

		FOR BHF USE					

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

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: 0054148 Facility Name: Central Plaza Resid Home Address: 321 N Central Avenue Chicago 60644 County: Cook Telephone Number: (773) 626-2300 Fax #: (773) 626-7647 HFS ID Number: Date of Initial License for Current Owners: 12/1/1963 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "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: Steven N. Lavenda Telephone Number: (847) 282-6300 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 01/01/20 to 12/31/20 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) (Title) Paid Preparer (Signed) 05/05/2021 * Subject to the attached Accountants' Consulting Report (Date) (Print Name Steven N. Lavenda, CPA and Title Partner) (Firm Name Marcum, LLP & Address 9 Parkway North, Suite 200 Deerfield, IL 60015) (Telephone) (847) 282-6300 Fax # (847) 282-6301 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
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Facility Name & ID Number Central Plaza Resid Home

0054148 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 N/A

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	240	Intermediate (ICF)	240	87,840
4		Intermediate/DD		4
5		Sheltered Care (SC)		5
6		ICF/DD 16 or Less		6
7	240	TOTALS	240	87,840

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	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	66,136	457		66,593	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	66,136	457		66,593	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.81%

D. How many bed reserve days during this year were paid by the Department? 94 (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/01/1963

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Central Plaza Resid Home # 0054148 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	368,235	48,563	8,928	425,726		425,726		425,726			1
2	Food Purchase		480,976		480,976		480,976	(33)	480,943			2
3	Housekeeping	519,645	91,219		610,864		610,864		610,864			3
4	Laundry		18,995	37,015	56,010		56,010		56,010			4
5	Heat and Other Utilities			235,991	235,991		235,991	(29,088)	206,903			5
6	Maintenance			539,604	539,604		539,604	(39,179)	500,425			6
7	Other (specify):*											7
8	TOTAL General Services	887,880	639,753	821,538	2,349,171		2,349,171	(68,300)	2,280,871			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,860,766	142,036	320,432	2,323,234		2,323,234	(23,096)	2,300,138			10
10a	Therapy											10a
11	Activities	354,778	42,175	1,615	398,568		398,568		398,568			11
12	Social Services	1,430,989		44,000	1,474,989		1,474,989		1,474,989			12
13	CNA Training											13
14	Program Transportation			5,620	5,620		5,620		5,620			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,646,533	184,211	381,267	4,212,011		4,212,011	(23,096)	4,188,915			16
	C. General Administration											
17	Administrative	605,691			605,691		605,691		605,691			17
18	Directors Fees											18
19	Professional Services			127,007	127,007	(25,913)	101,094	(739)	100,355			19
20	Dues, Fees, Subscriptions & Promotions			123,026	123,026		123,026	(61,344)	61,682			20
21	Clerical & General Office Expenses	192,561	2,205	143,583	338,349		338,349	(97,875)	240,474			21
22	Employee Benefits & Payroll Taxes			842,463	842,463		842,463		842,463			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,206	3,206		3,206		3,206			24
25	Other Admin. Staff Transportation			1,872	1,872		1,872		1,872			25
26	Insurance-Prop.Liab.Malpractice			307,584	307,584		307,584	269	307,853			26
27	Other (specify):*											27
28	TOTAL General Administration	798,252	2,205	1,548,741	2,349,198	(25,913)	2,323,285	(159,689)	2,163,596			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,332,665	826,169	2,751,546	8,910,380	(25,913)	8,884,467	(251,085)	8,633,382			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			159,866	159,866		159,866	(24,553)	135,313			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,740	13,740		13,740	(13,740)				32
33	Real Estate Taxes			392,616	392,616	25,913	418,529	8,637	427,166			33
34	Rent-Facility & Grounds			30,744	30,744		30,744	(13,915)	16,829			34
35	Rent-Equipment & Vehicles			8,644	8,644		8,644		8,644			35
36	Other (specify):*											36
37	TOTAL Ownership			605,610	605,610	25,913	631,523	(43,571)	587,952			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											42
43	Other (specify):*	367,336		943,285	1,310,621		1,310,621	(1,310,621)				43
44	TOTAL Special Cost Centers	367,336		943,285	1,310,621		1,310,621	(1,310,621)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,700,001	826,169	4,300,441	10,826,611		10,826,611	(1,605,277)	9,221,334			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	(30,610)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,553)	30		9
10	Interest and Other Investment Income	(14,194)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	02		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	(47)	21		19
20	Contributions	(41,941)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,913)	21		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	(1,423,713)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,606,004)		\$	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)	727		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 727		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,605,277)		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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Capitalized R&M	\$ (43,608)	06	1
2	Bank Charges	(19,556)	21	2
3	Patient Clothing	(2,096)	10	3
4	Resident Stipend	(21,000)	10	4
5	Non Allowable Fees	(941,092)	43	5
6	Marketing	(2,193)	43	6
7	Non Allowable Compensation	(367,336)	43	7
8	Additional R&M	1,085	06	8
9	Misc Income	(320)	21	9
10	Non Allowable Legal Fees	(1,069)	19	10
11	PAC Dues	(19,482)	20	11
12	Meals	(7,046)	21	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	(1,423,713)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Plaza Resid Home # 0054148 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(33)											(33)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(30,610)		1,522									(29,088)	5
6	Maintenance	(42,523)		3,344									(39,179)	6
7	Other (specify):*													7
8	TOTAL General Services	(73,166)		4,866									(68,300)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(23,096)											(23,096)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(23,096)											(23,096)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(1,069)		330									(739)	19
20	Fees, Subscriptions & Promotions	(61,423)		79									(61,344)	20
21	Clerical & General Office Expenses	(97,882)		7									(97,875)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			269									269	26
27	Other (specify):*													27
28	TOTAL General Administration	(160,374)		685									(159,689)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(256,636)		5,551									(251,085)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Plaza Resid Home # 0054148 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(24,553)											(24,553)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,194)			454								(13,740)	32
33	Real Estate Taxes			8,637									8,637	33
34	Rent-Facility & Grounds			(13,915)									(13,915)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(38,747)		(5,278)	454								(43,571)	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													42
43	Other (specify):*	(1,310,621)											(1,310,621)	43
44	TOTAL Special Cost Centers	(1,310,621)											(1,310,621)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,606,004)		273	454								(1,605,277)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	NORMA JANN	17.39%	BARTON SENIOR RESIDENCES (SLF)	ZION	BARTON HEALTHCARE	NORTHFIELD	BOND ISSUE CO.	1
2	RONNIE BELL	17.02%	CLAYTON RESIDENTIAL HOME	CHICAGO	BARTON MANAGEMENT	NORTHFIELD	BOOKKEEPING	2
3	MARLA COQUILLETTE	5.55%	THORNTON HEIGHTS TERRACE, LTD.	CHICAGO HEIGHTS				3
4	STANTON ARON	5.59%	RUSH BARTON (SLF)	CHICAGO				4
5	JOHN SHLOFROCK	16.34%	SHARON HEALTH CARE ELMS, INC.	PEORIA				5
6	ELISA SHLOFROCK-ZUSMAN	16.34%	SHARON HEALTH CARE PINES, INC.	PEORIA				6
7	DAVID BECKER	4.91%	SHARON HEALTH CARE WILLOWS, INC.	PEORIA				7
8	MIRIAM BECKER	4.91%	SHARON HEALTH CARE WOODS, INC.	PEORIA				8
9	THE SONIA GETHNER TRUST	4.72%						9
10	CAROL ROSS IRREVOCABLE TRUST	7.22%						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

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
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16								16
17								17
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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)

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)	
15	V	5	Utilities	\$	Barton Management Inc.		\$ 1,522	\$ 1,522	15
16	V	6	Repairs & Maintenance		Barton Management Inc.		3,344	3,344	16
17	V	19	Professional Fees		Barton Management Inc.		330	330	17
18	V	20	Dues, Licenses, Fees		Barton Management Inc.		79	79	18
19	V	21	Clerical & General		Barton Management Inc.		7	7	19
20	V	26	Insurance		Barton Management Inc.		269	269	20
21	V	33	Real Estate Taxes		Barton Management Inc.		8,637	8,637	21
22	V	34	Rent Office Space		Barton Management Inc.		16,385	16,385	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	Rent	30,300	Barton Management Inc.			(30,300)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 30,300			\$ 30,573	\$ * 273	39

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

VII. RELATED PARTIES (continued)

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)	
15	V	32	INTEREST		BARTON HEALTHCARE LLC		14,194	\$	14,194
16	V								16
17	V								17
18	V								18
19	V	32	Interest	13,740	BARTON HEALTHCARE LLC				(13,740)
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 13,740			\$ 14,194	\$ *	454

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Central Plaza Resid Home # 0054148 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	John Shlofrock	Shareholder	Administrative	16.34	See Attached	5.00	11.90%	Salary	\$ 42,816	17-1	1
2	Arnold Kanter	Relative	Administrative	0.00	See Attached	6.50	17.33%	Salary	82,923	17-1	2
3	Stan Aron	Shareholder	Administrative	5.59	See Attached	7.00	18.92%	Salary	4,795	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 130,534		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.

Ending: 12/31/20

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

Facility Name & ID Number Central Plaza Resid Home # 0054148 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

	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

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	Barton Healthcare		X	Mortgage			\$	448,299			\$ 14,194	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	448,299			\$ 14,194	9
	B. Non-Facility Related*											
10	Interest Income		X								(14,194)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (14,194)	14
15	TOTALS (line 9+line14)						\$	448,299			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

* 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 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	416,903	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.)				\$	606,139	2
3. Under or (over) accrual (line 2 minus line 1).				\$	189,236	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	212,017	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.)				\$	25,913	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 \$ 76,530 For 2016 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.				\$	427,166	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	288,681	8		
		2016	315,530	9		
		2017	339,131	10		
		2018	379,003	11		
		2019	385,485	12		
2020 Accrual = \$385,485 x 1.10 = \$424,034 -212,017 2020 tax prepayment = \$212,017						
Payment made in 2020 for RE Tax due in 2021.						
Allocated from Barton Management \$8,637						

FOR BHF USE ONLY		
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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Plaza Resid Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054148

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 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)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 16-09-300-004-0000	Long Term Care Property	\$ 72,156.08	\$ 72,156.08
2. 16-09-300-005-0000	Long Term Care Property	\$ 306,451.70	\$ 306,451.70
3. 16-09-300-011-0000	Long Term Care Property	\$ 764.10	\$ 764.10
4. 16-08-405-020-0000	Long Term Care Property	\$ 6,113.36	\$ 6,113.36
5. 05-19-112-017-0000	Allocated from Barton Mngmnt	\$ 98,680.58	\$ 8,636.70
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 484,165.82	\$ 394,121.94

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? X 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME Central Plaza Resid Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054148

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10B

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,310

B. General Construction Type: Exterior BrickFrame

Number of Stories Wing#1-Wing#2 - 4

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

X(b) Rent equipment from a Related Organization.

X(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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building	29,048	1974	\$ 57,000	1
2	Building - Parking Lot		2001	199,168	2
3	TOTALS	29,048		\$ 256,168	3

Facility Name & ID Number Central Plaza Resid Home

0054148

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	240		1974	1972	\$ 311,666	\$	30	\$	\$	311,666	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1975	303,849		20			303,849	9
10	Various			1976	53,526		20			53,526	10
11	Various			1977	47,780		20			47,780	11
12	Various			1978	66,037		20			66,037	12
13	Various			1979	59,303		20			59,303	13
14	Various			1980	24,816		20			24,816	14
15	Various			1981	10,665		20			10,665	15
16	Various			1982	13,492		20			13,492	16
17	Various			1983	48,201		20			48,201	17
18	Various			1984	50,812		20			50,812	18
19	Various			1985	295,316		20			295,316	19
20	Various			1986	144,407		20			144,407	20
21	Various			1987	11,075		20			11,075	21
22	Various			1988	10,240		20			10,240	22
23	Various			1989	39,943		20			39,943	23
24	Various			1990	65,848		20			65,848	24
25	Various			1991	77,448		20			77,448	25
26	Various			1992	89,051		20			89,051	26
27	Various			1993	44,478		20			44,478	27
28	Various			1994	218,313		20			218,313	28
29	Various			1995	125,206		20	3,210	3,210	81,992	29
30	Various			1996	89,049		20	2,283	2,283	54,887	30
31	Various			1997	294,224		20	7,543	7,543	172,027	31
32	Various			1998	83,616		20	2,146	2,146	47,833	32
33	Various			1999	133,366		20	3,418	3,418	74,558	33
34	Various			2000	201,851		20	5,175	5,175	106,479	34
35	Various			2001	212,001		20	5,583	5,583	102,129	35
36	Various			2002	65,579		20	1,682		30,782	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 Central Plaza Resid Home

0054148

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	Various	2003	\$ 56,336	\$	20	\$ 1,444	\$ 1,444	\$ 25,284	37
38	Various	2004	469,868		20	12,048	12,048	198,447	38
39	Various	2005	308,731		20	7,914	7,914	123,611	39
40	Various	2006	183,158		20	4,698	4,698	68,324	40
41	Various	2007	169,009		20	4,334	4,334	59,480	41
42	Various	2008	109,440		20	2,807	2,807	34,219	42
43	Various	2009	25,223		20	647	647	7,504	43
44	Various	2010	262,410		20	6,728	6,728	71,790	44
45	Various	2011	53,344		20	1,409	1,409	13,230	45
46	Various	2012	97,707		20	5,562	5,562	47,173	46
47	Various	2013	38,991		20	1,950	1,950	14,685	47
48	Various	2014	95,992		20	4,059	4,059	25,424	48
49	Various	2015	17,993		20	900	900	4,793	49
50	Various	2016	39,948		20	2,642	2,642	11,811	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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			159,866			(159,866)		69
70	TOTAL (lines 4 thru 69)		\$ 5,119,308	\$ 159,866		\$ 88,181	\$ (73,367)	\$ 3,362,728	70

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

Facility Name & ID Number Central Plaza Resid Home

0054148

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,119,308	\$ 159,866		\$ 88,181	\$ (71,685)	\$ 3,362,728	1
2	Install Fire Sprinklers And Smoke Detectors - Main System	2017	18,107		20	905	905	3,621	2
3	Hoistway Switches, Car Top Selector, Closures - Main Elevator	2017	88,400		20	4,420	4,420	16,575	3
4	New Surveillance Equipment - Main Kitchen & Kitchen Alley	2017	7,378		20	369	369	1,353	4
5	Installed 3 Ao Water Heaters, 2 Pumps - Pump Room	2017	20,070		20	1,004	1,004	3,512	5
6	Install Mainline Disconnect, A/C, Circuits - Elevator Room	2017	8,585		20	429	429	1,467	6
7	Swept, Patched Potholes, Striped, Reset Stops - Parking Lot	2017	6,770		20	339	339	1,072	7
8	New Relay & Controller - North & South Elevators	2017	9,258		20	463	463	1,736	8
9	230 Volt Hoist Motor, Repaired Buttons - North Elevator	2017	4,161		20	208	208	746	9
10	Centrifugal Safety & Hitch - South Elevator	2017	2,665		20	133	133	422	10
11	230 Volt Motor & Protection - Rear Freight Elevator	2017	3,920		20	196	196	621	11
12	Camera Surveillance Equip-Install/Repair Throughout Facility	2018	3,258		20	163	163	434	12
13	Boiler #2 Repair	2018	3,703		20	185	185	540	13
14	Install New Condense & Evaporator For Walk In Cooler	2019	7,589		20	379	379	569	14
15	Install New Condenser For Freezer	2019	3,637		20	182	182	303	15
16	Chimneys And Machine Room Tuckpointing	2019	17,000		20	850	850	1,063	16
17	Return Piping Repairs For Steam System	2019	25,745		20	1,287	1,287	2,575	17
18	Flooring (Carpeting & Vinyl)	2019	85,071		20	4,254	4,254	7,798	18
19	Sewage Pump Replacement	2019	18,750		20	938	938	1,484	19
20	Cleaned Lift Station & Install Temp Pumps	2019	9,974		20	499	499	790	20
21	Install New Waterproof Roof Energy Efficient	2019	59,500		20	2,975	2,975	4,215	21
22	Install New Gutters And Downspouts	2019	10,600		20	530	530	707	22
23	Install New Hoist Cables For North Passenger Elevator	2019	4,860		20	243	243	324	23
24	Install New Door Operator, Hangers, And Rollers	2019	5,035		20	252	252	315	24
25	Replaced Existing Water Heater	2019	8,325		20	416	416	520	25
26	Piping Replacement In Southwest Section Of The Building, Cleani	2019	6,120		20	306	306	612	26
27	Replace Main Steam Trap	2019	2,604		20	130	130	130	27
28	Install Camera Surveillance System	2020	11,386		20	569	569	569	28
29	Flooring / Adhesive - Hallways, Mezanin, 2Nd Floor	2020	3,869		20	193	193	193	29
30	Flooring / Adhesive - Hallways, Mezanin, 2Nd Floor	2020	12,328		20	616	616	616	30
31	Replace Sprinkler Heads	2020	4,573		20	229	229	229	31
32	Replace Steam Pipe	2020	16,032		20	802	802	802	32
33	Repair Boiler Room Leaking Pipes	2020	2,770		20	139	139	139	33
34	TOTAL (lines 1 thru 33)		\$ 5,611,351	\$ 159,866		\$ 112,783	\$ (47,083)	\$ 3,418,778	34

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

Facility Name & ID Number Central Plaza Resid Home

0054148

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	
1 Totals from Page 12B, Carried Forward		\$ 5,611,351	\$ 159,866		\$ 112,783	\$ (47,083)	\$ 3,418,778	1
2 Cubicle Curtains	2020	7,678		20	384	384	384	2
3 Replace Compressor	2020	3,936		20	197	197	197	3
4 Replace Condensate Pump For West End Of South Bldg	2020	3,367		20	168	168	168	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 TOTAL (lines 1 thru 33)		\$ 5,626,332	\$ 159,866		\$ 113,532	\$ (46,334)	\$ 3,419,527	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,626,332	\$ 159,866		\$ 113,532	\$ (46,334)	\$ 3,419,527	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	TOTAL (lines 1 thru 33)		\$ 5,626,332	\$ 159,866		\$ 113,532	\$ (46,334)	\$ 3,419,527	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,626,332	\$ 159,866		\$ 113,532	\$ (46,334)	\$ 3,419,527	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	TOTAL (lines 1 thru 33)		\$ 5,626,332	\$ 159,866		\$ 113,532	\$ (46,334)	\$ 3,419,527	34

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

Facility Name & ID Number Central Plaza Resid Home

0054148

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$241,885	\$	\$10,772	\$10,772	10	\$192,460	71
72	Current Year Purchases	16,805		1,680	1,680	10	1,680	72
73	Fully Depreciated Assets	1,050,350				10	1,050,350	73
74								74
75	TOTALS	\$1,309,040	\$	\$12,453	\$12,453		\$1,244,490	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		Chevy Blazer 1997	2000	\$21,295	\$	\$	\$	5	\$21,295	76
77		Nissan Pathfinder 2001	2002	26,104				5	26,104	77
78		Ford Van 2003	2002	28,925				5	27,935	78
79		See Attached		46,641		9,328	9,328		9,328	79
80	TOTALS			\$122,965	\$	\$9,328	\$9,328		\$84,662	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$7,314,505	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$159,866	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$135,313	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(24,553)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,748,680	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: N/A
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	Storage				444			5
6	Allocated from Barton Management				16,385			6
7	TOTAL				\$ 16,829			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: \$ 8,644
- Description: See Attached

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

* 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)	\$			

- (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.

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	

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
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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	\$ 2,013,077	\$	1
2	Cash-Patient Deposits	18,110		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,142,505		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	258,354		6
7	Other Prepaid Expenses	46,529		7
8	Accounts Receivable (owners or related parties)	2,000		8
9	Other(specify):	19,555		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,500,130	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	311,666		14
15	Leasehold Improvements, at Historical Cost	5,477,797		15
16	Equipment, at Historical Cost	1,598,628		16
17	Accumulated Depreciation (book methods)	(5,605,363)		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)	\$ 1,782,728	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,282,858	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,355,993	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	85,663		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	448,845		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,385		31
32	Accrued Real Estate Taxes(Sch.IX-B)	212,017		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,454,278		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,569,181	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	448,299		40
41	Bonds Payable			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)	\$ 448,299	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,017,480	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,265,378	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,282,858	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,731,678	1
2	Restatements (describe):		2
3	State Replacement Tax	2,592	3
4	Other	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,734,269	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(998,891)	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	(470,000)	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)	\$ (1,468,891)	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)	\$ 1,265,378	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Central Plaza Resid Home

0054148

Report Period Beginning: 01/01/20

Ending: 12/31/20

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	\$ 11,336,393	1
2	Discounts and Allowances for all Levels	(1,966,592)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,369,801	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		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,743	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,743	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	435,176	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 435,176	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,827,720	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,349,171	31
32	Health Care	4,212,011	32
33	General Administration	2,349,198	33
	B. Capital Expense		
34	Ownership	605,610	34
	C. Ancillary Expense		
35	Special Cost Centers	1,310,621	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,826,611	40
41	Income before Income Taxes (line 30 minus line 40)**	(998,891)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (998,891)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,279,101	44
45	Private Pay - Net Inpatient Revenue	90,700	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,369,801	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** 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	3,048	3,048	\$ 184,244	\$ 60.45	1
2	Assistant Director of Nursing	1,473	1,526	60,506	39.65	2
3	Registered Nurses	15,979	2,662	73,171	27.49	3
4	Licensed Practical Nurses	17,774	18,812	570,648	30.33	4
5	CNAs & Orderlies	52,375	55,215	892,112	16.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	19,793	20,777	354,778	17.08	10
11	Social Service Workers	62,510	65,552	1,430,989	21.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,382	20,625	368,235	17.85	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	28,967	30,831	519,645	16.85	18
19	Laundry					19
20	Administrator	2,080	2,080	199,870	96.09	20
21	Assistant Administrator	1,944	2,048	89,925	43.91	21
22	Other Administrative	3,855	3,855	315,896	81.94	22
23	Office Manager					23
24	Clerical	8,024	8,272	192,561	23.28	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	4,364	4,677	80,085	17.12	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	4,483	4,483	367,336	81.94	33
34	TOTAL (lines 1 - 33)	246,051	244,463	\$ 5,700,001 *	\$ 23.32	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	186	\$ 8,928	01-03	35
36	Medical Director	181	9,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	1,615	11-03	44
45	Social Service Consultant				45
46	Other(specify) Anixter Consultant	960	38,751	10-03	46
47	Psychiatrist	416	44,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	1,879	\$ 104,694		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	4,444	279,881	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,444	\$ 279,881		53

* 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) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Alliance for Living \$31,136

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(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? N/A

(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 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A

(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. N/A

(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. N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$
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. \$ N/A Has any meal income been offset against related costs? N/A 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. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14

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? No

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? No
Firm Name: N/A

(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.