

		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: <u>0054148</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Central Plaza Resid Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>321 N Central Avenue</u> <u>Chicago</u> <u>60644</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 626-2300</u> Fax # <u>(773) 626-7647</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u>	(Telephone) <u>(630) 361-2868</u> 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												
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	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																								
Date of Initial License for Current Owners: <u>12/1/1963</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☒ "Sub-S" Corp.																								
	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Central Plaza Resid Home # 0054148 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 <u>N/A</u>					
	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	<u>206</u>	Intermediate (ICF)	<u>206</u>	<u>75,190</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>206</u>	TOTALS	<u>206</u>	<u>75,190</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									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	3,505	49,563	1,782		500			55,350	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,505	49,563	1,782		500			55,350	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 73.61%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? 415 (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 12/1/1963

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 certified beds.
number of certified beds

Medicare Intermediary N/A

IV. ACCOUNTING BASIS
ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/25 Fiscal Year: 12/31/25
* All facilities other than governmental must report on the accrual basis.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	404,528	39,483	8,933	452,944		452,944		452,944			1
2	Food Purchase		455,382		455,382		455,382	(43)	455,339			2
3	Housekeeping	499,149	60,667		559,816		559,816		559,816			3
4	Laundry		9,166	49,838	59,004		59,004		59,004			4
5	Heat and Other Utilities			266,193	266,193		266,193	1,939	268,132			5
6	Maintenance			412,943	412,943		412,943	(45,747)	367,196			6
7	Other (specify):* Waste Disposal			40,065	40,065		40,065		40,065			7
8	TOTAL General Services	903,677	564,698	777,972	2,246,347		2,246,347	(43,851)	2,202,496			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	2,172,902	61,399	139,755	2,374,056		2,374,056		2,374,056			10
10a	Therapy											10a
11	Activities	166,121	24,601		190,722		190,722		190,722			11
12	Social Services	1,063,297		24,000	1,087,297		1,087,297		1,087,297			12
13	CNA Training											13
14	Program Transportation			2,401	2,401		2,401		2,401			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,402,320	86,000	175,756	3,664,076		3,664,076		3,664,076			16
	C. General Administration											
17	Administrative	503,440			503,440		503,440		503,440			17
18	Directors Fees											18
19	Professional Services			86,960	86,960		86,960	(2,755)	84,205			19
20	Dues, Fees, Subscriptions & Promotions			57,537	57,537		57,537	(25,941)	31,596			20
21	Clerical & General Office Expenses	244,430	31,290	16,119	291,839		291,839	(29,670)	262,169			21
22	Employee Benefits & Payroll Taxes			845,050	845,050		845,050		845,050			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,759	4,759		4,759		4,759			24
25	Other Admin. Staff Transportation			5,154	5,154		5,154	(699)	4,455			25
26	Insurance-Prop.Liab.Malpractice			371,256	371,256		371,256	408	371,664			26
27	Other (specify):*											27
28	TOTAL General Administration	747,870	31,290	1,386,835	2,165,995		2,165,995	(58,657)	2,107,338			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,053,867	681,988	2,340,563	8,076,418		8,076,418	(102,508)	7,973,910			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			104,759	104,759		104,759	127,782	232,541			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,338	16,338		16,338	(16,338)				32
33	Real Estate Taxes			420,808	420,808		420,808	33,810	454,618			33
34	Rent-Facility & Grounds			33,065	33,065		33,065	(18,586)	14,479			34
35	Rent-Equipment & Vehicles			10,594	10,594		10,594		10,594			35
36	Other (specify):*											36
37	TOTAL Ownership			585,564	585,564		585,564	126,668	712,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			775	775		775		775			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* Disallowed Costs	569,115		1,325,415	1,894,530		1,894,530	(1,894,530)				43
44	TOTAL Special Cost Centers	569,115		1,326,190	1,895,305		1,895,305	(1,894,530)	775			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,622,982	681,988	4,252,317	10,557,287		10,557,287	(1,870,370)	8,686,917			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	(4,903)	43		4
5	Telephone, TV & Radio in Resident Rooms	(26,802)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	127,782	30		9
10	Interest and Other Investment Income	(17,354)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	2		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	(1,130)	43		18
19	Entertainment				19
20	Contributions	(37,947)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,211)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(96,878)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,761,917)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,868,403)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(1,967)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,967)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,870,370)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	(25,986)	20	2
3				3
4	Offset Medical Records Income	(1,420)	21	4
5	Patient Clothing	(461)	43	5
6	Resident Stipend	(16,041)	43	6
7	Disallow 50% of Admission Director as Marketing	(28,278)	21	7
8	Marketing Expense	(3,662)	43	8
9	Trust Fees	(200)	43	9
10	Capitalized R&M	(49,523)	06	10
11	Adjust RE Tax Refund	24,403	33	11
12	Non-Allowable Expense - Wages	(569,115)	43	12
13	Non-Allowable Expense - Mgmt Fees	(1,088,180)	43	13
14	Reverse PY Accrued Remainder of Appraisal Inv	(2,755)	19	14
15	Auto Expense-Marketing	(699)	25	15
16				16
17				17
18				18
19				19
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48				48
49	Total	(1,761,917)		49

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 Ownership Listing-1		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	5	Utilities	\$	Barton Management Inc.		\$ 1,939	\$ 1,939	1
2	V	6	Repairs & Maintenance		Barton Management Inc.		3,776	3,776	2
3	V	20	Dues, Licenses, Fees		Barton Management Inc.		45	45	3
4	V	21	Clerical & General		Barton Management Inc.		28	28	4
5	V	26	Insurance		Barton Management Inc.		408	408	5
6	V	33	Real Estate Taxes		Barton Management Inc.		9,407	9,407	6
7	V	34	Rent Office Space	32,400	Barton Management Inc.		13,814	(18,586)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 32,400			\$ 29,417	\$ * (2,983)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	16,126	Barton Healthcare, LLC		\$ 17,142	\$ 1,016	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			\$ 16,126			\$ 17,142	\$ * 1,016	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS					Ownership Listing-1		
Central Plaza Resid Home							
ID#					0054148		
Report Period Beginning:					1/1/2025		
Ending:					12/31/2025		
					N/A		
					Barton Management, Ir		
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Management		
-Owners of companies must be listed instead of company names.					Co./Home Office		
-Names of trust beneficiaries must be listed.							
First Name		M.I.	Last Name	Place of Residence	Operator/Licensee	Building Co.	Ownership
				City	State	Ownership Percentage	Ownership Percentage
1	Norma		Jean	Fontana	WI	17.61152	
2	Ronnie		Bell	Gainesville	FL	17.23080	
3	Marla		Coquillette	Chicago	IL	4.36230	
4	Stanton	F.	Aron	Buffalo Grove	IL	5.66220	
5	John		Shlofroek	Northfield	IL	16.54696	25.00000
6	Elisa		Shlofroek-Zusman	Deerfield	IL	16.54696	25.00000
7	David		Becker	Libertyville	IL	4.97354	
8	Miriam		Becker	Schaumburg	IL	4.97354	
9							
10	The Sonia Gethner Trust						
11	Beneficiary:						
12	Sonia		Gethner	Chicago	IL	4.78371	
13							
14	Carol Ross Irrevocable Trust						
15	Beneficiary:						
16	Carol		Ross	Northbrook	IL	7.30848	
17							
18	Gary		Weintraub	Northfield	IL		25.00000
19							
20	Richard Dean Duros Decl. of Trust						
21	Beneficiary:						
22	Richard		Duros	Vernon Hills	IL		25.00000
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VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Barton Senior Residences of Zion (SLF)	Zion			Barton Healthcare	Northfield	Bond Issue Co.	1
2	Clayton Residential Home	Chicago			Barton Management, I	Northfield	Bookkeeping	2
3	Thornton Heights Terrace, LTD.	Chicago Heights						3
4	Barton Senior Residences of Chicago (SLF)	Chicago						4
5	Sharon Health Care Elms, Inc.	Peoria						5
6	Sharon Health Care Pines, Inc.	Peoria						6
7	Sharon Health Care Willows, Inc.	Peoria						7
8	Sharon Health Care Woods, Inc.	Peoria						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Shlofrock	Shareholder	Administrative	16.55%	See Att. Sch 7A	5.00	11.90%	Salary	\$ 40,613	17-1	1
2	Stan Aron	Shareholder	Administrative	5.66%	See Att. Sch 7A	7.00	18.92%	Salary	7,524	17-1	2
3											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	\$ 48,137		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: 2/31/2025

(847) 441-0800

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Central Plaza Resid Home # 0054148 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 Barton Healthcare, LLC
Street Address 465 Central Ave.
City / State / Zip Code Northfield, IL 60093
Phone Number (847) 441-8200
Fax Number (847) 441-0800

	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	32	Interest	Note Receivable	6,187,451	7	236,441	\$	448,299	\$ 17,142	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					\$ 236,441	\$		\$ 17,142	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			\$	17,142	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	448,299			\$	17,142	9
	B. Non-Facility Related*												
10									Misc Interest Exp		212	10	
11									Offset Interest Income		(17,354)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$				\$	(17,142)	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	245,520	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.)		2024	\$	210,920	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(34,600)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	504,214	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.)			\$	25,000	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.		Allocated from Barton Management Rounding		9,407 1	
TOTAL REFUND \$ 73,807 For 2021 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(49,404)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	454,618	7
Assessed Value from Real Estate Tax Bill:	2024	1,686,453	8		
Real Estate Tax Bill for Calendar Year:	2020	415,406	9		
	2021	371,506	10		
	2022	439,557	11		
	2023	355,826	12		
	2024	406,624	13		
2025 Accrual = \$406,624 x 1.24 = \$504,214					
Line 2 above includes the 2024 taxes less the prepayment of 1st installment of 2024 tax made in December 2024 of \$195,704					

FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
15	PLUS APPEAL COST FROM LINE 5 \$	15
16	LESS REFUND FROM LINE 6 \$	16
17	AMOUNT TO USE FOR RATE CALCULATION \$	17

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.

2024 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 Anca Oviedo

TELEPHONE (847) 441-8200 FAX #: (847) 441-0800

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. 16-09-300-004-0000	Long Term Care Property	\$ 35,666.32	\$ 35,666.32
2. 16-09-300-005-0000	Long Term Care Property	\$ 358,085.21	\$ 358,085.21
3. 16-09-300-011-0000	Long Term Care Property	\$ 1,078.90	\$ 1,078.90
4. 16-08-405-020-0000	Long Term Care Property	\$ 11,793.88	\$ 11,793.88
5. 05-19-112-017-0000	Allocated from Barton Mngmnt	\$ 124,168.59	\$ 9,407.00
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 530,792.90	\$ 416,031.31

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 X 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: 90,310 B. General Construction Type: Exterior Brick Frame Number of Stories Wing #1-Wing #2-4

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. N/A
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. N/A
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.
N/A

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:

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

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	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	6,260	6,260	113,292	29
30	Various			1996	89,049		20	4,451	4,451	77,142	30
31	Various			1997	294,224		20	14,713	14,713	245,592	31
32	Various			1998	83,616		20	4,181	4,181	68,738	32
33	Various			1999	133,366		20	6,669	6,669	107,903	33
34	Various			2000	201,851		20	10,092	10,092	156,939	34
35	Various			2001	212,001		20	10,889	10,889	156,574	35
36											36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Central Plaza Resid Home

0054148

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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	2002	\$ 65,579	\$	20	\$ 3,281	\$ 3,281	\$ 47,187	37
38	Various	2003	56,336		20	2,818	2,818	39,374	38
39	Various	2004	469,868		20	23,494	23,494	315,917	39
40	Various	2005	308,731		20	15,440	15,440	200,811	40
41	Various	2006	183,158		20	9,161	9,161	114,129	41
42	Various	2007	169,009		20	8,449	8,449	101,725	42
43	Various	2008	109,440		20	5,472	5,472	61,579	43
44	Various	2009	25,223		20	1,261	1,261	13,809	44
45	Various	2010	262,410		20	13,121	13,121	137,395	45
46	Various	2011	53,344		20	2,749	2,749	25,350	46
47	Various	2012	97,707		20	4,427	4,427	70,507	47
48	Various	2013	38,991		20	1,950	1,950	24,435	48
49	Various	2014	95,992		20	4,800	4,800	49,424	49
50	Various	2015	17,993		20	900	900	9,293	50
51	Various	2016	39,949		20	1,783	1,783	21,155	51
52	Various	2017	169,314		20	8,466	8,466	73,455	52
53	Various	2018	6,961		20	348	348	2,714	53
54	Various	2019	264,810		20	13,241	13,241	87,610	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)		\$ 5,560,394	\$		\$ 178,416	\$ 178,416	\$ 4,308,315	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

1/1/2025

Ending:

12/31/2025

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		\$ 5,560,394	\$		\$ 178,416	\$ 178,416	\$ 4,308,315	1
2	Install Camera Surveillance System	2020	11,386		20	569	569	3,414	2
3	Flooring / Adhesive - Hallways, Mezanin, 2Nd Floor	2020	3,869		20	193	193	1,158	3
4	Flooring / Adhesive - Hallways, Mezanin, 2Nd Floor	2020	12,328		20	616	616	3,696	4
5	Replace Sprinkler Heads	2020	4,573		20	229	229	1,374	5
6	Replace Steam Pipe	2020	16,032		20	802	802	4,812	6
7	Repair Boiler Room Leaking Pipes	2020	2,770		20	139	139	834	7
8	Cubicle Curtains	2020	7,678		20	384	384	2,304	8
9	Replace Compressor	2020	3,936		20	197	197	1,182	9
10	Replace Condensate Pump For West End Of South Bldg	2020	3,367		20	168	168	1,008	10
11	Repair Boiler # 2 - Weld Cracks, Piping	2021	11,500		20	575	575	2,875	11
12	Water Meter, Chemical Pump, Controller	2021	7,835		20	392	392	1,960	12
13	Install Water Softener,Pumps,Coolers For Steam Boiler System	2021	4,325		20	216	216	1,080	13
14	Install Surveillance System	2021	2,843		20	142	142	710	14
15	Repave Driveway	2021	26,500		20	1,325	1,325	6,625	15
16	Boiler #2 Repair Valves, Repair Leak In Combustion Chamber	2021	7,175		20	359	359	1,795	16
17	Replace Check Valve For North Bldg Condensate Pump	2021	2,520		20	126	126	630	17
18	Install Gas Pipe, New Gas Line At Cook Line	2021	4,989		20	249	249	1,245	18
19	Replace Heating Boiler #2	2022	103,327		20	5,166	5,166	20,664	19
20	Replace 2 5-Ton Condensing Units/Air Handlers For Cafeteria	2022	17,691		20	885	885	3,540	20
21	Replace Heating Boiler #1 (South Side)	2022	117,580		20	5,879	5,879	23,516	21
22	Common Area Rtu Replacement	2022	21,033		20	1,052	1,052	4,208	22
23	Repairs To West Wall Corner - Tuckpointing, Repair Cracks	2022	11,400		20	570	570	2,280	23
24	Replace 2 Domestic Hot Water Storage Tanks	2022	17,673		20	884	884	3,536	24
25	Replace Leaking Steam Main Piping In Kitchen Area	2022	5,153		20	258	258	1,032	25
26	Replace 15-Gallon Condensate Pump In Boiler Room	2022	5,857		20	293	293	1,172	26
27	Replace Vacuum Pump #2 On Shipco Vacuum/Condensate Unit	2022	6,053		20	303	303	1,212	27
28	Piping - Repair Steam Leaks In Guest Bathroom,Kitchen,Basement	2022	5,790		20	290	290	1,160	28
29	Replace Faulty Steam Trap - Se Section Of South Building	2022	2,734		20	137	137	548	29
30	Installation Of New Phone System	2023	21,923		20	1,096	1,096	3,288	30
31	North Passenger Elevator - Control Replacement	2023	98,700		20	4,935	4,935	14,805	31
32	Replace Radiator Valve In Rms 222,240 & Steam Trap In Rms 22	2023	19,352		20	968	968	2,904	32
33	Replace Heater In Exercise Room	2023	3,385		20	169	169	507	33
34	TOTAL (lines 1 thru 33)		\$ 6,151,671	\$		\$ 207,982	\$ 207,982	\$ 4,429,389	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

1/1/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,151,671	\$		\$ 207,982	\$ 207,982	\$ 4,429,389	1
2	Installation Of New Steam Pipe In South Building	2023	3,892		20	195	195	585	2
3	Roof Repair - Apply Polyemer Coating, Resin Base Coat, Final To	2023	62,600		20	3,130	3,130	9,390	3
4	Installation Of Fire Pump Controller & Jockey Pump Controller	2023	21,829		20	1,091	1,091	3,273	4
5	New Vacuum Pump To Replace Faulty Vacuum Pump #1	2023	6,080		20	304	304	912	5
6	Flooring Installation - Roppe Rubber Treads For Stairs	2023	4,146		20	207	207	621	6
7	Repair Leaky Fire Pump - Replacement Of Jockey Pump	2023	4,558		20	228	228	684	7
8	Dentrav Roofing - Facility Roof Repairs	2023	2,650		20	133	133	399	8
9	Installation Of Metal Steel Door	2023	3,051		20	153	153	459	9
10	Replace Condensate Pumps in N Basement & Cafeteria Mech Rm								10
11	& Position Switch for Vacuum/Feed Pump Unit in Boiler Rm	2024	11,595		20	580	580	870	11
12	Replace Leaking Pipe in Kitchen Ceiling	2024	2,870		20	144	144	216	12
13	Remove and Replace Asphalt Parking Lot	2024	62,500		20	3,125	3,125	4,688	13
14	Replace Piping and Fittings-Southwest Basement	2025	14,723		20	368	368	368	14
15	Replaced Controllers in 2 Boilers	2025	3,665		20	92	92	92	15
16	Retrofit Lighting-Throughout Building	2025	17,981		20	450	450	450	16
17	Replaced Pippings/Fittings-Boiler Room/Activity Room	2025	24,186		20	605	605	605	17
18	Replaced Condensate Pump-Furnace Room Near Cafeteria	2025	3,691		20	92	92	92	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Financial Statement Depreciation			104,759			(104,759)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,401,688	\$ 104,759		\$ 218,879	\$ 114,120	\$ 4,453,093	34

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	\$ 129,273	\$	\$ 12,653	\$ 12,653	10 Yrs	\$ 83,390	71
72	Current Year Purchases	20,187		1,009	1,009	10 Yrs	1,009	72
73	Fully Depreciated Assets	1,219,094					1,219,094	73
74								74
75	TOTALS	\$ 1,368,554	\$	\$ 13,662	\$ 13,662		\$ 1,303,493	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	28,925	78
79		Ford Transit Van 2020	2020	46,641				5	46,641	79
80	TOTALS			\$ 122,965	\$	\$	\$		\$ 122,965	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)	\$ 8,149,375	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 104,759	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,541	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 127,782	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,879,551	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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				665			5
6	Allocated from Barton Management				13,814			6
7	TOTAL				\$14,479			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?
16. Rental Amount for movable equipment: \$10,594 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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.

Facility Name:Central Plaza Resid Home

IDPH License ID Number:0054148

Fiscal Year End:12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Ice Machine	3,811
Dishwasher	2,957
Cooler	666
Copier	3,160
Total - Line 16	10,594

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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): <u>Lab/Xray</u>	39(3)				775			775	12
13	Other (specify): <u></u>									13
14	TOTAL			\$		\$ 775	\$		\$ 775	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 2,204,419	\$ 2,204,419	1
2	Cash-Patient Deposits	55,918	55,918	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 400,000)	1,450,910	1,450,910	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	305,343	305,343	6
7	Other Prepaid Expenses	44,233	44,233	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	28,700	28,700	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,089,523	\$ 4,089,523	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		256,168	13
14	Buildings, at Historical Cost	311,666	311,666	14
15	Leasehold Improvements, at Historical Cost	5,895,024	6,090,022	15
16	Equipment, at Historical Cost	1,661,757	1,491,519	16
17	Accumulated Depreciation (book methods)	(6,086,351)	(5,879,551)	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)	\$ 1,782,096	\$ 2,269,824	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,871,619	\$ 6,359,347	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,014,574	\$ 2,014,574	26
27	Officer's Accounts Payable	1,200,000	1,200,000	27
28	Accounts Payable-Patient Deposits	45,857	45,857	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	424,231	424,231	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,733	4,733	31
32	Accrued Real Estate Taxes(Sch.IX-B)	504,214	504,214	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,193,609	\$ 4,193,609	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	448,299	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	\$ 448,299	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,641,908	\$ 4,641,908	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,229,711	\$ 1,717,439	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,871,619	\$ 6,359,347	48

Facility Name:Central Plaza Resid Home

IDPH License ID Number:0054148

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 9 Other Assets (specify):

Description	Operating	After Consolidation
Exchange Account	349	349
Deferred SRT Benefit	24,226	24,226
Interest Receivable	4,125	4,125
Total - Line 9	28,700	28,700

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 414,144	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 414,144	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,315,567	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	(1,500,000)	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)	\$ 815,567	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)	\$ 1,229,711	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Central Plaza Resid Home

0054148

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	\$ 15,270,306	1
2	Discounts and Allowances for all Levels	(4,432,281)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,838,025	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	800,000	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)	\$ 800,000	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42,469	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 42,469	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Records Income	1,420	28
28a	Bed Buy Back Income	1,190,940	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,192,360	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,872,854	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,246,347	31
32	Health Care	3,664,076	32
33	General Administration	2,165,995	33
	B. Capital Expense		
34	Ownership	585,564	34
	C. Ancillary Expense		
35	Special Cost Centers	1,895,305	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)*	\$ 10,557,287	40
41	Income before Income Taxes (line 30 minus line 40)**	2,315,567	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,315,567	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 685,410	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	9,692,142	45
46	MMAI-Medicaid is the Primary Payer	348,474	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	112,000	48
49	Medicare Part A		49
50	Other-(specify)		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)	\$ 10,838,025	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	1,365	1,406	\$ 100,841	\$ 71.72	1
2	Assistant Director of Nursing	1,967	2,202	102,922	46.74	2
3	Registered Nurses	4,130	4,544	211,835	46.62	3
4	Licensed Practical Nurses	16,119	17,486	675,939	38.66	4
5	CNAs & Orderlies	47,757	49,947	1,004,488	20.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,373	8,192	166,121	20.28	10
11	Social Service Workers	37,738	40,170	1,063,297	26.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,273	19,250	404,528	21.01	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	23,284	25,655	499,149	19.46	18
19	Laundry					19
20	Administrator	1,960	2,080	173,741	83.53	20
21	Assistant Administrator	702	886	35,060	39.57	21
22	Other Administrative	1,104	1,104	294,639	266.88	22
23	Office Manager					23
24	Clerical	8,330	8,825	244,430	27.70	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	2,803	2,991	76,877	25.70	31
32	Other Health Care(specify)					32
33	Other(specify) Non Allowable Exp (adj P	2,588	2,588	569,115	219.91	33
34	TOTAL (lines 1 - 33)	174,493	187,326	\$ 5,622,982 *	\$ 30.02	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	Monthly	\$ 8,933	L1, C3	35
36	Medical Director	Monthly	9,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	Monthly	24,000	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,333		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	2,300	137,179	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,300	\$ 137,179		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Michelle Wimberly	Administrator	0	\$ 173,741	Workers' Compensation Insurance	\$ 51,393	IDPH License Fee	\$ 5,828		
Tatian Lane	Assistant Admin	0	35,060	Unemployment Compensation Insurance	34,135	Advertising: Employee Recruitment	1,775		
Arnold Kanter	Other Administrative	0	84,767	FICA Taxes	370,932	Health Care Worker Background Check			
John Shlofrock	Other Administrative	16.55%	40,613	Employee Health Insurance	276,481	(Indicate # of checks performed 114)	3,983		
Richard Duros	Other Administrative	0	81,351	Employee Meals	30,576	Patient Background Checks 50	1,750		
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)			
See Attached Schedule 21A			87,908	401K Contribution	44,512	The Joint Commission	8,125		
TOTAL (agree to Schedule V, line 17, col. 1)				Union Pension Contrib	29,388	Relias	8,439		
(List each licensed administrator separately.)			\$ 503,440	Christmas Expense	3,958	Other Dues & Subscriptions, Licens, Permits	1,651		
B. Administrative - Other				Other Employee Benefits	3,675	Barton Mgmt Home Office Allocation	45		
Description						Less: Public Relations Expense	()		
N/A						PAC and Lobbying payments	()		
						All non-allowable advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 845,050	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 31,596	
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Paychex	Payroll Processing	\$	14,214			\$	Out-of-State Travel	\$	
Personnel Planners	Unemployment Consultant		1,509						
Galaxy	Computer Expense		4,410						
Pension Performance	Superannuation Consultant		2,354				In-State Travel		
Cohn Reznick	Accounting Fees		20,180						
Point Click Care	E.H.R. Software		23,623						
Waystar	Computer Expense		2,854						
Constant Virtual Solutions	Computer Expense		9,471				Seminar Expense	4,759	
Intuit	Computer Expense		66						
Stout Risius Ross LLC	Appraisal		2,755						
Legat Architects	Architect		2,475						
See Attached Schedule 21A			3,049				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 86,960				TOTAL	\$ 4,759	

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name:

Central Plaza Resid Home

IDPH License ID Number:

0054148

Fiscal Year End:

12/31/2025

Schedule 21A

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gary Weintraub	Other Administrative	0%	\$ 40,580
Anca Zota-Oviedo	Other Administrative	0%	39,804
Stan Aron	Other Administrative	5.66%	7,524
		Total	87,908

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 | Amount |
|------------------------|--|
| _____ | _____ |
| _____ | _____ |
| _____ <u>N/A</u> _____ | _____ |
| | <u> </u> 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.
- | | |
|------------------------|--|
| _____ | _____ |
| _____ | _____ |
| _____ <u>N/A</u> _____ | _____ |
| _____ | _____ |
| | <u> </u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|------------------------|--|
| _____ | _____ |
| _____ | _____ |
| _____ <u>N/A</u> _____ | _____ |
| _____ | _____ |
| | <u> </u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 5,672 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. \$ None
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. \$ 30,576 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 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
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.