

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0053934</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>The Carlton at the Lake</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>725 W Montrose Ave</u> <u>Chicago</u> <u>60613</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>(773) 929-1700</u> Fax # <u>(773) 929-3066</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>11/10/2015</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) _____ 05/27/2020 (Date)	
		* Subject to the attached Accountants' Consulting Report	
		(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>	
		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	
		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	
		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	

Facility Name & ID Number

The Carlton at the Lake

#0053934

Report Period Beginning:01/01/20

Ending:12/31/20

III. STATISTICAL DATA

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

N/A

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	244	Skilled (SNF)	244	89,304
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	244	TOTALS	244	89,304

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
8	SNF	53,663	3,147	6,493	63,303
9	SNF/PED				
10	ICF	2,568			2,568
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	56,231	3,147	6,493	65,871

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

73.76%

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

None

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

X

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

YES

NO

X

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

Date started

11/10/2015

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

YES

X

Date

11/10/2015

NO

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

YES

X

NO

If YES, enter number of beds certified

244

and days of care provided

5,325

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2020

Fiscal Year:

12/31/2020

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

Facility Name & ID Number The Carlton at the Lake # 0053934 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		6,398	1,433,572	1,439,970		1,439,970	4,605	1,444,575			1
2	Food Purchase							8,762	8,762			2
3	Housekeeping		252	488,681	488,933		488,933	2,987	491,920			3
4	Laundry	154,778	37,123		191,901		191,901	203	192,104			4
5	Heat and Other Utilities			223,492	223,492		223,492	(5,778)	217,714			5
6	Maintenance	112,242	15,134	201,101	328,477		328,477	13,156	341,633			6
7	Other (specify):*											7
8	TOTAL General Services	267,020	58,907	2,346,846	2,672,773		2,672,773	23,934	2,696,707			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	5,724,355	701,217	60,047	6,485,619		6,485,619	143,851	6,629,470			10
10a	Therapy	153,546			153,546		153,546		153,546			10a
11	Activities	147,935	7,560	1,109	156,604		156,604	12	156,616			11
12	Social Services	352,368	46,704	3,783	402,855		402,855	8,000	410,855			12
13	CNA Training											13
14	Program Transportation			27,030	27,030		27,030		27,030			14
15	Other (specify):*							8,298	8,298			15
16	TOTAL Health Care and Programs	6,378,204	755,481	121,969	7,255,654		7,255,654	160,161	7,415,815			16
	C. General Administration											
17	Administrative	199,974			199,974		199,974	89,056	289,030			17
18	Directors Fees											18
19	Professional Services			158,903	158,903	(534)	158,369	(17,075)	141,294			19
20	Dues, Fees, Subscriptions & Promotions			110,496	110,496		110,496	(56,839)	53,657			20
21	Clerical & General Office Expenses	228,893	3,298	528,192	760,383		760,383	48,876	809,259			21
22	Employee Benefits & Payroll Taxes			1,098,958	1,098,958		1,098,958		1,098,958			22
23	Inservice Training & Education											23
24	Travel and Seminar			976	976		976	199	1,175			24
25	Other Admin. Staff Transportation			1,743	1,743		1,743	6,658	8,401			25
26	Insurance-Prop.Liab.Malpractice			700,144	700,144		700,144	567	700,711			26
27	Other (specify):*							35,694	35,694			27
28	TOTAL General Administration	428,867	3,298	2,599,412	3,031,577	(534)	3,031,043	107,135	3,138,179			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,074,091	817,686	5,068,227	12,960,004	(534)	12,959,470	291,230	13,250,700			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							159,051	159,051			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(0)	(0)			32
33	Real Estate Taxes			607,679	607,679	534	608,213	4,905	613,118			33
34	Rent-Facility & Grounds			1,896,827	1,896,827		1,896,827	139	1,896,966			34
35	Rent-Equipment & Vehicles			22,810	22,810		22,810	6,467	29,277			35
36	Other (specify):*											36
37	TOTAL Ownership			2,527,316	2,527,316	534	2,527,850	170,562	2,698,412			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	378,282	612,258	903,235	1,893,775		1,893,775	(33,609)	1,860,166			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			519,874	519,874		519,874		519,874			42
43	Other (specify):*			865,139	865,139		865,139	(865,139)	(0)			43
44	TOTAL Special Cost Centers	378,282	612,258	2,288,248	3,278,788		3,278,788	(898,749)	2,380,039			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,452,373	1,429,944	9,883,791	18,766,108		18,766,108	(436,957)	18,329,151			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,336)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	149,444	30		9
10	Interest and Other Investment Income	(5,399)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,238)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(130)	21		18
19	Entertainment	(5,467)	21		19
20	Contributions	(29,928)	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	(301,677)	21		24
25	Fund Raising, Advertising and Promotional	(5,389)	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	(966,523)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,176,643)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	739,686		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 739,686		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (436,957)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Non-Allowable Expense	\$ (863,115)	43	1
2	Patient Personal Items	(1,870)	10	2
3	Bank Charges	(6,874)	21	3
4	Sequestration Expense	(22,254)	21	4
5	Pharmacy Discounts	(476)	10	5
6	Miscellaneous Income	(609)	21	6
7	Additional R&M	515	06	7
8	Capitalized R&M	(3,840)	06	8
9	PAC Dues	(25,982)	20	9
10	Non-Allowable Expense	(2,024)	43	10
11	Non-Allowable Legal Fees	(39,462)	19	11
12	Prior Year Dues	(519)	20	12
13	Non Allowable Permits	(13)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(966,523)		49

DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS

Page 58

The Carlson at the Lake

08/03/24

01/01/25

12/01/20

Report Period Beginning:

Ending:

Sch. V Line

Amount

Reference

NON-ALLOWABLE EXPENSES

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Summary A

12/31/20

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Carlton at the Lake # 0053934 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	149,444				9,607							159,051	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,399)				5,399							(0)	32
33	Real Estate Taxes					4,905							4,905	33
34	Rent-Facility & Grounds			45,208		(45,069)							139	34
35	Rent-Equipment & Vehicles				6,467								6,467	35
36	Other (specify):*													36
37	TOTAL Ownership	144,045		45,208	6,467	(25,158)							170,562	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(33,609)				(33,609)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(865,139)											(865,139)	43
44	TOTAL Special Cost Centers	(865,139)							(33,609)				(898,749)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,176,643)		789,431	14,765	(20,682)	(2,713)	(7,505)	(33,609)				(436,957)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago			Building Company	1
2	Doros Generation Trust	50.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Chalet Skilled Nursing Facility LLC	Chicago				28
29			Clark Skilled Nursing Facility	Chicago				29
30			Elmbrook Skilled Nursing Facility LLC	Elmhurst				30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Evanston Skilled Nursing Facility LLC	Evanston				1
2			Grove at the Lake Skilled Nursing Facility LLC	Zion				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
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24								24
25								25
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28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 4,581	\$ 4,581	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		24	24	16
17	V	02	Food		Legacy Healthcare Financial Services		8,762	8,762	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,987	2,987	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		203	203	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		14,133	14,133	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		839	839	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		116,976	116,976	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		11,041	11,041	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		25,131	25,131	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		7,969	7,969	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		12	12	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		31	31	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		89,056	89,056	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		29,236	29,236	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		4,992	4,992	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		359,323	359,323	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		26,202	26,202	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		199	199	33
34	V	25	Travel		Legacy Healthcare Financial Services		6,658	6,658	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		176	176	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		35,694	35,694	36
37	V	34	Rent		Legacy Healthcare Financial Services		45,069	45,069	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		139	139	38
39	Total			\$			\$ 789,431	\$ * 789,431	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		602	\$	602
16	V	35	Auto Rental		Legacy Healthcare Financial Services		5,866		5,866
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		8,298		8,298
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			14,765	\$ *	14,765

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	CF St. Louis LLC		\$ 1,558	\$ 1,558	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,509	1,509	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		534	534	17
18	V	19	Accounting Fees		CF St. Louis LLC		121	121	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		362	362	20
21	V	26	Insurance		CF St. Louis LLC		391	391	21
22	V	30	Depreciation		CF St. Louis LLC		9,607	9,607	22
23	V	32	Interest Expense		CF St. Louis LLC		5,399	5,399	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		4,905	4,905	24
25	V								25
26	V	34	Rent	45,069	CF St. Louis LLC			(45,069)	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			\$ 45,069			\$ 24,387	\$ * (20,682)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	\$ 9,000	ReMED Services		\$ 6,287	\$ (2,713)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 9,000			\$ 6,287	\$ * (2,713)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 32,758	ProPay HR LLC		\$ 25,253	\$ (7,505)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 32,758			\$ 25,253	\$ * (7,505)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	\$ 82,578	Lifescan Labs of Illinois		\$ 48,969	\$ (33,609)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 82,578			\$ 48,969	\$ * (33,609)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Ending: 12/31/20

Facility Name & ID Number The Carlton at the Lake# 0053934

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Legacy Healthcare Financial Services

Street Address

3450 Oakton Street

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 679-9797

Fax Number

(847) 683-2900

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	01	Dietician Salary	Available Bed Days	53	\$ 130,303	\$ 130,303	89,304	\$ 4,581	1
2	01	Dietary Supplies	Available Bed Days	53	697		89,304	24	2
3	02	Food	Available Bed Days	53	249,220		89,304	8,762	3
4	03	Housekeeping	Available Bed Days	53	84,952		89,304	2,987	4
5	04	Linen Replacement	Available Bed Days	53	5,771		89,304	203	5
6	06	Maintenance Salary	Available Bed Days	53	401,986	401,986	89,304	14,133	6
7	06	Repairs & Maintenance	Available Bed Days	53	23,857		89,304	839	7
8	10	Nursing Salary	Available Bed Days	53	3,327,223	3,327,223	89,304	116,976	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	53	314,035		89,304	11,041	9
10	10	Medical Supplies	Available Bed Days	53	714,824		89,304	25,131	10
11	12	Social Service Salary	Available Bed Days	53	226,662	226,662	89,304	7,969	11
12	11	Activities Program	Available Bed Days	53	335		89,304	12	12
13	12	Social Service Consultant	Available Bed Days	53	893		89,304	31	13
14	17	COO / Administrative Salary	Available Bed Days	53	2,533,078	2,533,078	89,304	89,056	14
15	19	Professional Fees	Available Bed Days	53	831,592		89,304	29,236	15
16	20	Dues / Licenses / Permits	Available Bed Days	53	141,983		89,304	4,992	16
17	21	Clerical & General Wages	Available Bed Days	53	10,220,453	10,220,453	89,304	359,323	17
18	21	Clerical & Office Expense	Available Bed Days	53	745,293		89,304	26,202	18
19	24	Education & Seminars	Available Bed Days	53	5,655		89,304	199	19
20	25	Travel	Available Bed Days	53	189,364		89,304	6,658	20
21	26	Insurance - General	Available Bed Days	53	4,997		89,304	176	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	53	1,015,274		89,304	35,694	22
23	34	Rent	Available Bed Days	53	1,281,940		89,304	45,069	23
24	34	Offsite Storage / Parking	Available Bed Days	53	3,949		89,304	139	24
25	TOTALS				\$ 22,454,338	\$ 16,839,706		\$ 789,431	25

Ending: 12/31/20

(847) 683-2900

IL478-2471

Ending: 12/31/20

(847) 676-5348

Ending: 12/31/20

()

Ending: 12/31/20

()

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Allocated from CF St. Louis		X									5,399	6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$ 5,399	9
	B. Non-Facility Related*												
10	Interest Income											(5,399)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (5,399)	14
15	TOTALS (line 9+line14)						\$		\$			\$ (0)	15

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

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

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

B. Real Estate Taxes

[illegible]

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.

FACILITY NAME The Carlton at the Lake COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053934

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

Page 10A

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Carlton at the Lake COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053934

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2	Allocated from CF St. Louis, LLC			6,938	2
3	TOTALS			\$ 6,938	3

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2015		64,202		20	3,210	3,210	27,404
10	Various		2016		192,362		20	9,618	9,618	55,774
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										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Carlton at the Lake

0053934

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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51									51
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		326,552	8,857		15,527	6,670	69,463	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 583,117	\$ 8,857		\$ 28,355	\$ 19,498	\$ 152,641	70

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

Facility Name & ID Number The Carlton at the Lake

0053934

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 583,117	\$ 8,857		\$ 28,355	\$ 19,498	\$ 152,641	1
2	Interior Painting In Conference Rooms/Chapel/Cabinets/Wallpaper	2017	5,918		20	296	296	1,134	2
3	Carpeting In Chapel & Conference Room	2017	6,724		20	336	336	1,288	3
4	Removal Of Old Wallpaper & Bases On 3Rd/4Th/5Th Floors & P	2017	45,000		20	2,250	2,250	6,750	4
5	Intstall New Piping For Ejector Pumps/Control Panel/Supports Fo	2017	14,514		20	726	726	2,297	5
6	Flooring For Physican Lounge	2017	2,698		20	135	135	1,260	6
7	3Rd Floor Flooring Installation	2017	26,996		20	1,350	1,350	3,824	7
8	Fire Alarms	2017	5,168		20	258	258	1,034	8
9	Fire Alarms	2017	7,284		20	364	364	1,457	9
10	Trane Heat Exchangers	2017	3,480		20	174	174	696	10
11	New Valve And Gasket - Therapy Room	2017	8,106		20	405	405	1,621	11
12	1St Floor Pt/Dining Floor Tiles	2017	44,035		20	2,202	2,202	8,807	12
13	Bathroom Wall Tiles/Wallper/Resident Rooms	2017	20,784		20	1,039	1,039	4,157	13
14	Vinyl Plank And Base-2Nd Floor Resident Rooms	2017	18,785		20	939	939	3,757	14
15	Restroom Lock And Labor	2017	17,271		20	864	864	3,454	15
16	New Lighting Fixtures, Quad Outlets, New Outlets	2017	12,415		20	621	621	2,483	16
17	Grab Bar For Shower, Drywall, Sinks	2017	9,720		20	486	486	1,944	17
18	Replaced Ceiling Tiles-2Nd Floor Rooms	2017	9,440		20	472	472	1,888	18
19	Bathroom Plumbing Fixtures	2017	6,359		20	318	318	1,272	19
20	Repaired Hot Water Mixing Valve	2017	4,998		20	250	250	1,000	20
21	Physical Therapy Room, Bathrooms-Design Fees	2017	12,360		20	618	618	2,472	21
22	Cabinets - 1St Floor Pt/Dining Room	2017	3,653		20	183	183	731	22
23	Sink And Counter - 1St Floor Therapy Rooms	2017	3,599		20	180	180	720	23
24	Signs For Facility-Wide	2017	3,454		20	173	173	691	24
25	Repaired Plumbing In Shower Rooms	2017	3,094		20	155	155	619	25
26	Fire Proof Light Covers/Hvac Cover - 1St Floor Pt/Dining Room,	2017	2,576		20	129	129	515	26
27	Handrail Removal/Mounting Plate - 1St Fl Pt/Dining Rm	2017	10,505		20	525	525	2,101	27
28	Demo Vinyl Floor/Plans/Tiles-Doorways - 1St Floor	2017	10,330		20	516	516	2,066	28
29	1St/2Nd Fl Pt/Dining- Carpentry/Drywall/Doors/Lighting	2017	624,395		20	31,220	31,220	107,608	29
30	3Rd Floor - New Circuits And Duplex Outlets (\$33,000)	2018	30,545		20	1,527	1,527	4,979	30
31	Booster Pump Installation (\$5,370)	2018	4,970		20	249	249	1,124	31
32	Chandalier Installation, Paiting-Lobby Area,Carpet -Fireplace Rn	2018	5,091		20	255	255	1,013	32
33	Remove And Replace 100 Ton Compressor (\$26,891)	2018	24,891		20	1,245	1,245	3,734	33
34	TOTAL (lines 1 thru 33)		\$ 1,592,274	\$ 8,857		\$ 78,813	\$ 69,956	\$ 331,135	34

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

Facility Name & ID Number The Carlton at the Lake

0053934

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,592,274	\$ 8,857		\$ 78,813	\$ 69,956	\$ 331,135	1
2	Repair Front Façade, Tuckpoint Large Cracks, 3Rd-5Th Flr Ligh	2018	2,545		20	127	127	382	2
3	System Piping - Install Plugs, Cooling Tower Repair (\$27,655)	2018	25,597		20	1,280	1,280	3,840	3
4	Condensor Installation, 3 Ton Ac Unit - Elevator Shaft (\$5,635)	2018	5,216		20	261	261	782	4
5	Hot Water Boiler Repair (\$14,687)	2018	13,594		20	680	680	2,039	5
6	Resident Room Signs, Other Room Signs (\$21,808)	2018	20,185		20	1,009	1,009	4,037	6
7	Install Magnetic Lock/Door Bell - Main Door (\$3,649)	2019	3,377		20	169	169	647	7
8	Rms 318/319 - Install Emergency Circuits & Duplex Outlets (\$6,00	2019	5,554		20	278	278	728	8
9	Provide & Install Roller Guides On Both Elevators (\$13,000)	2019	12,033		20	602	602	1,468	9
10	Installation Of Back Door Alarm And Delivery Door Alarm (\$4,40	2019	4,270		20	213	213	476	10
11	Install (2) Chiller Tvx Power Head Assemblies (\$4,608)	2019	4,465		20	223	223	415	11
12	Electric For Split Unit In Elevator Rm With Pump & Compressor	2019	2,592		20	130	130	690	12
13	Fire Alarm Panel (\$8,865)	2019	8,591		20	430	430	957	13
14	Automatic Door Repair - New Bottom Track (\$4,150)	2019	4,022		20	201	201	478	14
15	New P-Teck Window Units In Dining/Lounge Rooms (\$12,960)	2019	12,560		20	628	628	718	15
16	Ac Unit (\$4,948)	2019	4,795		20	240	240	308	16
17	Elevator Upgrade (\$13,000)	2019	12,682		20	634	634	634	17
18	Installation Of Carpet Tiles On 2Nd Floor (\$10,757)	2020	10,494		20	525	525	525	18
19	Elevator # 2 Door Lock Assembly Repair (\$4,500)	2020	4,390		20	219	219	225	19
20	Fix 27 Leaking Bathrooms, Install P-Trap Covers,Valve And Supp	2020	3,536		20	177	177	181	20
21	2Nd Floor Carpet Removal And Tile Installation (\$10,900)	2020	10,633		20	532	532	545	21
22	Electrical Work - Vent Wing Power Distribution (\$11,875)	2020	11,584		20	579	579	579	22
23	Elevator # 2 Door Repair - Hoistway And Car Gate,Clutch And D	2020	12,194		20	610	610	625	23
24	Repair Damaged Elevator Door-Hoistway And Car Door (\$4,500)	2020	4,390		20	219	219	225	24
25	Boiler - Pump And Flow Switch Repair (\$5,767)	2020	5,625		20	281	281	281	25
26	Main Air Handler Coil Leak Repair (\$14,785)	2020	14,422		20	721	721	721	26
27	Elevator Door Lock Assembly Repair (\$4,208)	2020	4,105		20	205	205	205	27
28	Chiller Repair - Relief Valve (\$8,689)	2020	8,476		20	424	424	424	28
29	Remodel 27 Bathrooms- Paint, Fix Toilet Leaks (\$9,800)	2020	9,560		20	478	478	490	29
30	Boiler Pipe Insulation (\$4,972)	2020	4,850		20	243	243	243	30
31	Electrical Work - Rewire Cables For Resident Rooms (\$7,594)	2020	7,407		20	370	370	370	31
32	Install New Domestic Hot Water Boiler (\$14,875)	2020	14,511		20	726	726	726	32
33	Replaced Pressure Swtch Inside Fire Pump Controller (\$2,697)	2020	2,631		20	132	132	135	33
34	TOTAL (lines 1 thru 33)		\$ 1,863,160	\$ 8,857		\$ 92,357	\$ 83,500	\$ 356,233	34

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

Facility Name & ID Number The Carlton at the Lake

0053934

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,863,160	\$ 8,857		\$ 92,357	\$ 83,500	\$ 356,233	1
2	Elevator Dr Repair - 2Nd Flr Car 2, New Base Plate,Guard,Hange	2020	3,746		20	187	187	192	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 1,866,906	\$ 8,857		\$ 92,545	\$ 83,688	\$ 356,425	34

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

Facility Name & ID Number The Carlton at the Lake

0053934

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,866,906	\$ 8,857		\$ 92,545	\$ 83,688	\$ 356,425	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,866,906	\$ 8,857		\$ 92,545	\$ 83,688	\$ 356,425	34

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

Facility Name & ID Number The Carlton at the Lake

0053934

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

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

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

Facility Name & ID Number The Carlton at the Lake

0053934

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number The Carlton at the Lake

0053934

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	37,361	1,735	35	1,067	(667)	5,337	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	231,957	5,722	20	11,598	5,876	57,989	9
10	Allocated from CF St. Louis, LLC	2017	5,384	133	20	269	136	1,077	10
11	Allocated from CF St. Louis, LLC	2019	48,797	1,204	20	2,440	1,236	4,880	11
12	Allocated from CF St. Louis, LLC	2019	2,567	63	20	128	65	128	12
13									13
14	Allocated from Legacy HC	2018	277		20	14	14	42	14
15	Allocated from Legacy HC	2020	209		20	10	10	10	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)		\$ 326,552	\$ 8,857		\$ 15,527	\$ 6,670	\$ 69,463	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 326,552	\$ 8,857		\$ 15,527	\$ 6,670	\$ 69,463	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 326,552	\$ 8,857		\$ 15,527	\$ 6,670	\$ 69,463	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 659,652	\$ 748	\$ 65,965	\$ 65,217	10	\$ 300,159	71
72	Current Year Purchases	6,916	2	541	539	10	541	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 666,569	\$ 750	\$ 66,506	\$ 65,756		\$ 300,700	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	2,540,413
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	9,607
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	159,051
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	149,444
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	657,126

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Architect Fees	\$ 8,830
93		
94		
95		\$ 8,830

* 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: Carlton Associates Limited Partnership
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:	1971	244		\$ 1,896,827			3
4	Additions							4
5	Allocated from Legacy Financial				139			5
6								6
7	TOTAL		244		\$ 1,896,966			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: \$ 18,528
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford Ecoline	\$ 407.00	\$ 4,884	17
18	Allocated from Legacy Financial			5,866	18
19					19
20					20
21	TOTAL		\$ 407	\$ 10,750	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 223,860	\$		\$ 223,860	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			194,694			194,694	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			264,675			264,675	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				305,412		305,412	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			378,282		220,006	306,846		905,134	13
14	TOTAL			\$ 378,282		\$ 903,235	\$ 612,258		\$ 1,893,775	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 72,108	\$	1
2	Cash-Patient Deposits	10,962		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,817,596		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,609		6
7	Other Prepaid Expenses	594,119		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	46,168		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,552,562	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,058,473		15
16	Equipment, at Historical Cost	1,193,304		16
17	Accumulated Depreciation (book methods)	(783,756)		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): See Attached	1,698,771		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,166,792	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,719,354	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 806,793	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	422,659		30
31	Accrued Taxes Payable (excluding real estate taxes)	329,375		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,953,042		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,511,869	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,645,057		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,645,057	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,156,926	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (437,572)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,719,354	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (328,785)	1
2	Restatements (describe):		2
3	Equity Restatement	(291,920)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (620,705)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	183,133	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 183,133	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (437,572)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Carlton at the Lake# 0053934Report Period Beginning: 01/01/20Ending: 12/31/20**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 21,848,159	1
2	Discounts and Allowances for all Levels	(7,361,645)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,486,514	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,125,688	6
7	Oxygen	5,958	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,131,646	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	288,671	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,176	19
20	Radiology and X-Ray		20
21	Other Medical Services	91,300	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 430,147	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	38,302	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,302	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	1,862,632	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,862,632	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,949,241	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,672,773	31
32	Health Care	7,255,654	32
33	General Administration	3,031,577	33
	B. Capital Expense		
34	Ownership	2,527,316	34
	C. Ancillary Expense		
35	Special Cost Centers	2,758,914	35
36	Provider Participation Fee	519,874	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,766,108	40
41	Income before Income Taxes (line 30 minus line 40)**	183,133	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 183,133	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 11,745,598	44
45	Private Pay - Net Inpatient Revenue	581,068	45
46	Medicare - Net Inpatient Revenue	1,789,944	46
47	Other-(specify) <u>Insurance</u>	369,904	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,486,514	49

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,952	2,096	\$ 125,066	\$ 59.67	1
2	Assistant Director of Nursing	1,880	2,151	103,091	47.93	2
3	Registered Nurses	50,617	62,240	2,451,618	39.39	3
4	Licensed Practical Nurses	28,935	36,714	1,238,899	33.74	4
5	CNAs & Orderlies	78,576	97,971	1,732,276	17.68	5
6	CNA Trainees					6
7	Licensed Therapist	10,286	11,209	378,282	33.75	7
8	Rehab/Therapy Aides	5,560	6,457	153,546	23.78	8
9	Activity Director	1,976	2,056	40,114	19.51	9
10	Activity Assistants	6,335	7,340	107,821	14.69	10
11	Social Service Workers	8,272	9,121	207,348	22.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,472	3,804	112,242	29.51	17
18	Housekeepers					18
19	Laundry	9,440	10,250	154,778	15.10	19
20	Administrator	2,032	2,180	132,786	60.91	20
21	Assistant Administrator	1,848	2,079	67,188	32.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,947	12,971	228,893	17.65	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	1,864	2,080	47,875	23.02	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	8,310	9,642	170,551	17.69	33
34	TOTAL (lines 1 - 33)	233,302	280,361	\$ 7,452,374 *	\$ 26.58	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 1,433,572	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	54,249	10-03	38
39	Pharmacist Consultant	Monthly	5,798	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	Monthly	1,109	11-03	44
45	Social Service Consultant	Monthly	3,783	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,528,511		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Joanne Ventrella	Administrator	0	\$ 132,786
Sydney Garver	Assistant Admin	0	32,895
Thomas Cicero	Assistant Admin	0	34,293
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 199,974
B. Administrative - Other			
Description			Amount
		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Marcum LLP	Accounting	\$	24,000
Onyx Procurement Solutions	Procurement Services		15,070
ProPay HR LLC	Payroll Processing		32,758
2401 Incorporated of Illinois	Architect Fees		2,550
Achieve Accreditation LLC	Accreditation Services		8,452
Compliagent	Compliance Services		2,043
Cortex Health Inc	Data Processing		10,020
Hygieneering, Inc.	Environmental Consultant		917
Jensen Hughes, Inc.	Risk-Based Engineering		6,250
Language Line Services	Interpreter		316
See Attached	Legal		45,048
See Supplemental Schedule			11,479
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 158,902
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	127,160
Unemployment Compensation Insurance			30,090
FICA Taxes			570,107
Employee Health Insurance			263,845
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension			37,776
401K			19,024
Other Employee Benefits			19,779
Employee Physical Exams			11,447
Voluntary Benefit Contributions			19,729
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,098,958
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,824
Advertising: Employee Recruitment			400
Health Care Worker Background Check (Indicate # of checks performed _____)	78		780
Patient Background Checks	227		2,270
Dues & Subscriptions			38,697
Licenses & Fees			4,694
See Supplemental Schedule			4,993
Less: Public Relations Expense		(	
Non-allowable advertising		(	
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 53,657
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			976
See Supplemental Schedule			199
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	1,175

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCL- \$40,565, IHCA - \$20,739
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,413 Line 10
- (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. \$ 519,874
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- 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.