

		FOR BHF USE					

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**2015  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2015)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0016634</u></p> <p><b>Facility Name:</b> <u>Clayton Residential Home</u></p> <p><b>Address:</b> <u>2026 N. Clark Street</u> <u>Chicago</u> <u>60614</u> Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 549-1840</u> <b>Fax #</b> <u>(773) 549-2036</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1969</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 282-6300</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/15</u> to <u>12/31/15</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2"><b>Paid Preparer</b></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> <b>Fax #</b> <u>(847) 282-6301</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	<b>Paid Preparer</b>	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> <b>Fax #</b> <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																							
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Facility Name & ID Number Clayton Residential Home

# 0016634 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>235</u>	Intermediate (ICF)	<u>235</u>	<u>85,775</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>235</u>	TOTALS	<u>235</u>	<u>85,775</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>51,706</u>	<u>337</u>	<u>23,922</u>	<u>75,965</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>51,706</u>	<u>337</u>	<u>23,922</u>	<u>75,965</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.56%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

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 11/28/1996

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name &amp; ID Number

Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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
	<b>A. General Services</b>										
1	Dietary	329,993	54,977	13,700	398,670		398,670		398,670		1
2	Food Purchase		459,154		459,154	(14,162)	444,992	(20)	444,972		2
3	Housekeeping	376,238	57,911		434,149		434,149		434,149		3
4	Laundry		24,387	57,510	81,897		81,897		81,897		4
5	Heat and Other Utilities			189,738	189,738		189,738	1,590	191,328		5
6	Maintenance	120,050		204,916	324,966		324,966	2,727	327,693		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	826,281	596,429	465,864	1,888,574	(14,162)	1,874,412	4,297	1,878,709		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,707,970	91,265	115,880	1,915,115		1,915,115	(46,895)	1,868,220		10
10a	Therapy										10a
11	Activities	154,979	47,256	15,801	218,036		218,036		218,036		11
12	Social Services	1,347,865		38,668	1,386,533		1,386,533		1,386,533		12
13	CNA Training										13
14	Program Transportation			3,755	3,755		3,755		3,755		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,210,814	138,521	176,504	3,525,839		3,525,839	(46,895)	3,478,944		16
	<b>C. General Administration</b>										
17	Administrative	457,813			457,813		457,813		457,813		17
18	Directors Fees										18
19	Professional Services			82,085	82,085	(8,496)	73,589	453	74,043		19
20	Dues, Fees, Subscriptions & Promotions			86,144	86,144		86,144	(50,530)	35,614		20
21	Clerical & General Office Expenses	287,767	2,606	98,558	388,931		388,931	(65,910)	323,021		21
22	Employee Benefits & Payroll Taxes			801,405	801,405	14,162	815,567		815,567		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,822	3,822		3,822		3,822		24
25	Other Admin. Staff Transportation			3,856	3,856		3,856		3,856		25
26	Insurance-Prop.Liab.Malpractice			185,434	185,434		185,434	261	185,695		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	745,580	2,606	1,261,304	2,009,490	5,666	2,015,156	(115,725)	1,899,431		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,782,675	737,556	1,903,672	7,423,903	(8,496)	7,415,407	(158,324)	7,257,083		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Clayton Residential Home

#0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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			100,191	100,191		100,191	98,341	198,532			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,110	50,110		50,110	(5,249)	44,861			32
33	Real Estate Taxes			267,497	267,497	8,496	275,993	7,007	283,000			33
34	Rent-Facility & Grounds			32,162	32,162		32,162	(15,778)	16,384			34
35	Rent-Equipment & Vehicles			10,081	10,081		10,081		10,081			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			460,041	460,041	8,496	468,537	84,321	552,857			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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):*	239,698		918,365	1,158,063		1,158,063	(1,158,063)	(0)			43
44	<b>TOTAL Special Cost Centers</b>	239,698		918,365	1,158,063		1,158,063	(1,158,063)	(0)			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,022,373	737,556	3,282,078	9,042,007		9,042,007	(1,232,067)	7,809,940			45

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,396)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	98,341	30		9
10	Interest and Other Investment Income	(5,393)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,184)	21		19
20	Contributions	(33,803)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,000)	21		24
25	Fund Raising, Advertising and Promotional	(2,500)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,228,315)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,229,271)		\$	30

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	2	
		Amount	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)	(2,796)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (2,796)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,232,067)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY

48		49		50		51		52	
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Clayton Residential Home

ID# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (13)	21	1
2	Patient Clothing	(5,186)	10	2
3	Resident Stipend	(41,709)	10	3
4	Marketing	(1,549)	43	4
5	Bank Charges	(11,513)	21	5
6	Trust Fees	(200)	21	6
7	PAC Dues	(14,388)	20	7
8	Additional R&M	7,622	06	8
9	Non Allowable Expense	(916,816)	43	9
10	Non Allowable Legal Fees	(226)	19	10
11	Capitalized R&M	(4,639)	06	11
12	Non Allowable Compensation	(239,698)	43	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
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27				27
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32				32
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,228,315)		49

Clayton Residential Home

ID# 0016634  
 Report Period Beginning: 01/01/15  
 Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
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79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(20)											(20)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,590									1,590	5
6	Maintenance	(413)		3,140									2,727	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(433)</b>		<b>4,730</b>									<b>4,297</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(46,895)											(46,895)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(46,895)</b>											<b>(46,895)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(226)		679									453	19
20	Fees, Subscriptions & Promotions	(50,691)		161									(50,530)	20
21	Clerical & General Office Expenses	(65,910)											(65,910)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			261									261	26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(116,826)</b>		<b>1,101</b>									<b>(115,725)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(164,155)</b>		<b>5,831</b>									<b>(158,324)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	98,341											98,341	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,393)			144								(5,249)	32
33	Real Estate Taxes			7,007									7,007	33
34	Rent-Facility & Grounds			(15,778)									(15,778)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>92,948</b>		<b>(8,771)</b>	<b>144</b>								<b>84,321</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,158,063)											(1,158,063)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,158,063)</b>											<b>(1,158,063)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(1,229,271)		(2,940)	144								(1,232,067)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 1,590	\$ 1,590
16	V	6 REPAIRS AND MAINT.		BARTON MANAGEMENT INC.	100.00%	3,140	3,140
17	V	19 PROFESSIONAL FEES		BARTON MANAGEMENT INC.	100.00%	679	679
18	V	20 DUES, LICENSES, FEES		BARTON MANAGEMENT INC.	100.00%	161	161
19	V	26 INSURANCE		BARTON MANAGEMENT INC.	100.00%	261	261
20	V	33 REAL ESTATE TAXES		BARTON MANAGEMENT INC.	100.00%	7,007	7,007
21	V	34 RENT OFFICE SPACE		BARTON MANAGEMENT INC.	100.00%	14,222	14,222
22	V						
23	V						
24	V						
25	V						
26	V						
27	V	34 RENT	30,000	BARTON MANAGEMENT INC.	100.00%		(30,000)
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 30,000			\$ 27,060	\$ * (2,940)

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	32 INTEREST		BARTON HEALTHCARE LLC	100.00%	48,639	\$	48,639	15
16	V								16
17	V								17
18	V								18
19	V	32 INTEREST	48,495	BARTON HEALTHCARE LLC	100.00%			(48,495)	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		\$ 48,495			\$ 48,639	\$ *	144	39

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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



Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending: 12/31/15

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name &amp; ID Number

Clayton Residential Home

#

0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	14.218%	See Attached	5.00	11.90%	Salary	\$ 33,506	17-1	1	
2	Anca Zota-Oviedo	Shareholder	Administrative	0.250%	See Attached	12.00	21.82%	Salary	31,635	17-1	2	
3	Rick Duros	COO	Administrative	0	See Attached	6.50	14.61%	Salary	67,011	17-1	3	
4	Jake Shlofrock	Relative	Clerical	0	See Attached	8.00	33.33%	Salary	3,358	21-1	4	
5	Jeffery Ross	Relative	Clerical	0	See Attached	13.00	32.50%	Salary	14,130	21-1	5	
6	Arnold Kanter	Shareholder	Administrative	0.250%	See Attached	7.00	18.67%	Salary	64,482	17-1	6	
7	Gary Weintraub	Shareholder	Administrative	2.468%	See Attached	6.00	16.22%	Salary	35,944	17-1	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	\$ 250,066		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

# 0016634 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 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	5	UTILITIES	AVAILABLE DAYS	500,425	8	\$ 9,276	\$ 85,775	\$ 1,590	1
2	6	REPAIRS AND MAINT.	AVAILABLE DAYS	500,425	8	18,320	85,775	3,140	2
3	19	PROFESSIONAL FEES	AVAILABLE DAYS	500,425	8	3,962	85,775	679	3
4	20	DUES, LICENSES, FEES	AVAILABLE DAYS	500,425	8	940	85,775	161	4
5	26	INSURANCE	AVAILABLE DAYS	500,425	8	1,522	85,775	261	5
6	33	REAL ESTATE TAXES	AVAILABLE DAYS	500,425	8	40,881	85,775	7,007	6
7	34	RENT OFFICE SPACE	AVAILABLE DAYS	500,425	8	82,971	85,775	14,222	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					\$ 157,872	\$	\$ 27,060	25



Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	8,260,001	7	409,294	981,598	48,639	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					\$ 409,294	\$	\$ 48,639	25

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home

# 0016634 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25



Facility Name & ID Number

Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>											
<b>Long-Term</b>											
1	Barton Management		X	Mortgage Payable			\$	981,598			\$ 48,639
2											
3											
4											
5											
<b>Working Capital</b>											
6	Barton Healthcare		X	Line of Credit				750,000			1,615
7											
8											
9	<b>TOTAL Facility Related</b>						\$	1,731,598			\$ 50,254
<b>B. Non-Facility Related*</b>											
10	Interest Income										(5,393)
11											
12											
13											
14	<b>TOTAL Non-Facility Related</b>						\$				\$ (5,393)
15	<b>TOTALS (line 9+line14)</b>						\$	1,731,598			\$ 44,861

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.)

Facility Name & ID Number

Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>											7								
	<b>Working Capital</b>																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Working Capital</b>											14								
	<b>B. Non-Facility Related*</b>																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	<b>TOTAL Non-Facility Related</b>											20								

\* 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' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number **Clayton Residential Home**

# **0016634**

Report Period Beginning:

**01/01/15**

Ending:

**12/31/15**

**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 2014 report.

\$ **270,796** 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.)

\$ **269,589** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(1,207)** 3

4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **275,711** 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.)**

\$ **8,496** 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

**TOTAL REFUND \$ 25,078 For 2007-08 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.

\$ **282,999** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2010	<b>287,866</b>	8
2011	<b>287,395</b>	9
2012	<b>255,208</b>	10
2013	<b>257,901</b>	11
2014	<b>262,582</b>	12

2015 Accrual = \$262,582 x 1.05 = \$275,711

\*Beginning accrual adjusted

Allocated from Barton Mangement, Inc - \$7,007

<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2014	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

**NOTES:**

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

**2014 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Clayton Residential Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016634

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-33-208-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>262,581.68</u>	\$ <u>262,581.68</u>
2. <u>05-19-112-017-0000</u>	<u>Allocated from Barton Management</u>	\$ <u>81,762.96</u>	\$ <u>7,007.26</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>344,344.64</u>	\$ <u>269,588.94</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    X    YES    \_\_\_\_\_    NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Clayton Residential Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0016634

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & 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 a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,604 B. General Construction Type: Exterior Frame Number of Stories

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an unlabeled column. Row 1: Facility, 17,608, 1967, \$ 19,250, 1. Row 2: 2, 2. Row 3: TOTALS, 17,608, \$ 19,250, 3.

Facility Name &amp; ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	235			1967	\$ 255,750	\$		\$		\$ 255,750	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1969	591,996		20			591,996	9
10	Various			1971	1,150		20			732	10
11	Various			1972	86,256		20			58,370	11
12	Various			1975	15,890		20			14,000	12
13	Various			1978	11,746		20			11,746	13
14	Various			1979	9,036		20			9,036	14
15	Various			1980	45,469		20			44,529	15
16	Various			1981	17,720		20			17,720	16
17	Various			1982	718		20			718	17
18	Various			1983	57,392		20			57,392	18
19	Various			1984	48,928		20			48,928	19
20	Various			1985	100,852		20			100,851	20
21	Various			1986	156,306		20			156,306	21
22	Various			1987	25,101		20			24,985	22
23	Various			1988	16,259		20			16,257	23
24	Various			1989	23,627		20			23,616	24
25	Various			1990	183,167		20	1,713	1,713	183,152	25
26	Various			1991	53,962		20			53,948	26
27	Various			1992	158,472		20			158,464	27
28	Various			1993	71,192		20	(214)	(214)	74,816	28
29	Various			1994	104,923		20	(17)	(17)	105,229	29
30	Various			1995	221,995		20	3,423	3,423	221,987	30
31	Various			1996	237,569		20	11,878	11,878	230,456	31
32	Various			1997	81,461		20	4,073	4,073	74,578	32
33	Various			1998	159,916		20	7,996	7,996	142,227	33
34	Various			1999	195,522		20	9,776	9,776	162,544	34
35	Various			2000	393,212		20	19,661	19,661	308,833	35
36	Various			2001	194,173		20	4,979	4,979	73,088	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15 Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2002	\$ 81,202	\$	20	\$	\$	\$ 81,202	37
38 Various	2003	176,825		20	3,994	3,994	148,510	38
39 Various	2004	133,639		20			133,639	39
40 Various	2005	173,293		20	5,021	5,021	173,293	40
41 Various	2006	63,076		20	6,308	6,308	60,148	41
42 Various	2007	150,104		20	13,758	13,758	127,884	42
43 Various	2008	54,557		20	5,456	5,456	40,765	43
44 Various	2009	140,737		20	13,337	13,337	95,669	44
45 Various	2010	92,960		20	9,487	9,487	53,833	45
46 Various	2011	7,870		20	884	884	4,011	46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67 <u>Related Building Company (Pages 12F &amp; 12G)</u>								67
68 <u>Related Party Allocations (Pages 12H &amp; 12I)</u>								68
69 <u>Financial Statement Depreciation</u>					100,191	(100,191)		69
70 TOTAL (lines 4 thru 69)		\$ 4,594,023	\$ 100,191		\$ 121,512	\$ 21,321	\$ 4,141,209	70

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



Facility Name &amp; ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

## XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,594,023	\$ 100,191		\$ 121,512	\$ 21,321	\$ 4,141,209	1
2	2012	8,253		20	825	825	3,301	2
3	2012	52,083		20	5,208	5,208	19,965	3
4	2012	51,288		20	5,129	5,129	15,814	4
5	2012	6,250		20	625	625	2,500	5
6	2013	3,790		20	758	758	2,274	6
7	2013	16,470		20	1,647	1,647	4,529	7
8	2013	3,948		20	790	790	1,777	8
9	2014	9,070		20	259	259	454	9
10	2014	6,635		20	190	190	332	10
11	2014	5,000		20	250	250	313	11
12	2014	6,575		20	329	329	575	12
13	2015	631,000		20	23,663	23,663	23,663	13
14	2015	22,445		20	1,122	1,122	1,122	14
15	2015	10,000		20	42	42	42	15
16	2015	29,986		20	125	125	125	16
17	2015	8,683		20	36	36	36	17
18	2015	8,037		20	33	33	33	18
19	2015	43,250		20	1,622	1,622	1,622	19
20	2015	4,639		20	232	232	232	20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 5,521,425	\$ 100,191		\$ 164,397	\$ 64,206	\$ 4,219,917	34

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 5,521,425	\$ 100,191		\$ 164,397	\$ 64,206	\$ 4,219,917
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 5,521,425	\$ 100,191		\$ 164,397	\$ 64,206	\$ 4,219,917

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,521,425	\$ 100,191		\$ 164,397	\$ 64,206	\$ 4,219,917	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,521,425	\$ 100,191		\$ 164,397	\$ 64,206	\$ 4,219,917	34

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,521,425	\$ 100,191		\$ 164,397	\$ 64,206	\$ 4,219,917	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,521,425	\$ 100,191		\$ 164,397	\$ 64,206	\$ 4,219,917	34

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 <b>Building Company</b>		\$	\$		\$	\$	\$
2 <b>Buildings:</b>							
3							
4							
5							
6							
7							
8 <b>Leasehold Improvements:</b>							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 <b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15 Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
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22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	<b>TOTAL (lines 1 thru 33)</b>	\$	\$		\$	\$	\$

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Related Party		\$	\$		\$	\$	\$
2 Buildings:							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15 Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
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21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	<b>TOTAL (lines 1 thru 33)</b>	\$	\$		\$	\$	\$

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



Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 632,695	\$	\$ 30,110	\$ 30,110	10	\$ 567,153	71
72	Current Year Purchases	17,992		2,256	2,256	10	2,256	72
73	Fully Depreciated Assets	544,956				10	544,956	73
74								74
75	TOTALS	\$ 1,195,643	\$	\$ 32,366	\$ 32,366		\$ 1,114,365	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	76
77		2006 FORD E350	2009	14,523		1,769	1,769	5	12,974	77
78										78
79										79
80	TOTALS			\$ 29,044	\$	\$ 1,769	\$ 1,769		\$ 27,495	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)	\$ 6,765,361	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 100,191	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 198,532	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 98,341	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,361,778	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				2,162			5
6	Allocated from Barton Management				14,222			6
7	TOTAL				\$ 16,384			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: \$ 10,081 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2016 \$ \_\_\_\_\_

13. \_\_\_\_\_/2017 \$ \_\_\_\_\_

14. \_\_\_\_\_/2018 \$ \_\_\_\_\_

\* 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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					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 prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): <a href="#">See Supplemental</a>															13
14	<b>TOTAL</b>			\$		\$		\$		\$		\$		\$		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.

Facility Name &amp; ID Number Clayton Residential Home

# 0016634

Report Period Beginning: 01/01/15

Ending:

12/31/15

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 632,472	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,896,152		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,131		6
7	Other Prepaid Expenses	35,463		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,649,218	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	255,750		14
15	Leasehold Improvements, at Historical Cost	4,918,566		15
16	Equipment, at Historical Cost	1,467,430		16
17	Accumulated Depreciation (book methods)	(4,543,754)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,097,992	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,747,210	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 216,877	\$	26
27	Officer's Accounts Payable	10,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	750,000		29
30	Accrued Salaries Payable	324,363		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,917		31
32	Accrued Real Estate Taxes(Sch.IX-B)	275,711		32
33	Accrued Interest Payable	1,089		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,851		35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	152,341		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,749,149	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	981,598		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 981,598	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,730,747	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,016,463	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,747,210	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 2,267,737	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>PY Office</u>	(110,000)	<b>3</b>
<b>4</b>	<u>PY Revenue</u>	(207,482)	<b>4</b>
<b>5</b>	<u>PY Depreciation</u>	(75,017)	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,875,238	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	151,225	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(10,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 141,225	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 2,016,463	<b>24</b> *

\* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,218,795	1
2	Discounts and Allowances for all Levels	(56,047)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,162,748</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,393	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 5,393</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	25,091	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 25,091</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 9,193,232</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,888,574	31
32	Health Care	3,525,839	32
33	General Administration	2,009,490	33
<b>B. Capital Expense</b>			
34	Ownership	460,041	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,158,063	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 9,042,007</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>151,225</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 151,225</b>	<b>43</b>

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 9,087,358	44
45	Private Pay - Net Inpatient Revenue	75,390	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 9,162,748</b>	<b>49</b>

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

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

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

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

Facility Name & ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	2,630	2,630	\$ 152,167	\$ 57.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,944	2,159	70,535	32.67	3
4	Licensed Practical Nurses	21,682	24,091	591,008	24.53	4
5	CNAs & Orderlies	68,343	75,936	849,023	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,292	12,315	154,979	12.58	10
11	Social Service Workers	69,086	76,761	1,347,865	17.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,949	24,388	329,993	13.53	15
16	Dishwashers					16
17	Maintenance Workers	5,795	6,439	120,050	18.64	17
18	Housekeepers	22,475	27,172	376,238	13.85	18
19	Laundry					19
20	Administrator	2,200	2,200	134,721	61.24	20
21	Assistant Administrator	2,300	2,300	90,514	39.35	21
22	Other Administrative	4,115	4,115	232,578	56.52	22
23	Office Manager					23
24	Clerical	9,163	9,936	287,767	28.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,080	45,237	21.75	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,142	3,494	239,698	68.60	33
34	TOTAL (lines 1 - 33)	248,196	276,016	\$ 5,022,373 *	\$ 18.20	34

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

\*\* See instructions.

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	240	\$ 13,700	01-03	35
36	Medical Director	96	2,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	289	15,801	11-03	44
45	Social Service Consultant	32	1,933	12-03	45
46	Other(specify)				46
47	Consultant - Psychological	200	12,735	12-03	47
48	Consultant - Psychiatric Director	414	24,000	12-03	48
49	TOTAL (lines 35 - 48)	1,367	\$ 72,369		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,852	\$ 114,080	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,852	\$ 114,080		53



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jessica Lyke	Administrator	0	\$ 134,721	Workers' Compensation Insurance	\$ 61,794	IDPH License Fee	\$ 1,990	
Gretchen Sand	Asst. Admin	0	90,514	Unemployment Compensation Insurance	38,539	Advertising: Employee Recruitment	148	
Arnie Kanter	Administrative	0.25%	64,482	FICA Taxes	349,696	Health Care Worker Background Check		
John Shlofrock	Administrative	14.218%	33,506	Employee Health Insurance	272,075	(Indicate # of checks performed 370 )	3,700	
Rick Duros	C.O.O.	0	67,011	Employee Meals	14,162	Patient Background Checks	62	
Gary Weintraub	Administrative	2.47%	35,944	Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscription	16,370	
See Supplemental Schedule			31,635	Christmas Expense	5,670	License, Permits, & Fees	12,625	
TOTAL (agree to Schedule V, line 17, col. 1)				Union Pension Contribution	22,561	Allocated from Barton Mgmt	161	
(List each licensed administrator separately.)			\$ 457,813	401K Contribution	31,237			
B. Administrative - Other				Employee Benefit	19,833			
Description			Amount			Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 815,567	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,614	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
FRR/Marcum LLP	Accounting		\$ 12,600				Out-of-State Travel	\$
Ascensus	Accounting		3,284					
Pension Performance	Accounting		2,490					
HK Payroll Services	Accounting		256				In-State Travel	
Personnel Planners	Unemployment Consultant		2,043					
Paychex of New York LLC	Payroll Processing		3,492					
ADP LLC	Payroll Processing		1,133					
HiNext LLC	Computer Expense		2,733				Seminar Expense	3,822
A-Tech Computer Service, Inc.	Computer Expense		5,513					
Constant Virtual Solutions	Computer Expense		2,090					
Barton Management	Computer Expense/Payroll		4,413					
See Supplemental Schedule			42,039				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)			\$ 82,086				TOTAL	\$ 3,822

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Clayton Residential Home

# 0016634

Report Period Beginning:

01/01/15

Ending: 12/31/15

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. Alliance for Living \$ 30,484 Yes
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period? Yes  
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ \_\_\_\_\_  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,162 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.