

Facility Name & ID Number Carlton At The Lake

0053934 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	89,060	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	244	TOTALS	244	89,060	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	56,657	5,220	6,052	67,929	8
9	SNF/PED					9
10	ICF	2,711			2,711	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,368	5,220	6,052	70,640	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.32%

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

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 11/10/2015

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/10/2015 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 244 and days of care provided 5,072

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Carlton At The Lake # 0053934 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	558,565	56,698	17,717	632,980		632,980	1,638	634,618		1
2	Food Purchase		470,273		470,273	(80,592)	389,681	(18,265)	371,416		2
3	Housekeeping	226,109	51,793	2,210	280,112		280,112	2,576	282,688		3
4	Laundry	112,266	39,649	(196)	151,719		151,719	16	151,735		4
5	Heat and Other Utilities			242,366	242,366		242,366	1,532	243,898		5
6	Maintenance	142,634	23,756	219,999	386,389		386,389	16,514	402,903		6
7	Other (specify):*										7
8	TOTAL General Services	1,039,574	642,169	482,096	2,163,839	(80,592)	2,083,247	4,011	2,087,258		8
	B. Health Care and Programs										
9	Medical Director			37,587	37,587		37,587		37,587		9
10	Nursing and Medical Records	4,354,720	122,661	69,755	4,547,136		4,547,136	74,254	4,621,390		10
10a	Therapy	291,174			291,174		291,174		291,174		10a
11	Activities	138,475	3,588	951	143,014		143,014	102	143,116		11
12	Social Services	295,950		1,746	297,696		297,696	6,377	304,073		12
13	CNA Training										13
14	Program Transportation			12,194	12,194		12,194		12,194		14
15	Other (specify):*							11,746	11,746		15
16	TOTAL Health Care and Programs	5,080,319	126,249	122,233	5,328,801		5,328,801	92,480	5,421,281		16
	C. General Administration										
17	Administrative	175,357			175,357		175,357	135,640	310,997		17
18	Directors Fees										18
19	Professional Services			140,367	140,367		140,367	(4,597)	135,770		19
20	Dues, Fees, Subscriptions & Promotions			96,024	96,024		96,024	(54,233)	41,791		20
21	Clerical & General Office Expenses	262,877	6,675	646,328	915,880		915,880	84,278	1,000,158		21
22	Employee Benefits & Payroll Taxes			1,030,795	1,030,795	80,592	1,111,387	(11,726)	1,099,661		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,961	1,961		1,961	4,494	6,455		24
25	Other Admin. Staff Transportation			1,079	1,079		1,079		1,079		25
26	Insurance-Prop.Liab.Malpractice			552,515	552,515		552,515	8,226	560,741		26
27	Other (specify):*							85,955	85,955		27
28	TOTAL General Administration	438,234	6,675	2,469,069	2,913,978	80,592	2,994,570	248,035	3,242,605		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,558,127	775,093	3,073,398	10,406,618		10,406,618	344,526	10,751,144		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 & ID Number Carlton At The Lake

#0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			280,444	280,444		280,444	(133,853)	146,591			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,384	82,384		82,384	(39,382)	43,002			32
33	Real Estate Taxes			426,600	426,600		426,600	31,340	457,940			33
34	Rent-Facility & Grounds			2,250,000	2,250,000		2,250,000	235	2,250,235			34
35	Rent-Equipment & Vehicles			40,783	40,783		40,783	(2,742)	38,041			35
36	Other (specify):*											36
37	TOTAL Ownership			3,080,211	3,080,211		3,080,211	(144,401)	2,935,810			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	68,806	469,968	989,786	1,528,560		1,528,560		1,528,560			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			458,304	458,304		458,304		458,304			42
43	Other (specify):*			798,685	798,685		798,685	(798,685)				43
44	TOTAL Special Cost Centers	68,806	469,968	2,246,775	2,785,549		2,785,549	(798,685)	1,986,864			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,626,933	1,245,061	8,400,384	16,272,378		16,272,378	(598,559)	15,673,819			45

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

Carlton At The Lake

ID# 0053934

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (867)	21	1
2	Patient Personal Items	(4,007)	10	2
3	Bank Charges	(4,680)	21	3
4	Sequestration Expense	(57,162)	21	4
5	Pharmacy Discounts	(6,876)	10	5
6	Non-Allowable Expense	(798,685)	43	6
7	Building Co - Accounting Fees	(5,948)	19	7
8	Building Co - Interest	(337,326)	32	8
9	R/E Taxes	24,393	33	9
10	Additional R&M	1,588	06	10
11	Non-Allowable Auto Lease	(8,873)	35	11
12	PAC Dues	(20,740)	20	12
13	Non-Allowable Legal	(12,353)	19	13
14	Collections	(1,051)	21	14
15	Donations	(500)	20	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,233,087)		49

Carlton At The Lake

Report Period Beginning: ID# 0053934
 Ending: 01/01/18
12/31/18

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
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlton At The Lake# 0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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			1,638									1,638	1
2	Food Purchase	(18,293)		28									(18,265)	2
3	Housekeeping			2,576									2,576	3
4	Laundry			16									16	4
5	Heat and Other Utilities					1,532							1,532	5
6	Maintenance	1,588		12,863		2,063							16,514	6
7	Other (specify):*													7
8	TOTAL General Services	(16,705)		17,121		3,595							4,011	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(10,883)		85,396			(259)						74,254	10
10a	Therapy													10a
11	Activities			102									102	11
12	Social Services			6,377									6,377	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				11,746								11,746	15
16	TOTAL Health Care and Programs	(10,883)		91,875	11,746		(259)						92,480	16
	C. General Administration													
17	Administrative			135,640									135,640	17
18	Directors Fees													18
19	Professional Services	(18,301)	5,948	16,490		64		(8,798)					(4,597)	19
20	Fees, Subscriptions & Promotions	(55,172)		938		1							(54,233)	20
21	Clerical & General Office Expenses	(413,594)		497,367		505							84,278	21
22	Employee Benefits & Payroll Taxes				(11,726)								(11,726)	22
23	Inservice Training & Education													23
24	Travel and Seminar			4,494									4,494	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			7,635		591							8,226	26
27	Other (specify):*			85,955									85,955	27
28	TOTAL General Administration	(487,067)	5,948	748,518	(11,726)	1,161		(8,798)					248,035	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(514,655)	5,948	857,514	20	4,756	(259)	(8,798)					344,526	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	(133,853)											(133,853)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(384,057)	337,326	50		7,299							(39,382)	32
33	Real Estate Taxes	24,393				6,947							31,340	33
34	Rent-Facility & Grounds			63,350		(63,115)							235	34
35	Rent-Equipment & Vehicles	(8,873)			6,132								(2,742)	35
36	Other (specify):*													36
37	TOTAL Ownership	(502,390)	337,326	63,400	6,132	(48,869)							(144,401)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(798,685)											(798,685)	43
44	TOTAL Special Cost Centers	(798,685)											(798,685)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,815,730)	343,274	920,915	6,152	(44,113)	(259)	(8,798)					(598,559)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	19 Accounting Fees	\$	Montrose Property Holdings LLC		\$ 5,948	\$ 5,948	1
2	V	32 Interest Expense		Montrose Property Holdings LLC		337,326	337,326	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		\$			\$ 343,274	\$ * 343,274	14

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

Facility Name & ID Number Carlton At The Lake# 0053934Report Period Beginning: 01/01/18Ending: 12/31/18

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		\$ 1,544	\$ 1,544	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		94	94	16
17	V	02	FOOD		Legacy Healthcare Financial Services		28	28	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		2,576	2,576	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		16	16	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		10,953	10,953	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		1,910	1,910	21
22	V	10	NURSING SALARY	20,155	Legacy Healthcare Financial Services		101,286	81,131	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		4,148	4,148	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		116	116	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		6,340	6,340	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		102	102	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		37	37	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		135,640	135,640	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		16,490	16,490	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		938	938	30
31	V	21	CLERICAL AND GENERAL WAGES	70,111	Legacy Healthcare Financial Services		551,526	481,415	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		15,952	15,952	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		4,494	4,494	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		7,635	7,635	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		85,955	85,955	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		50	50	36
37	V	34	RENT		Legacy Healthcare Financial Services		63,115	63,115	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		235	235	38
39	Total			\$ 90,266			\$ 1,011,181	\$ * 920,915	39

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

1,029,059

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		329	\$	329	15
16	V	35 AUTO RENTAL		Legacy Healthcare Financial Services		5,803		5,803	16
17	V	15 NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		11,746		11,746	17
18	V								18
19	V	22 PAYROLL TAXES	11,726	Legacy Healthcare Financial Services				(11,726)	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		\$ 11,726			\$ 17,878	\$ *	6,152	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	5 UTILITIES	\$	CF St. Louis LLC		\$ 1,532	\$ 1,532
16	V	6 REPAIRS & MAINTENANCE		CF St. Louis LLC		2,063	2,063
17	V	19 PROFESSIONAL FEES		CF St. Louis LLC		64	64
18	V	20 DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1
19	V	21 OFFICE EXPENSE		CF St. Louis LLC		505	505
20	V	26 INSURANCE		CF St. Louis LLC		591	591
21	V	32 INTEREST EXPENSE		CF St. Louis LLC		7,299	7,299
22	V	33 REAL ESTATE TAXES		CF St. Louis LLC		6,947	6,947
23	V						
24	V						
25	V						
26	V	34 RENT	63,115	CF St. Louis LLC			(63,115)
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		\$ 63,115			\$ 19,002	\$ * (44,113)

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

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning: 01/01/18

Ending: 12/31/18

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		\$ 8,741	\$ (259)
16	V						
17	V						
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		\$ 9,000			\$ 8,741	\$ * (259)

* 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 Processing	\$ 33,604	ProPay HR		\$ 24,806	\$ (8,798)	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		\$ 33,604			\$ 24,806	\$ * (8,798)	39

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

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Carlton At The Lake

#

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

Facility Name & ID Number Carlton At The Lake

0053934 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 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	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	\$ 33,257	\$ 33,257	89,060	\$ 1,544	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		89,060	94	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		89,060	28	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		89,060	2,576	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		89,060	16	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	89,060	10,953	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		89,060	1,910	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	89,060	101,286	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		89,060	4,148	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		89,060	116	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	89,060	6,340	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		89,060	102	12
13	12	SOCIAL SERVICE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	800		89,060	37	13
14	17	CFO/ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	89,060	135,640	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		89,060	16,490	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		89,060	938	16
17	21	CLERICAL AND GENERAL WAGES	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	89,060	551,526	17
18	21	CLERICAL AND OFFICE EXPENSE	AVAIL. BED DAYS	1,918,919	34	343,715		89,060	15,952	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		89,060	4,494	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		89,060	7,635	20
21	27	NON-NURSING PAYROLL TAX	AVAIL. BED DAYS	1,918,919	34	1,852,008		89,060	85,955	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		89,060	50	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		89,060	63,115	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		89,060	235	24
25	TOTALS					\$ 21,787,253	\$ 17,394,136		\$ 1,011,181	25

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 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	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088	89,060	329	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028	89,060	5,803	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092	89,060	11,746	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					\$ 385,208	\$	\$ 17,878	25

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 CF St. Louis LLC
 Street Address 3450 Oakton Street
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 676-5300
 Fax Number (847) 676-5348

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	AVAIL. BED DAYS	1,916,917	34	\$ 32,982	\$ 89,060	\$ 1,532	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396	89,060	2,063	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378	89,060	64	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23	89,060	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860	89,060	505	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721	89,060	591	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106	89,060	7,299	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528	89,060	6,947	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					\$ 408,994	\$	\$ 19,002	25

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Name of Related Organization

ReMED Services LLC

Street Address

3424 Oakton Street, Suite 102

City / State / Zip Code

Skokie, IL

Phone Number

(847) 440-2600

Fax Number

()

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	10	Medical Supplies	Direct		\$	\$		\$ 8,741	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				\$	\$		\$ 8,741	25

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Name of Related Organization

ProPay HR LLC

Street Address

2201 W. Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3268

Fax Number

()

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	19	Payroll Services	Direct		\$	\$		\$ 24,806	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				\$	\$		\$ 24,806	25

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	The Private Bank		X	Mortgage Payable			\$	\$ 5,973,884		\$ 337,326	1									
2				Adjusted out on Page 5a						(337,326)	2									
3											3									
4											4									
5											5									
Working Capital																				
6	The Private Bank		X	Note Payable				1,085,000		82,384	6									
7	Capex		X	Note Payable				63,404			7									
8											8									
9	TOTAL Facility Related						\$	\$ 7,122,288		\$ 82,384	9									
B. Non-Facility Related*																				
10	Interest Income		X							(46,731)	10									
11	Allocated from Legacy HC		X							50	11									
12	Allocated from CF St. Louis		X							7,299	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (39,382)	14									
15	TOTALS (line 9+line14)						\$	\$ 7,122,288		\$ 43,002	15									

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

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlton At The Lake COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053934

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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. <u>14-16-300-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>108,648.36</u>	\$ <u>108,648.36</u>
2. <u>14-16-300-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>111,683.63</u>	\$ <u>111,683.63</u>
3. <u>14-16-300-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>105,378.53</u>	\$ <u>105,378.53</u>
4. <u>14-16-300-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>108,648.36</u>	\$ <u>108,648.36</u>
5. <u>14-16-300-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,708.84</u>	\$ <u>1,708.84</u>
6. <u>14-16-300-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>14,925.57</u>	\$ <u>14,925.57</u>
7. <u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	\$ <u>492,481.94</u>	\$ <u>6,947.07</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>943,475.23</u></u>	\$ <u><u>457,940.36</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? 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlton At The Lake COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0053934
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18 Ending:

12/31/18

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	<u>Allocated from CF St. Louis</u>			\$ <u>9,169</u>	1
2					2
3	TOTALS			\$ <u>9,169</u>	3

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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											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											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 Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		\$	\$		\$	\$	\$	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
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								67
68			363,383		17,111	17,111	50,941	68
69				280,444		(280,444)		69
70		\$	\$		\$	\$	\$	70
TOTAL (lines 4 thru 69)		363,383	280,444		17,111	(263,333)	50,941	

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

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		\$ 363,383	\$ 280,444		\$ 17,111	\$ (263,333)	\$ 50,941	1
2	Light Sconces (Eighty-Eight) - Common Area/Residents' Rooms	2015	10,402		20	2,080	2,080	6,588	2
3	Flooring - Non-Carpeting Vinyl - Common Area /Residents' Rooms	2015	32,445		20	2,163	2,163	6,849	3
4	Carpeting - Noland Sales - Common Area/Residents' Rooms	2015	12,590		20	1,799	1,799	5,695	4
5	Vinyl Flooring - Noland Sales - Common Area/Residents' Rooms	2015	8,766		20	584	584	1,851	5
6	Wireless Access Point, Zone Director, Hp E2530 - 21921	2016	48,933		20	1,223	1,223	3,670	6
7	Ethernet Cables	2016	4,442		20	222	222	666	7
8	Roam Alert Devices, Egress Locks - Southwest Exit	2016	12,000		20	538	538	1,613	8
9	Exhaust Fan	2016	2,815		20	375	375	1,126	9
10	United Drilling - Elevator Cylinder	2016	46,829		20	7,024	7,024	21,073	10
11	Exhaust Fans On Rooftop	2016	2,900		20	242	242	725	11
12	Drain Stacks For A/C	2016	16,450		20	274	274	823	12
13	Repair & Overlay/Stripe The Existing Parking Lot	2016	43,842		20	1,305	1,305	3,915	13
14	Water Heater	2016	3,490		20	349	349	1,047	14
15	Shaft Motors W/ Base	2016	3,710		20	247	247	742	15
16	Roam Alert Devices	2016	2,955		20	246	246	739	16
17	Ductwork - Medical Records Room	2016	3,997		20	133	133	400	17
18	Interior Painting In Conference Rooms/Chapel/Cabinets/Wallpaper	2017	5,918		20	271	271	542	18
19	Carpeting In Chapel & Conference Room	2017	6,724		20	308	308	616	19
20	Removal Of Old Wallpaper & Bases On 3Rd/4Th/5Th Floors & Pr	2017	45,000		20	1,125	1,125	2,250	20
21	Intstall New Piping For Ejector Pumps/Control Panel/Supports For	2017	14,514		20	423	423	846	21
22	Flooring For Physican Lounge	2017	2,698		20	495	495	990	22
23	3Rd Floor Flooring Installation	2017	26,996		20	562	562	1,124	23
24	Fire Alarms	2017	5,168		20	258	258	517	24
25	Fire Alarms	2017	7,284		20	364	364	728	25
26	Trane Heat Exchangers	2017	3,480		20	174	174	348	26
27	New Valve And Gasket - Therapy Room	2017	8,106		20	405	405	811	27
28	1St Floor Pt/Dining Floor Tiles	2017	44,035		20	2,202	2,202	4,404	28
29	Bathroom Wall Tiles/Wallper/Resident Rooms	2017	20,784		20	1,039	1,039	2,078	29
30	Vinyl Plank And Base-2Nd Floor Resident Rooms	2017	18,785		20	939	939	1,879	30
31	Restroom Lock And Labor	2017	17,271		20	864	864	1,727	31
32	New Lighting Fixtures, Quad Outlets, New Outlets	2017	12,415		20	621	621	1,242	32
33	Grab Bar For Shower, Drywall, Sinks	2017	9,720		20	486	486	972	33
34	TOTAL (lines 1 thru 33)		\$ 868,846	\$ 280,444		\$ 46,453	\$ (233,991)	\$ 129,535	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 12B, Carried Forward		\$ 868,846	\$ 280,444		\$ 46,453	\$ (233,991)	\$ 129,535	1
2	Replaced Ceiling Tiles-2Nd Floor Rooms	2017	9,440		20	472	472	944	2
3	Bathroom Plumbing Fixtures	2017	6,359		20	318	318	636	3
4	Repaired Hot Water Mixing Valve	2017	4,998		20	250	250	500	4
5	Physical Therapy Room, Bathrooms-Design Fees	2017	12,360		20	618	618	1,236	5
6	Cabinets - 1St Floor Pt/Dining Room	2017	3,653		20	183	183	365	6
7	Sink And Counter - 1St Floor Therapy Rooms	2017	3,599		20	180	180	360	7
8	Signs For Facility-Wide	2017	3,454		20	173	173	345	8
9	Repaired Plumbing In Shower Rooms	2017	3,094		20	155	155	309	9
10	Fire Proof Light Covers/Hvac Cover - 1St Floor Pt/Dining Room, 2	2017	2,576		20	129	129	258	10
11	Handrail Removal/Mounting Plate - 1St Fl Pt/Dining Rm	2017	10,505		20	525	525	1,051	11
12	Demo Vinyl Floor/Plans/Tiles-Doorways - 1St Floor	2017	10,330		20	516	516	1,033	12
13	3Rd Floor - New Circuits And Duplex Outlets (\$33,000)	2018	30,545		20	1,925	1,925	1,925	13
14	Booster Pump Installation (\$5,370)	2018	4,970		20	627	627	627	14
15	Chandelier Installation, Painting-Lobby Area, Carpet -Fireplace Rm.	2018	5,091		20	504	504	504	15
16	Remove And Replace 100 Ton Compressor (\$26,891)	2018	24,891		20	1,245	1,245	1,245	16
17	Repair Front Façade, Tuckpoint Large Cracks, 3Rd-5Th Flr Light	2018	2,545		20	127	127	127	17
18	System Piping - Install Plugs, Cooling Tower Repair (\$27,655)	2018	25,597		20	1,280	1,280	1,280	18
19	Condensor Installation, 3 Ton Ac Unit - Elevator Shaft (\$5,635)	2018	5,216		20	261	261	261	19
20	Hot Water Boiler Repair (\$14,687)	2018	13,594		20	680	680	680	20
21	Resident Room Signs, Other Room Signs (\$21,808)	2018	20,185		20	2,019	2,019	2,019	21
22	1St/2Nd Fl Pt/Dining- Carpentry/Drywall/Doors/Lighting	2018	903,363		20	45,168	45,168	45,168	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)		\$ 1,975,210	\$ 280,444		\$ 103,806	\$ (176,638)	\$ 190,407	34

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

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		\$ 1,975,210	\$ 280,444		\$ 103,806	\$ (176,638)	\$ 190,407	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)		\$ 1,975,210	\$ 280,444		\$ 103,806	\$ (176,638)	\$ 190,407	34

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

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		\$ 1,975,210	\$ 280,444		\$ 103,806	\$ (176,638)	\$ 190,407	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)		\$ 1,975,210	\$ 280,444		\$ 103,806	\$ (176,638)	\$ 190,407	34

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

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	49,372		35	1,411	1,411	4,232	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	306,530		20	15,327	15,327	45,980	9
10	Allocated from CF St. Louis, LLC	2017	7,115		20	356	356	711	10
11									11
12									12
13	Allocated from Legacy HC	2018	366		20	18	18	18	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)		\$ 363,383	\$		\$ 17,111	\$ 17,111	\$ 50,941	34

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

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		\$ 363,383	\$		\$ 17,111	\$ 17,111	\$ 50,941	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)		\$ 363,383	\$		\$ 17,111	\$ 17,111	\$ 50,941	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	\$ 301,246	\$	\$ 37,318	\$ 37,318	10	\$ 109,473	71
72	Current Year Purchases	64,643		5,467	5,467	10	5,467	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 365,889	\$	\$ 42,785	\$ 42,785		\$ 114,940	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,350,269	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 280,444	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 146,591	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (133,853)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 305,346	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: 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:	<u>1971</u>	<u>244</u>		\$ <u>2,250,000</u>			3
4	Additions							4
5	<u>Allocated from Legacy HC</u>				<u>235</u>			5
6								6
7	TOTAL		<u>244</u>		\$ <u>2,250,235</u>			7

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. /2019 \$

13. /2020 \$

14. /2021 \$

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: \$ 27,355 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	<u>Facility</u>	<u>Ford Ecoline</u>	\$ <u>407</u>	\$ <u>4,884</u>	17
18	<u>Allocated from Legacy HC</u>			<u>5,803</u>	18
19					19
20					20
21	TOTAL		\$ <u>407.00</u>	\$ <u>10,687</u>	21

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

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

Facility Name & ID Number Carlton At The Lake # 0053934 Report Period Beginning: 01/01/18 Ending: 12/31/18
 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs		\$			\$	333,114	\$			\$		333,114	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						140,201						140,201	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs						453,003						453,003	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 prescripts							219,958					219,958	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):				68,806				63,468	250,010					382,284	13
14	TOTAL				\$ 68,806				\$ 989,786	\$ 469,968				\$	1,528,560	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 & ID Number Carlton At The Lake

0053934

Report Period Beginning: 01/01/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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	\$ 548	\$ 12,009	1
2	Cash-Patient Deposits	1,500	1,500	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,299,976	2,299,976	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(112,378)	(112,378)	6
7	Other Prepaid Expenses	30,724	30,724	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	148,593	148,593	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,368,963	\$ 2,380,424	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	924,630	924,630	15
16	Equipment, at Historical Cost	1,078,740	1,078,740	16
17	Accumulated Depreciation (book methods)	(474,749)	(474,749)	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): <u>See Attached Schedule</u>	429,467	6,675,611	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,958,088	\$ 8,204,232	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,327,051	\$ 10,584,656	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 970,987	\$ 970,988	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	332,234	332,234	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,873	13,873	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	<u>See Attached Schedule</u>	2,321,992	2,471,992	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,639,086	\$ 3,789,087	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,148,404	1,148,404	39
40	Mortgage Payable		5,973,884	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	50,541	1,195,556	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,198,945	\$ 8,317,844	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,838,031	\$ 12,106,931	46
47	TOTAL EQUITY(page 18, line 24)	\$ (510,980)	\$ (1,522,275)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,327,051	\$ 10,584,656	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (168,382)	1
2	Restatements (describe):		2
3	Prior Year Depreciation	(11,111)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (179,493)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(331,487)	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)	\$ (331,487)	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)	\$ (510,980)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	\$ 21,742,965	1
2	Discounts and Allowances for all Levels	(9,382,346)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,360,619	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,184,308	6
7	Oxygen	223	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,184,531	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	231,933	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,452	19
20	Radiology and X-Ray	65	20
21	Other Medical Services	44,871	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 323,321	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	46,731	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,731	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	25,689	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,689	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,940,891	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,163,839	31
32	Health Care	5,328,801	32
33	General Administration	2,913,978	33
B. Capital Expense			
34	Ownership	3,080,211	34
C. Ancillary Expense			
35	Special Cost Centers	2,327,245	35
36	Provider Participation Fee	458,304	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,272,378	40
41	Income before Income Taxes (line 30 minus line 40)**	(331,487)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (331,487)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,463,398	44
45	Private Pay - Net Inpatient Revenue	1,174,025	45
46	Medicare - Net Inpatient Revenue	667,939	46
47	Other-(specify) <u>Insurance</u>	55,257	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,360,619	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.

Facility Name & ID Number Carlton At The Lake

0053934

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	1,392	1,607	\$ 102,512	\$ 63.79	1
2	Assistant Director of Nursing	1,304	1,480	60,160	40.65	2
3	Registered Nurses	47,290	50,817	1,784,040	35.11	3
4	Licensed Practical Nurses	35,312	37,502	1,074,248	28.65	4
5	CNAs & Orderlies	80,702	87,089	1,244,698	14.29	5
6	CNA Trainees					6
7	Licensed Therapist	2,084	2,100	68,806	32.76	7
8	Rehab/Therapy Aides	12,765	13,815	291,174	21.08	8
9	Activity Director	1,952	2,016	37,243	18.47	9
10	Activity Assistants	8,107	8,685	101,232	11.66	10
11	Social Service Workers	14,027	15,502	295,950	19.09	11
12	Dietician	632	640	15,964	24.94	12
13	Food Service Supervisor	2,000	2,088	48,841	23.39	13
14	Head Cook	8,094	8,548	121,527	14.22	14
15	Cook Helpers/Assistants	25,579	28,552	372,233	13.04	15
16	Dishwashers					16
17	Maintenance Workers	6,274	6,857	142,634	20.80	17
18	Housekeepers	17,020	18,323	226,109	12.34	18
19	Laundry	8,270	9,385	112,266	11.96	19
20	Administrator	2,712	2,848	148,026	51.98	20
21	Assistant Administrator	896	984	27,331	27.78	21
22	Other Administrative					22
23	Office Manager	376	512	22,341	43.63	23
24	Clerical	11,959	12,930	240,536	18.60	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	1,968	2,120	45,529	21.48	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,976	2,080	43,533	20.93	33
34	TOTAL (lines 1 - 33)	292,691	316,480	\$ 6,626,933 *	\$ 20.94	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	Monthly	\$ 17,717	01-03	35
36	Medical Director	Monthly	37,587	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,600	10-03	38
39	Pharmacist Consultant	Monthly	19,792	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	951	11-03	44
45	Social Service Consultant	Monthly	1,746	12-03	45
46	Other(specify) <u>MDS Consultant</u>	Monthly	48,363	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 127,756		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

Facility Name & ID Number Carlton At The Lake# 0053934

Report Period Beginning:

01/01/18Ending: 12/31/18**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. HCCI - \$41,480
- (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. \$ 50,300 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. \$ 458,304
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 benefit on Schedule V. \$ 80,592 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? 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