

		FOR BHF USE					

LL1

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: 0054155

Facility Name: Clayton Residential Home

Address: 2026 North Clark St Chicago 60614
Number City Zip Code

County: Cook

Telephone Number: (773) 549-1840 Fax # (773) 549-2036

HFS ID Number:

Date of Initial License for Current Owners: 1969

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
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 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Clayton Residential Home # 0054155 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

1	2	3	4
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period
1		Skilled (SNF)	
2		Skilled Pediatric (SNF/PED)	
3	210	Intermediate (ICF)	210
4		Intermediate/DD	
5		Sheltered Care (SC)	
6		ICF/DD 16 or Less	
7	210	TOTALS	210

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
				Medicaid Primary	Medicare Primary			
8	SNF							
9	SNF/PED							
10	ICF							
11	ICF/DD	5,756	51,660	7,279		338		65,033
12	SC							
13	DD 16 OR LESS							
14	TOTALS	5,756	51,660	7,279		338		65,033

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

84.84%

D. How many bed reserve days during this year were paid by the Department?

656 (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 X 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 X

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

Date started 11/28/1966

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

YES Date NO X

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

YES NO X If YES, enter certified beds. number of certified beds

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL X CASH* CASH*

Is your fiscal year identical to your tax year?

YES X NO

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Clayton Residential Home

0054155

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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	354,748	73,332	10,464	438,544		438,544		438,544			1
2	Food Purchase		552,140		552,140		552,140	(30)	552,110			2
3	Housekeeping	344,791	55,108		399,899		399,899		399,899			3
4	Laundry		12,198	50,149	62,347		62,347		62,347			4
5	Heat and Other Utilities			273,809	273,809		273,809	1,977	275,786			5
6	Maintenance	156,366		450,467	606,833		606,833	(32,139)	574,694			6
7	Other (specify):* Waste Disposal			25,176	25,176		25,176		25,176			7
8	TOTAL General Services	855,905	692,778	810,065	2,358,748		2,358,748	(30,192)	2,328,556			8
	B. Health Care and Programs											
9	Medical Director			2,200	2,200		2,200		2,200			9
10	Nursing and Medical Records	2,268,788	70,865	216,206	2,555,859		2,555,859		2,555,859			10
10a	Therapy											10a
11	Activities	101,929	40,223	3,960	146,112		146,112		146,112			11
12	Social Services	1,663,005		41,276	1,704,281		1,704,281		1,704,281			12
13	CNA Training											13
14	Program Transportation			457	457		457		457			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,033,722	111,088	264,099	4,408,909		4,408,909		4,408,909			16
	C. General Administration											
17	Administrative	575,793			575,793		575,793		575,793			17
18	Directors Fees											18
19	Professional Services			131,161	131,161		131,161		131,161			19
20	Dues, Fees, Subscriptions & Promotions			65,494	65,494		65,494	(25,940)	39,554			20
21	Clerical & General Office Expenses	288,633	25,600	31,000	345,233		345,233	28	345,261			21
22	Employee Benefits & Payroll Taxes			969,798	969,798		969,798		969,798			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,166	3,166		3,166		3,166			24
25	Other Admin. Staff Transportation			11,118	11,118		11,118	(576)	10,542			25
26	Insurance-Prop.Liab.Malpractice			268,853	268,853		268,853	416	269,269			26
27	Other (specify):*											27
28	TOTAL General Administration	864,426	25,600	1,480,590	2,370,616		2,370,616	(26,072)	2,344,544			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,754,053	829,466	2,554,754	9,138,273		9,138,273	(56,264)	9,082,009			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			200,222	200,222		200,222	(91,898)	108,324			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			90,967	90,967		90,967	(90,967)				32
33	Real Estate Taxes			489,478	489,478		489,478	9,590	499,068			33
34	Rent-Facility & Grounds			36,777	36,777		36,777	(18,318)	18,459			34
35	Rent-Equipment & Vehicles			13,502	13,502		13,502		13,502			35
36	Other (specify):*											36
37	TOTAL Ownership			830,946	830,946		830,946	(191,593)	639,353			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):* Disallowed Costs	670,178		1,763,128	2,433,306		2,433,306	(2,433,306)				43
44	TOTAL Special Cost Centers	670,178		1,763,128	2,433,306		2,433,306	(2,433,306)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,424,231	829,466	5,148,828	12,402,525		12,402,525	(2,681,163)	9,721,362			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	(5,251)	43		4
5	Telephone, TV & Radio in Resident Rooms	(4,670)	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	(91,898)	30		9
10	Interest and Other Investment Income	(95,473)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	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				18
19	Entertainment				19
20	Contributions	(42,696)	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	(35,753)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(204,800)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(2,202,686)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,683,257)		\$	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)	2,094		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,094		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,681,163)		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	Resident Stipend	(7,060)	43	4
5	Marketing Expense	(3,025)	43	5
6	Trust Fees	(205)	43	6
7	Capitalized R&M	(35,988)	06	7
8	Non-Allowable Expense-Wages	(670,178)	43	8
9	Non-Allowable Expense-Management Fee	(1,459,668)	43	9
10	Auto Expense-Marketing	(576)	25	10
11				11
12				12
13				13
14				14
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45				45
46				46
47				47
48				48
49	Total	(2,202,686)		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.		\$ 1,977	\$ 1,977	1
2	V	6	Repairs & Maintenance		Barton Management Inc.		3,849	3,849	2
3	V	20	Dues, Licenses, Fees		Barton Management Inc.		46	46	3
4	V	21	Clerical & General		Barton Management Inc.		28	28	4
5	V	26	Insurance		Barton Management Inc.		416	416	5
6	V	33	Real Estate Taxes		Barton Management Inc.		9,590	9,590	6
7	V	34	Rent Office Space	32,400	Barton Management Inc.		14,082	(18,318)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 32,400			\$ 29,988	\$ * (2,412)	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	89,881	Barton Healthcare, LLC		\$ 94,387	\$ 4,506	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			\$ 89,881			\$ 94,387	\$ * 4,506	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS					Ownership Listing-1		
Clayton Residential Home							
ID#		0054155					
Report Period Beginning:		1/1/2025			Barton Management, Ir		
Ending:		12/31/2025			N/A		
-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.					Ownership Percentage		
First Name	M.I.	Last Name	City	State	Ownership Percentage	Building Co. Ownership Percentage	Ownership Percentage
1	Carol	Ross Irrevocable Trust					1
2	Beneficiary:						2
3	Carol	Ross	Northbrook	IL	12.48048		3
4							4
5	David	Becker	Libertyville	IL	9.61694		5
6	Gary	Weintraub	Northfield	IL	2.49233		25.00000
7	Elisa	Shlofrock-Zusman	Deerfield	IL	14.35655		25.00000
8	Jerold	Stinebiser	Lake Oswego	OR	7.82204		8
9	John	Shlofrock	Northfield	IL	14.35655		25.00000
10							10
11	The Sonia Gethner Investment Trust						11
12	Beneficiary:						12
13	Sonia	Gethner	Chicago	IL	16.81080		13
14							14
15	Miriam	Becker	Schaumburg	IL	9.62694		15
16							16
17	Richard	Dean Duros Deel of Trust					17
18	Beneficiary:						18
19	Richard	Duros	Vernon Hills	IL	2.49233		25.00000
20							20
21	Robert	Baily	Lake Oswego	OR	7.82204		21
22	Anca	Oviedo	Highland Park	IL	0.25254		22
23	Marian	Simon	Chicago	IL	0.25254		23
24	Arnold	Kanter	Highland Park	IL	0.25254		24
25	Stanton	Aron	Buffalo Grove	IL	0.25254		25
26	Robyn	Mogul	Northbrook	IL	0.92438		26
27	Marla	Coquillette	Chicago	IL	0.19847		27
28							28
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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	Central Plaza 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
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30								30

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Shlofrock	Shareholder	Administrative	14.36%	See Att. Sch 7A	5.00	11.90%	Salary	44,882	17-1	1
2	Anca Zota-Oviedo	Shareholder	Administrative	0.25%	See Att. Sch 7A	12.00	21.83%	Salary	43,987	17-1	2
3	Richard Duros	COO	Administrative	2.49%	See Att. Sch 7A	6.50	14.60%	Salary	89,900	17-1	3
4	Arnold Kanter	Shareholder	Administrative	0.25%	See Att. Sch 7A	7.00	18.67%	Salary	83,178	17-1	4
5	Gary Weintraub	Shareholder	Legal	0.25%	See Att. Sch 7A	6.00	14.29%	Salary	44,845	17-1	5
6	Stan Aron	Shareholder	Administrative	0.25%	See Att. Sch 7A	7.00	18.92%	Salary	8,314	17-1	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	\$ 315,106		13

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

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

Facility Name & ID Number Clayton Residential Home # 0054155 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 Management Inc.
Street Address 465 Cental Ave.
City / State / Zip Code Northfield, IL 60093
Phone Number (847) 441-8200
Fax Number (847) 441-0800

	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	5	Utilities	Available Days	496,213	8	\$ 12,800	\$	76,650	\$ 1,977	1
2	6	Repairs & Maintenance	Available Days	496,213	8	24,917		76,650	3,849	2
3	20	Dues, Licenses, Fees	Available Days	496,213	8	300		76,650	46	3
4	21	Clerical & General	Available Days	496,213	8	183		76,650	28	4
5	26	Insurance	Available Days	496,213	8	2,690		76,650	416	5
6	33	Real Estate Taxes	Available Days	496,213	8	62,084		76,650	9,590	6
7	34	Rent Office Space	Available Days	496,213	8	91,160		76,650	14,082	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					\$ 194,134	\$		\$ 29,988	25

Facility Name & ID Number Clayton Residential Home # 0054155 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	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	32	Interest	Note Receivable	6,187,451	7	236,441	\$	2,469,894	\$ 94,387	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	\$		\$ 94,387	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			\$	2,469,898			\$	94,387	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	2,469,898			\$	94,387	9
	B. Non-Facility Related*												
10									Other Interest		1,086	10	
11									Offset Interest Income		(95,473)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$				\$	(94,387)	14
15	TOTALS (line 9+line14)						\$	2,469,898			\$		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	206,097	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		\$	223,271	2
3. Under or (over) accrual (line 2 minus line 1).				\$	17,174	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	472,305	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Allocated from Barton Management Rounding			9,590 (1)	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	499,068	7
Assessed Value from Real Estate Tax Bill:	2024	1,719,005	8			
Real Estate Tax Bill for Calendar Year:	2020	371,212	9			
	2021	357,135	10			
	2022	365,179	11			
	2023	374,722	12			
	2024	429,368	13			
2025 Accrual = \$429,368 x 1.10 = \$472,305						
Line 2 above includes the 2024 taxes less the prepayment of 1st installment of 2024 tax made in December 2024 of \$206,097						

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 Clayton Residential Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054155

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. 14-33-208-008-0000	Long Term Care Facility	\$ 429,367.88	\$ 429,367.88
2. 05-19-112-017-0000	Allocated from Barton Mgmt	\$ 124,168.59	\$ 9,590.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 553,536.47	\$ 438,957.88

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: 57,064 B. General Construction Type: Exterior Frame Number of Stories

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:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Facility	17,608	1967	\$ 19,250	1
2					2
3	TOTALS	17,608		\$ 19,250	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Clayton Residential Home

0054155

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	232			1967	\$ 255,750	\$		\$	\$	255,750
5										
6										
7										
8										
	Improvement Type**									
9	Various		1974	591,996		20				591,996
10	Various		1978	11,746		20				11,746
11	Various		1979	9,036		20				9,036
12	Various		1980	23,187		20				23,187
13	Various		1981	17,720		20				17,720
14	Various		1982	718		20				718
15	Various		1983	60,412		20				60,412
16	Various		1984	48,928		20				48,928
17	Various		1985	96,652		20				96,652
18	Various		1986	79,806		20				79,806
19	Various		1987	25,101		20				25,101
20	Various		1988	16,259		20				16,259
21	Various		1989	23,627		20				23,627
22	Various		1990	183,167		20				183,167
23	Various		1991	53,962		20				53,962
24	Various		1992	158,472		20				158,472
25	Various		1993	71,192		20				71,192
26	Various		1994	104,923		20				104,923
27	Various		1995	221,995		20				221,995
28	Various		1996	237,569		20				237,569
29	Various		1997	81,461		20				81,461
30	Various		1998	159,916		20				159,916
31	Various		1999	195,522		20				195,522
32	Various		2000	393,212		20				393,212
33	Various		2001	194,173		20	9,709	9,709		146,528
34	Various		2002	81,202		20				81,202
35	Various		2003	176,825		20				176,825
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

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	2004	\$ 133,639	\$	20	\$		\$ 133,639	37
38	Various	2005	173,293		20			173,293	38
39	Various	2006	63,076		20			63,076	39
40	Various	2007	150,104		20	340	340	149,620	40
41	Various	2008	54,557		20			54,557	41
42	Various	2009	140,738		20	308	308	140,292	42
43	Various	2010	92,959		20	300	300	92,627	43
44	Various	2011	7,870		20			7,870	44
45	Various	2012	117,874		20			117,874	45
46	Various	2013	24,208		20	410	410	24,208	46
47	Various	2014	27,280		20	1,365	1,365	13,636	47
48	Various	2015	739,357		20	35,846	35,846	406,520	48
49	Various	2016	71,936		20	3,347	3,347	40,716	49
50	Various	2017	64,120		20	3,206	3,206	26,433	50
51	Various	2018	163,588		20	8,180	8,180	62,031	51
52	Various	2019	122,135		20	6,107	6,107	40,310	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,721,263	\$		\$ 69,118	\$ 69,118	\$ 5,073,586	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Clayton Residential Home

0054155

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		\$ 5,721,263	\$		\$ 69,118	\$ 69,118	\$ 5,073,586	1
2	Replace Pump Unit	2020	23,662			1,183	1,183	7,098	2
3	Surveillance System Add-Ons	2020	2,842		20	142	142	852	3
4	Surveillance System Takeover	2020	6,418		20	321	321	1,926	4
5	Repair Boiler Feed Pump	2020	3,270		20	164	164	984	5
6	Replace Pumps For Domestic Hot Water Heaters	2020	4,870		20	244	244	1,464	6
7	Install New Small Dining Room Compressor	2020	3,969		20	198	198	1,188	7
8	Replace Boiler Feed Pump Unit	2020	16,538		20	827	827	4,962	8
9	Sewer Line Repair	2021	8,335		20	417	417	2,085	9
10	Install 1 Temperature Pump, 2 New Sewage Pumps	2021	14,997		20	750	750	3,750	10
11	Replace Faulty 1 1/4" Valve For Pump In Boiler Room	2022	2,527		20	126	126	504	11
12	Tuckpointing - Chimney, West Wall, East Elevation W/Elevator R	2022	58,532		20	2,927	2,927	11,708	12
13	Upgrade Phone System - Esi Voip Server,6 Gateways,Poe Switch	2023	31,282		20	1,564	1,564	4,692	13
14	Install Laminate Flooring - Top Floor, Rubber Treads & Risers - S	2023	31,678		20	1,584	1,584	4,752	14
15	Replace Old Concrete In Room	2023	6,000		20	300	300	900	15
16	Roof Repair - Apply Polyemer Coating, Resin Base Coat, Final To	2023	86,500		20	4,325	4,325	12,975	16
17	Install Front Door Camera System	2023	2,850		20	143	143	429	17
18	Replace Dining Room Hvac Rooftop Unit	2023	22,424		20	1,121	1,121	3,363	18
19	Sewer Repairs - Repair Bad Piping	2023	15,980		20	799	799	2,397	19
20	Replacement Of The Sprinkler System Jockey Pump	2023	2,879		20	144	144	432	20
21	Replace 17 Smoke Detectors On 3Rd Flr, Replace Pull Station By	2023	3,852		20	193	193	579	21
22	Install New Flooring-Top Floor Office	2024	33,098		20	1,655	1,655	2,482	22
23	Unclog 2 Shower Drains/Replace Pipes/Install New Clean-Out Cor	2024	4,460		20	223	223	335	23
24	Install 4 New Fire Doors	2024	5,071		20	254	254	381	24
25	Replace Ceiling Tiles - Resident Shower	2024	4,957		20	248	248	372	25
26	Painting/Epoxy Floor-Interior Stairs	2025	11,900		20	298	298	298	26
27	Paint/Install Drywall, Flooring and Sink-Rm 460/463	2025	10,910		20	273	273	273	27
28	Repaired Radiator/Piping Rm 233/142/171	2025	16,910		20	423	423	423	28
29	Paint/Install New Flooring Rm 171/142	2025	6,165		20	154	154	154	29
30	Paint/Install New Flooring Rm 143/238/140	2025	10,820		20	271	271	271	30
31	Paint/Install New Flooring Rm 439/440/457	2025	11,180		20	280	280	280	31
32	Paint/Install New Flooring Resident Rooms	2025	11,320		20	283	283	283	32
33	Paint/Install New Flooring Rm 322/323	2025	12,240		20	306	306	306	33
34	TOTAL (lines 1 thru 33)		\$ 6,209,699	\$		\$ 91,258	\$ 91,258	\$ 5,146,484	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Clayton Residential Home

0054155

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		\$ 6,209,699	\$		\$ 91,258	\$ 91,258	\$ 5,146,484	1
2	Paint/Install New Flooring/Drywall Rm 359/330	2025	16,700		20	418	418	418	2
3	Flooring for Resident Rooms	2025	11,803		20	295	295	295	3
4	Flooring for Resident Rooms	2025	11,803		20	295	295	295	4
5	Paint/Install New Flooring/Drywall Rm 360/437	2025	12,410		20	310	310	310	5
6	Installed 2 New Water Heaters/Storage Tanks	2025	98,926		20	2,473	2,473	2,473	6
7	Paint/Install New Flooring/Drywall Rm 316/337/350	2025	18,615		20	465	465	465	7
8	Paint/Install New Flooring/Drywall Rm 434	2025	6,185		20	155	155	155	8
9	Paint/Install New Flooring/Drywall Rm 447	2025	6,185		20	155	155	155	9
10	Paint/Install New Flooring/Drywall Rm 306	2025	5,600		20	140	140	140	10
11	Paint/Install New Flooring/Drywall Rm 454	2025	6,205		20	155	155	155	11
12	Paint/Install New Flooring/Drywall Rm 452	2025	12,410		20	310	310	310	12
13	Paint/Install New Flooring/Drywall Rm 148	2025	6,205		20	155	155	155	13
14	Paint/Install New Flooring/Drywall Rm 152	2025	4,475		20	112	112	112	14
15	Paint/Install New Flooring/Drywall Rm 321	2025	4,475		20	112	112	112	15
16	Paint/Install New Flooring/Drywall Rm 356	2025	6,185		20	155	155	155	16
17	Retrofit Lighting-Throughout Building	2025	32,460		20	812	812	812	17
18	Ceiling Tiles-Resident Rooms	2025	3,528		20	88	88	88	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28	Financial Statement Depreciation			200,222			(200,222)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,473,869	\$ 200,222		\$ 97,863	\$ (102,359)	\$ 5,153,089	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	\$ 52,309	\$	\$ 5,459	\$ 5,459	10 Yrs	\$ 33,853	71
72	Current Year Purchases	100,037		5,002	5,002	10 Yrs	5,002	72
73	Fully Depreciated Assets	1,209,686					1,209,686	73
74								74
75	TOTALS	\$ 1,362,032	\$	\$ 10,461	\$ 10,461		\$ 1,248,541	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		1999 FORD E350	2002	\$ 14,521	\$	\$	\$	5	\$ 14,521
77		2019 CHEVY EXPRESS 3500	2020	36,257				5	36,257
78									
79									
80	TOTALS			\$ 50,778	\$	\$	\$		\$ 50,778

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	7,905,929
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	200,222
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	108,324
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(91,898)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	6,452,408

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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93	N/A	
94		
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				4,377			5
6	Allocated from Barton Management				14,082			6
7	TOTAL				\$ 18,459			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: \$ 13,502 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name:

Clayton Residential Home

IDPH License ID Number:

0054155

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Ice Machine	3,109
Dishwasher	4,711
Cooler	450
Copiers	5,098
Water Cooler	134
Total - Line 16	13,502

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

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

		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,704,098	\$ 2,704,098	1
2	Cash-Patient Deposits	118,481	118,481	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 403,449)	2,015,017	2,015,017	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,690,000	2,690,000	5
6	Prepaid Insurance	124,911	124,911	6
7	Other Prepaid Expenses	62,219	62,219	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	93,777	93,777	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,808,503	\$ 7,808,503	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		19,250	13
14	Buildings, at Historical Cost	255,750	255,750	14
15	Leasehold Improvements, at Historical Cost	5,612,353	6,218,119	15
16	Equipment, at Historical Cost	1,672,955	1,412,810	16
17	Accumulated Depreciation (book methods)	(5,802,485)	(6,452,408)	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)	\$ 1,738,573	\$ 1,453,521	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,547,076	\$ 9,262,024	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,810,691	\$ 2,810,691	26
27	Officer's Accounts Payable	1,500,254	1,500,254	27
28	Accounts Payable-Patient Deposits	109,224	109,224	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	564,177	564,177	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,561	6,561	31
32	Accrued Real Estate Taxes(Sch.IX-B)	472,305	472,305	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)	\$ 5,463,212	\$ 5,463,212	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,469,898	2,469,898	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)	\$ 2,469,898	\$ 2,469,898	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,933,110	\$ 7,933,110	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,613,966	\$ 1,328,914	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,547,076	\$ 9,262,024	48

Facility Name: Clayton Residential Home

IDPH License ID Number: 0054155

Fiscal Year End: 12/31/2025

Schedule 17A

XV. Balance Sheet

Line 9 Other Assets (specify):

Description	Operating	After Consolidation
Deferred SRT Benefit	12,396	12,396
Interest Receivable	81,381	81,381
Total - Line 9	93,777	93,777

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,040,807	1
2	Restatements (describe):		2
3	Accrued Distribution	(600,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,440,807	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,503,159	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	(2,330,000)	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)	\$ 173,159	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)	\$ 1,613,966	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Clayton Residential Home

0054155

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	\$ 18,022,056	1
2	Discounts and Allowances for all Levels	(3,581,696)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,440,360	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***	180,534	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 180,534	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bed Buy Back Income	284,790	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 284,790	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,905,684	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,358,748	31
32	Health Care	4,408,909	32
33	General Administration	2,370,616	33
	B. Capital Expense		
34	Ownership	830,946	34
	C. Ancillary Expense		
35	Special Cost Centers	2,433,306	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)*	\$ 12,402,525	40
41	Income before Income Taxes (line 30 minus line 40)**	2,503,159	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,503,159	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,274,673	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	11,440,169	45
46	MMAI-Medicaid is the Primary Payer	1,611,943	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	113,575	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)	\$ 14,440,360	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	2,372	2,572	\$ 181,936	\$ 70.74	1
2	Assistant Director of Nursing	867	924	34,916	37.79	2
3	Registered Nurses	7,114	7,655	317,663	41.50	3
4	Licensed Practical Nurses	15,551	17,124	610,372	35.64	4
5	CNAs & Orderlies	48,344	52,271	1,079,391	20.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,777	4,463	101,929	22.84	10
11	Social Service Workers	53,972	60,984	1,663,005	27.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,894	17,356	354,748	20.44	15
16	Dishwashers					16
17	Maintenance Workers	4,318	4,687	156,366	33.36	17
18	Housekeepers	16,551	18,669	344,791	18.47	18
19	Laundry					19
20	Administrator	1,960	2,080	176,241	84.73	20
21	Assistant Administrator	1,816	2,040	84,446	41.40	21
22	Other Administrative	1,124	1,124	315,106	280.34	22
23	Office Manager					23
24	Clerical	9,356	9,653	288,633	29.90	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	1,939	2,059	44,510	21.62	31
32	Other Health Care(specify)					32
33	Other(specify) Non Allowable Exp (adj P	2,854	2,854	670,178	234.82	33
34	TOTAL (lines 1 - 33)	187,809	206,515	\$ 6,424,231 *	\$ 31.11	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	\$ 10,464	L1, C3	35
36	Medical Director	Monthly	2,200	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	Monthly	3,960	L11, C3	44
45	Social Service Consultant	Monthly	17,276	L12, C3	45
46	Other(specify) Psychiatric Director	Monthly	24,000	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 59,700		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	3,245	214,267	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,245	\$ 214,267		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number		Clayton Residential Home		STATE OF ILLINOIS		Report Period Beginning:		1/1/2025		Page 21							
				# 0054155				Ending:		12/31/2025							
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions									
Name		Function		Ownership %		Amount		Description		Amount							
Sarah Leicher		Executive Director		0		\$ 176,241		Workers' Compensation Insurance		\$ 70,319							
Lakeshia Redmond		Assistant Exec. Director		0		84,446		Unemployment Compensation Insurance		33,843							
Stan Aron		Other Administrative		0.25%		8,314		FICA Taxes		438,259							
Arnold Kanter		Other Administrative		0.25%		83,178		Employee Health Insurance		285,337							
John Shlofrock		Other Administrative		14.36%		44,882		Employee Meals		32,614							
Richard Duros		Other Administrative		0		89,900		Illinois Municipal Retirement Fund (IMRF)*									
See Attached Schedule 21A						88,832		401K Contribution		75,753							
TOTAL (agree to Schedule V, line 17, col. 1)								Union Pension Contrib				22,708					
(List each licensed administrator separately.)				\$ 575,793				Christmas Expense				5,464					
B. Administrative - Other								Other Employee Benefits				5,501					
Description				Amount													
N/A				\$													
								TOTAL (agree to Schedule V, line 22, col.8)				\$ 969,798					
TOTAL (agree to Schedule V, line 17, col. 3)				\$				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)																	
C. Professional Services																	
Vendor/Payee		Type		Amount		Description		Line #		Amount		Description		Amount			
See Attached Legal Schedule		Legal		\$ 34,690						\$		Out-of-State Travel		\$			
Paychex		Payroll Processing		17,828													
Personnel Planners		Unemployment Consultant		1,464													
Intuit		Computer Expense		75								In-State Travel					
Galaxy		Computer Expense		4,410													
Pension Performance		Superannuation Consultant		3,476													
Cohn Reznick		Accounting Fees		20,180													
Barrins & Associates		Accreditation Consulting		9,900								Seminar Expense		3,166			
Point Click Care		E.H.R. Software		23,620													
Constant Virtual Solutions		Computer Expense		9,299													
Waystar		Billing Software		3,030													
See Attached Schedule 21A				3,189								Entertainment Expense		(			
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL				\$					
(For legal fee disclosure, see page 39 of instructions)				\$ 131,161								TOTAL (agree to Sch. V, line 24, col. 8)				\$ 3,166	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name:

Clayton Residential Home

IDPH License ID Number:

0054155

Fiscal Year End:

12/31/2025

Schedule 21A

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gary Weintraub	Other Administrative	2.49%	\$ 44,845
Anca Zota-Oviedo	Other Administrative	0.25%	43,987
		Total	88,832

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
N/A	
	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.

N/A	
	Total
- (4)

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

N/A	
	Total
- (5)

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

\$

None

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.

\$

32,614

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?

Yes

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

N/A

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

No

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

\$

N/A
- (13)

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

Firm Name:

N/A

No
- (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.

Yes

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