	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Stock Drugs</u>	39-2					22,108		22,108	12
13	Other (specify): <u>Radiology</u>	39-3				1,071			1,071	13
14	TOTAL			\$	8,695	\$ 185,245	\$ 22,108	8,695	\$ 207,353	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

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,408,858	\$	1
2	Cash-Patient Deposits	9,151		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,932)	348,821		3
4	Supply Inventory (priced at Cost)	14,804		4
5	Short-Term Investments	964,378		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Property Taxes Receivable	580,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,326,012	\$	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	2,812,073		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	671,761		16
17	Accumulated Depreciation (book methods)	(1,668,542)		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)	\$ 1,820,292	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,146,304	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 78,531	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,683		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,128		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	192,470		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Property Taxes	580,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 963,812	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	655,000		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)	\$ 655,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,618,812	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,527,492	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,146,304	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,545,984	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,545,984	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	481,874	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)	\$ 481,874	17
	B. Transfers (Itemize):		
18	Transfer in from County IMRF Fund	150,149	18
19	Transfer in from County FICA Fund	242,485	19
20	Transfer in from County Insurance Fund	100,000	20
21	Transfer in from Audit Fees	7,000	21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 499,634	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,527,492	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/2024

Ending: 11/30/2024

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,185,431	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,185,431	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	33,988	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	214,021	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)	\$ 248,009	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	131,148	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 131,148	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	3,500	27
28	Property Tax Revenue	581,145	28
28a	Miscellaneous Income	817	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 585,462	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,150,050	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,280,797	31
32	Health Care	2,519,932	32
33	General Administration	1,304,882	33
	B. Capital Expense		
34	Ownership	153,587	34
	C. Ancillary Expense		
35	Special Cost Centers	331,887	35
36	Provider Participation Fee	77,091	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,668,176	40
41	Income before Income Taxes (line 30 minus line 40)**	481,874	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 481,874	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,836,121.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer	2,345,361.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	658,305.00	48
49	Medicare Part A	248,335.00	49
50	Other-(specify) Managed Medicare	97,309.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,185,431	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,714	2,080	\$ 92,044	\$ 44.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,223	9,271	397,921	42.92	3
4	Licensed Practical Nurses	8,202	9,749	352,488	36.16	4
5	CNAs & Orderlies	31,418	35,422	1,031,544	29.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,048	3,987	121,357	30.44	8
9	Activity Director	1,726	2,084	50,307	24.14	9
10	Activity Assistants	3,781	4,413	88,979	20.16	10
11	Social Service Workers	1,816	2,052	56,785	27.67	11
12	Dietician					12
13	Food Service Supervisor	2,347	2,540	66,898	26.34	13
14	Head Cook	7,447	8,614	158,772	18.43	14
15	Cook Helpers/Assistants	7,842	8,698	186,313	21.42	15
16	Dishwashers					16
17	Maintenance Workers	3,359	3,908	92,605	23.70	17
18	Housekeepers	12,212	13,901	239,654	17.24	18
19	Laundry					19
20	Administrator	1,776	2,080	101,480	48.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,680	2,080	73,125	35.16	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: Care Plan Coordinator	1,815	2,111	88,498	41.92	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,406	112,990	\$ 3,198,770 *	\$ 28.31	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	96	\$ 4,742	1-3	35
36	Medical Director	4	500	9-3	36
37	Medical Records Consultant	26	2,458	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	3,990	39-3	39
40	Physical Therapy Consultant	2,234	96,926	39-3	40
41	Occupational Therapy Consultant	1,027	78,993	39-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	61	4,265	39-3	43
44	Activity Consultant				44
45	Social Service Consultant	48	2,475	11-3	45
46	Other(specify) Radiology		1,071	43-3	46
47	Lab		1,026	43-3	47
48					48
49	TOTAL (lines 35 - 48)	3,594	\$ 196,446		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,412	\$ 177,156	10-3	50
51	Licensed Practical Nurses	235	14,903	10-3	51
52	Certified Nurse Assistants/Aides	643	24,371	10-3	52
53	TOTAL (lines 50 - 52)	3,290	\$ 216,430		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

4,439

4,439

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)

Total

(4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)

4,439

4,439

Total

(5)

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

\$ 21,337 Line 10

(6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$ 77,091

This amount is to be recorded on line 42 of Schedule V.

(8)

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.
- (9)

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

(10)

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.

(11)

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

\$ Has any meal income been offset against
related costs?

Yes

Indicate the amount. \$ 16,867

(12)

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

(13)

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

Firm Name: Gray Hunter Stenn LLP

Yes

(14)

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

Yes

(15)

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 4, line 43	Laboratory	\$	1,026
	Radiology		<u>1,071</u>
		\$	2,097

Page 14, line 16	Dishwasher \$83 for 12 months	\$	996
	1 Copier \$518 for 11 months and \$814 for 1 month		6,512
	Therapy Equipment \$331.50 for 11 months and \$325 for 1 month		<u>3,972</u>
		\$	11,480

Page 19, line 28	Property Taxes	\$	581,145
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Page 19, line 28A	Misc. Reimbursements	\$	817
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Page 21, part XIX, C., description of legal fees

Firm Name	Invoice Date	Description of Services	Non-Allowable Amount	Allowable Amount
The Stewart Law Firm	12/16/2024	Employment-related legal services (employee relations & personnel matters)	\$ -	\$ 69
The Stewart Law Firm	1/17/2025	Employment-related legal services (employee relations & personnel matters)	-	2,062
Davis and Campbell LLC	2/18/2025	Employment-related legal services (employee relations & personnel matters)	-	525
Davis and Campbell LLC	3/17/2025	Employment-related legal services (employee relations & personnel matters)	-	2,455
Davis and Campbell LLC	4/15/2025	Employment-related legal services (employee relations & personnel matters)	-	203
Davis and Campbell LLC	5/16/2025	Employment-related legal services (employee relations & personnel matters)	-	287
Davis and Campbell LLC	6/16/2025	Employment-related legal services (employee relations & personnel matters)	-	798
Davis and Campbell LLC	7/15/2025	Employment-related legal services (employee relations & personnel matters)	-	67
Davis and Campbell LLC	8/15/2025	Employment-related legal services (employee relations & personnel matters)	-	2,903
Davis and Campbell LLC	9/15/2025	Employment-related legal services (employee relations & personnel matters)	-	135
Davis and Campbell LLC	12/15/2025	Employment-related legal services (employee relations & personnel matters)	-	<u>810</u>
			\$ -	\$ 10,314