FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053934

Facility Name: Carlton Skilled Nursing Facility

Address: 725 W. Montrose Ave (Number) Chicago (City) 60613 (Zip Code)

County: Cook

Telephone Number: (773) 929-1700 **Fax #** (773) 929-3066

HFS ID Number:

Date of Initial License for Current Owners: 11/10/2015

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	56,666	4,445	6,486	67,597	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	59,377	4,445	6,486	70,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.94%

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 5,695

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	573,014	58,354		631,368		631,368		631,368			1
2	Food Purchase		469,314		469,314	(80,592)	388,722	(9,614)	379,108			2
3	Housekeeping	265,862	46,868	1,091	313,821		313,821	324	314,145			3
4	Laundry	113,449	40,858	(2,006)	152,301		152,301	9	152,310			4
5	Heat and Other Utilities			227,615	227,615		227,615	1,891	229,506			5
6	Maintenance	97,454	19,934	217,667	335,055		335,055	133,835	468,890			6
7	Other (specify):*											7
8	TOTAL General Services	1,049,779	635,328	444,367	2,129,474	(80,592)	2,048,882	126,446	2,175,328			8
	B. Health Care and Programs											
9	Medical Director			28,785	28,785		28,785	996	29,781			9
10	Nursing and Medical Records	4,175,993	106,513	65,409	4,347,915		4,347,915	113,780	4,461,695			10
10a	Therapy	179,864			179,864		179,864		179,864			10a
11	Activities	146,623	3,702	4,133	154,458		154,458	7,565	162,023			11
12	Social Services	243,496	3,704	5,448	252,648		252,648	2,717	255,365			12
13	CNA Training											13
14	Program Transportation			22,167	22,167		22,167		22,167			14
15	Other (specify):*							25,962	25,962			15
16	TOTAL Health Care and Programs	4,745,976	113,919	125,942	4,985,837		4,985,837	151,019	5,136,856			16
	C. General Administration											
17	Administrative	242,029			242,029		242,029	260,133	502,162			17
18	Directors Fees											18
19	Professional Services			236,530	236,530	(348)	236,182	(68,969)	167,213			19
20	Dues, Fees, Subscriptions & Promotions			138,778	138,778		138,778	(82,762)	56,016			20
21	Clerical & General Office Expenses	312,372	7,508	590,516	910,396		910,396	(190,159)	720,237			21
22	Employee Benefits & Payroll Taxes			1,034,593	1,034,593	80,592	1,115,185	(29,294)	1,085,891			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,116	3,116		3,116	3,000	6,116			24
25	Other Admin. Staff Transportation			2,793	2,793		2,793		2,793			25
26	Insurance-Prop.Liab.Malpractice			575,181	575,181		575,181	5,531	580,712			26
27	Other (specify):*							108,877	108,877			27
28	TOTAL General Administration	554,401	7,508	2,581,507	3,143,416	80,244	3,223,660	6,356	3,230,017			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,350,156	756,755	3,151,816	10,258,727	(348)	10,258,379	283,821	10,542,200			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 Skilled Nursing Facility #0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			122,448	122,448		122,448	(32,063)	90,385			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			110,610	110,610		110,610	(5,321)	105,289			32
33	Real Estate Taxes			426,600	426,600	348	426,948	(944)	426,004			33
34	Rent-Facility & Grounds			2,220,328	2,220,328		2,220,328	239	2,220,567			34
35	Rent-Equipment & Vehicles			35,530	35,530		35,530	1,046	36,576			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,915,516	2,915,516	348	2,915,864	(37,043)	2,878,821			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		479,599	942,037	1,421,636		1,421,636		1,421,636			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			544,223	544,223		544,223		544,223			42
43	Other (specify):*			791,983	791,983		791,983	(791,983)	(0)			43
44	**TOTAL Special Cost Centers**		479,599	2,278,243	2,757,842		2,757,842	(791,983)	1,965,859			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,350,156	1,236,354	8,345,575	15,932,085		15,932,085	(545,205)	15,386,880			45

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(33,319)	30		9
10	Interest and Other Investment Income	(13,894)	32		10
11	Discounts, Allowances, Rebates & Refunds	(9,418)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(297)	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	(1,567)	21		18
19	Entertainment	(5,277)	21		19
20	Contributions	(44,369)	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	(271,414)	21		24
25	Fund Raising, Advertising and Promotional	(22,308)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,260,581)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,662,444)		$	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)	1,117,239		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,117,239		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (545,205)		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

Carlton Skilled Nursing Facility

ID# 0053934

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (6,375)	10	1
2	Bank Charges	(4,316)	21	2
3	Sequestration Expense	(61,690)	21	3
4	Pharmacy Discounts	(1,341)	10	4
5	Non-Allowable Expense	(791,983)	43	5
6	R/E Taxes	(7,948)	33	6
7	Additional R&M	58,863	06	7
8	Non-Allowable Auto Lease	(5,842)	35	8
9	PAC Dues	(17,690)	20	9
10	Non-Allowable Legal	(56,691)	19	10
11	Bldg Co - Amortization	(37,338)	36	11
12	Bldg Co - Interest	(328,230)	32	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
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**	(1,260,581)		49

Carlton Skilled Nursing Facility

ID# 0053934

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 Skilled Nursing Facility **#** 0053934 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(9,715)		73	28								(9,614)	2
3	Housekeeping			324									324	3
4	Laundry			9									9	4
5	Heat and Other Utilities					1,891							1,891	5
6	Maintenance	58,863		4,379	68,202	2,391							133,835	6
7	Other (specify):*													7
8	**TOTAL General Services**	49,148		4,785	68,230	4,283							126,446	8
	B. Health Care and Programs													
9	Medical Director			996									996	9
10	Nursing and Medical Records	(7,716)		62	122,170		(736)						113,780	10
10a	Therapy													10a
11	Activities			7,536	29								7,565	11
12	Social Services			119	2,598								2,717	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				25,962								25,962	15
16	**TOTAL Health Care and Programs**	(7,716)		8,712	150,758		(736)						151,019	16
	C. General Administration													
17	Administrative			34,258	225,875								260,133	17
18	Directors Fees													18
19	Professional Services	(56,691)		(1,726)	570	475		(11,598)					(68,969)	19
20	Fees, Subscriptions & Promotions	(84,367)		1,324	278	4							(82,762)	20
21	Clerical & General Office Expenses	(344,264)		271,783	(117,681)	2							(190,159)	21
22	Employee Benefits & Payroll Taxes				(29,294)								(29,294)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,749	1,251								3,000	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,467	3,574	490							5,531	26
27	Other (specify):*			55,768	53,109								108,877	27
28	**TOTAL General Administration**	(485,322)		364,624	137,682	970		(11,598)					6,356	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(443,890)		378,121	356,671	5,253	(736)	(11,598)					283,821	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Carlton Skilled Nursing Facility **#** 0053934 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(33,319)			1,256								(32,063)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(342,124)	328,230	28		8,546							(5,321)	32
33	Real Estate Taxes	(7,948)				7,004							(944)	33
34	Rent-Facility & Grounds			67,815	97	(67,674)							239	34
35	Rent-Equipment & Vehicles	(5,842)		4,966	1,923								1,046	35
36	Other (specify):*	(37,338)	37,338											36
37	**TOTAL Ownership**	(426,571)	365,568	72,809	3,276	(52,124)							(37,043)	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):*	(791,983)											(791,983)	43
44	**TOTAL Special Cost Centers**	(791,983)											(791,983)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,662,444)	365,568	450,930	359,946	(46,871)	(736)	(11,598)					(545,205)	45

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest	$	Montrose Property Holdings LLC	100.00%	$ 328,230	$ 328,230	1
2	V	36	Amortization		Montrose Property Holdings LLC	100.00%	37,338	37,338	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			$			$ 365,568	$ * 365,568	14

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 73	$ 73	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	324	324	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	9	9	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	19	19	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	4,360	4,360	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	996	996	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	62	62	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	7,536	7,536	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	119	119	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	34,258	34,258	24
25	V	19	PROFESSIONAL FEES	25,000	Legacy Healthcare Financial Services	100.00%	23,274	(1,726)	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	1,324	1,324	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	264,475	264,475	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	7,309	7,309	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,749	1,749	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,467	1,467	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	55,768	55,768	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	28	28	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	67,674	67,674	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	141	141	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	35	35	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	4,931	4,931	36
37	V								37
38	V								38
39	Total			$ 25,000			$ 475,930	$ * 450,930	39

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 28	$ 28	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	67,999	67,999	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	203	203	17
18	V	10	NURSING SALARIES	44,889	Progressive Healthcare Consulting	100.00%	167,059	122,170	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	29	29	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	2,592	2,592	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	6	6	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	25,962	25,962	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	225,875	225,875	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	570	570	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	278	278	25
26	V	21	CLERICAL WAGES	166,065	Progressive Healthcare Consulting	100.00%	47,874	(118,191)	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	511	511	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	1,251	1,251	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	53,109	53,109	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	3,574	3,574	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	1,256	1,256	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	97	97	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,923	1,923	33
34	V								34
35	V	22	PAYROLL TAXES	29,294	Progressive Healthcare Consulting	100.00%		(29,294)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 240,248			$ 600,194	$ * 359,946	39

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CF ST. LOUIS, LLC	100.00%	$ 1,891	$ 1,891	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	2,391	2,391	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	475	475	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	4	4	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	2	2	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	490	490	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	8,546	8,546	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	7,004	7,004	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	67,674	CF ST. LOUIS, LLC	100.00%		(67,674)	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			$ 67,674			$ 20,803	$ * (46,871)	39

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 18,079	ReMED Services		$ 17,343	$ (736)	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			$ 18,079			$ 17,343	$ * (736)	39

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 48,326	ProPay HR LLC	24.00%	$ 36,728	$ (11,598)	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			$ 48,326			$ 36,728	$ * (11,598)	39

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	MONTROSE PROPERTY HOLDINGS LLC		BUILDING COMPANY	1
2	Doros Generation Trust	50.00%	AVANTARA LONG GROVE	LONG GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA PARK RIDGE	PARK RIDGE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			AZRIA MIDTOWN	OMAHA, NE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			AZRIA MONTCLAIR	OMAHA, NE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			AZRIA OLATHE	OLATHE, KS	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			BETHANY TERRACE	MORTON GROVE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	9
10			CLARK SKILLED NURSING FACILITY	CHICAGO	PROPAY HR	EVANSTON	PAYROLL PROCESSING	10
11			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				11
12			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				12
13			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				13
14			GROVE OF FOX VALLEY	AURORA				14
15			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				15
16			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				16
17			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				18
19			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				19
20			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				20
21			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				21
22			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				22
23			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				23
24			WARREN BARR LIVING AND REHAB	CHICAGO				24
25			WARREN BARR NORTH SHORE	HIGHLAND PARK				25
26			WARREN BARR SOUTH LOOP	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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								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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,789,215	30	$ 1,460	$	89,060	$ 73	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		89,060	324	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		89,060	9	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		89,060	19	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		89,060	4,360	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		89,060	996	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		89,060	62	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		89,060	7,536	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		89,060	119	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	89,060	34,258	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		89,060	23,274	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		89,060	1,324	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	89,060	264,475	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		89,060	7,309	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		89,060	1,749	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		89,060	1,467	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		89,060	55,768	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		89,060	28	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		89,060	67,674	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		89,060	141	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		89,060	35	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		89,060	4,931	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 475,930	25

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] NO [ ]

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

Name of Related Organization: Progressive Healthcare Consulting
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,374,590	21	$ 432	$	89,060	$ 28	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	89,060	67,999	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		89,060	203	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	89,060	167,059	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		89,060	29	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		89,060	2,592	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		89,060	6	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		89,060	25,962	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	89,060	225,875	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		89,060	570	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		89,060	278	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	89,060	47,874	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		89,060	511	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		89,060	1,251	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		89,060	53,109	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		89,060	3,574	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		89,060	1,256	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		89,060	97	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		89,060	1,923	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 600,194	25

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	1,789,215	30	$ 37,998	$	89,060	$ 1,891	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		89,060	2,391	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		89,060	475	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		89,060	4	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		89,060	2	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		89,060	490	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		89,060	8,546	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		89,060	7,004	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					$ 417,927	$		$ 20,803	25

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] NO [ ]

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

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: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 17,343	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					$	$		$ 17,343	25

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] NO [ ]

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

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: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 36,728	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					$	$		$ 36,728	25

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage Payable			$	$ 6,086,942			$ 328,230	1
2				Adjusted out on Page 5a							(328,230)	2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Note Payable				850,000			110,610	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,936,942			$ 110,610	9
	B. Non-Facility Related*											
10	Interest Income		X								(13,894)	10
11	Allocated from Legacy HC		X								28	11
12	Allocated from CF St. Louis		X								8,546	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,320)	14
15	TOTALS (line 9+line14)						$	$ 6,936,942			$ 105,290	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.)

Facility Name & ID Number Carlton Skilled Nursing Facility **#** 0053934 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	425,656	2
3. Under or (over) accrual (line 2 minus line 1).	$	425,656	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	348	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	426,003	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	319,908	8
	2013	324,238	9
	2014	340,875	10
	2015	383,834	11
	2016	418,652	12

Allocated from CF St. Louis: $7,004

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlton Skilled Nursing Facility COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053934

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-16-300-003-0000	Long Term Care Property	$ 100,856.93	$ 100,856.93
2.	14-16-300-004-0000	Long Term Care Property	$ 103,674.61	$ 103,674.61
3.	14-16-300-005-0000	Long Term Care Property	$ 97,821.64	$ 97,821.64
4.	14-16-300-006-0000	Long Term Care Property	$ 100,856.93	$ 100,856.93
5.	14-16-300-007-0000	Long Term Care Property	$ 1,586.29	$ 1,586.29
6.	14-16-300-008-0000	Long Term Care Property	$ 13,855.23	$ 13,855.23
7.	10-23-406-034-0000	Home Office Allocation	$ 463,439.48	$ 7,003.98
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 882,091.11	$ 425,655.61

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlton Skilled Nursing Facility COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053934

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from CF St. Louis, LLC			$ 32,354	1
2					2
3	TOTALS			$ 32,354	3

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		388,926			18,312	18,312	36,245	68
69	Financial Statement Depreciation			122,448			(122,448)		69
70	TOTAL (lines 4 thru 69)		$ 388,926	$ 122,448		$ 18,312	$ (104,136)	$ 36,245	70

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 12A, Carried Forward		$ 388,926	$ 122,448		$ 18,312	$ (104,136)	$ 36,245	1
2	Light Sconces (Eighty-Eight) - Common Area/Residents' Rooms	2015	10,402		20	2,080	2,080	4,507	2
3	Flooring - Non-Carpeting Vinyl - Common Area /Residents' Room	2015	32,445		20	2,163	2,163	4,686	3
4	Carpeting - Noland Sales - Common Area/Residents' Rooms	2015	12,590		20	1,799	1,799	3,897	4
5	Vinyl Flooring - Noland Sales - Common Area/Residents' Rooms	2015	8,766		20	584	584	1,266	5
6	Wireless Access Point, Zone Director, Hp E2530 - 21921	2016	48,933		20	1,223	1,223	2,447	6
7	Ethernet Cables	2016	4,442		20	222	222	444	7
8	Roam Alert Devices, Egress Locks - Southwest Exit	2016	12,000		20	538	538	1,075	8
9	Exhaust Fan	2016	2,815		20	375	375	751	9
10	United Drilling - Elevator Cylinder	2016	46,829		20	7,024	7,024	14,049	10
11	Exhaust Fans On Rooftop	2016	2,900		20	242	242	483	11
12	Drain Stacks For A/C	2016	16,450		20	274	274	548	12
13	Repair & Overlay/Stripe The Existing Parking Lot	2016	43,842		20	1,305	1,305	2,610	13
14	Water Heater	2016	3,490		20	349	349	698	14
15	Shaft Motors W/ Base	2016	3,710		20	247	247	495	15
16	Roam Alert Devices	2016	2,955		20	246	246	493	16
17	Ductwork - Medical Records Room	2016	3,997		20	133	133	266	17
18	Interior Painting In Conference Rooms/Chapel/Cabinets/Wallpape	2017	5,918		20	271	271	271	18
19	Carpeting In Chapel & Conference Room	2017	6,724		20	308	308	308	19
20	Removal Of Old Wallpaper & Bases On 3Rd/4Th/5Th Floors & P	2017	45,000		20	1,125	1,125	1,125	20
21	Intstall New Piping For Ejector Pumps/Control Panel/Supports Fo	2017	14,514		20	423	423	423	21
22	Flooring For Physican Lounge	2017	2,698		20	495	495	495	22
23	3Rd Floor Flooring Installation	2017	26,996		20	562	562	562	23
24	Fire Alarms	2017	5,168		20	258	258	258	24
25	Fire Alarms	2017	7,284		20	364	364	364	25
26	Trane Heat Exchangers	2017	3,480		20	174	174	174	26
27	New Valve And Gasket - Therapy Room	2017	8,106		20	405	405	405	27
28	Floor Tiles	2017	44,035		20	2,202	2,202	2,202	28
29	Bathroom Wall Tiles/Wallper/Resident Rooms	2017	20,784		20	1,039	1,039	1,039	29
30	Vinyl Plank And Base-2Nd Floor Resident Rooms	2017	18,785		20	939	939	939	30
31	Restroom Lock And Labor	2017	17,271		20	864	864	864	31
32	New Lighting Fixtures, Quad Outlets, New Outlets	2017	12,415		20	621	621	621	32
33	Grab Bar For Shower, Drywall, Sinks	2017	9,720		20	486	486	486	33
34	TOTAL (lines 1 thru 33)		$ 894,389	$ 122,448		$ 47,654	$ (74,794)	$ 85,497	34

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 894,389	$ 122,448		$ 47,654	$ (74,794)	$ 85,497	1
2	Replaced Ceiling Tiles-2Nd Floor Rooms	2017	9,440		20	472	472	472	2
3	Bathroom Plumbing Fixtures	2017	6,359		20	318	318	318	3
4	Repaired Hot Water Mixing Valve	2017	4,998		20	250	250	250	4
5	Physical Therapy Room, Bathrooms-Design Fees	2017	12,360		20	618	618	618	5
6	Cabinets - 1St Floor Pt/Dining Room	2017	3,653		20	183	183	183	6
7	Sink And Counter - 1St Floor Therapy Rooms	2017	3,599		20	180	180	180	7
8	Signs For Facility-Wide	2017	3,454		20	173	173	173	8
9	Repaired Plumbing In Shower Rooms	2017	3,094		20	155	155	155	9
10	Fire Proof Light Covers/Hvac Cover - 1St Floor Pt/Dining Room, 2	2017	2,576		20	129	129	129	10
11	Handrail Removal/Mounting Plate - 1St Fl Pt/Dining Rm	2017	10,505		20	525	525	525	11
12	Demo Vinyl Floor/Plans/Tiles-Doorways - 1St Floor	2017	10,330		20	516	516	516	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)		$ 964,756	$ 122,448		$ 51,172	$ (71,276)	$ 89,015	34

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 964,756	$ 122,448		$ 51,172	$ (71,276)	$ 89,015	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)		$ 964,756	$ 122,448		$ 51,172	$ (71,276)	$ 89,015	34

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 964,756	$ 122,448		$ 51,172	$ (71,276)	$ 89,015	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)		$ 964,756	$ 122,448		$ 51,172	$ (71,276)	$ 89,015	34

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	52,896		35	1,511	1,511	3,023	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis LLC	2016	328,408		20	16,420	16,420	32,841	9
10	Allocated from CF St. Louis LLC	2017	7,622		20	381	381	381	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)		$ 388,926	$		$ 18,312	$ 18,312	$ 36,245	34

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 388,926	$		$ 18,312	$ 18,312	$ 36,245	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)		$ 388,926	$		$ 18,312	$ 18,312	$ 36,245	34

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 281,932	$ 1,256	$ 35,532	$ 34,276	10	$ 73,452	71
72	Current Year Purchases	38,262		3,681	3,681	10	3,681	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 320,194	$ 1,256	$ 39,213	$ 37,957		$ 77,133	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)	$ 1,317,304	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,704	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,385	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (33,319)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 166,149	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	CIP	$ 866,586	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.

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 2,220,000			3
4	Additions							4
5	Storage				328			5
6	Allocated from Legacy HC/Progressive HC				238			6
7	TOTAL		244		$ 2,220,566 **			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: _____ *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 26,066 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	Facility	Ford Ecoline	$ 407	$ 3,657	17
18	Allocated from Legacy HC			4,931	18
19	Allocated from Progressive HC			1,923	19
20					20
21	TOTAL		$ 407	$ 10,511	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 Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$		$ 310,307	$		$ 310,307	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			154,479			154,479	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			419,786			419,786	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				257,952		257,952	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					57,465	221,647		279,112	13
14	TOTAL			$		$ 942,037	$ 479,599		$ 1,421,636	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.

STATE OF ILLINOIS

Facility Name & ID Number Carlton Skilled Nursing Facility **#** 0053934 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 1,048	$ 12,509	1
2	Cash-Patient Deposits	1,500	1,500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,765,449	1,765,449	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	581,455	581,455	6
7	Other Prepaid Expenses	6,050	6,050	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	505,618	505,618	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,861,120	$ 2,872,581	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	455,691	455,691	15
16	Equipment, at Historical Cost	475,268	475,268	16
17	Accumulated Depreciation (book methods)	(183,202)	(183,202)	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 Schedule	1,362,411	7,608,555	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,110,168	$ 8,356,312	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,971,288	$ 11,228,893	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,519,068	$ 1,519,070	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	319,056	319,056	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,133	11,133	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 Schedule	2,440,413	3,279,096	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,289,670	$ 5,128,355	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	850,000	850,000	39
40	Mortgage Payable		6,086,942	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 850,000	$ 6,936,942	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,139,670	$ 12,065,297	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (168,382)	$ (836,404)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,971,288	$ 11,228,893	48

***(See instructions.)**

Facility Name & ID Number Carlton Skilled Nursing Facility **#** 0053934 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (109,280)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (109,280)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(59,102)	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)**	$ (59,102)	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)**	$ (168,382)	24 *

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

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 21,697,669	1
2	Discounts and Allowances for all Levels	(9,940,909)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,756,760	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,750,375	6
7	Oxygen	201	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,750,576	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	257,478	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,298	19
20	Radiology and X-Ray		20
21	Other Medical Services	42,218	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 340,994	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,894	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,894	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,759	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,759	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,872,983	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,129,474	31
32	Health Care	4,985,837	32
33	General Administration	3,143,416	33
	B. Capital Expense		
34	Ownership	2,915,516	34
	C. Ancillary Expense		
35	Special Cost Centers	2,213,619	35
36	Provider Participation Fee	544,223	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,932,085	40
41	**Income before Income Taxes (line 30 minus line 40)****	(59,102)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (59,102)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,647,377	44
45	Private Pay - Net Inpatient Revenue	513,777	45
46	Medicare - Net Inpatient Revenue	1,405,169	46
47	Other-(specify) Insurance	190,437	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,756,760	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,808	1,928	$ 112,117	$ 58.15	1
2	Assistant Director of Nursing	2,056	2,112	88,439	41.87	2
3	Registered Nurses	46,679	50,522	1,649,041	32.64	3
4	Licensed Practical Nurses	30,052	31,923	867,660	27.18	4
5	CNAs & Orderlies	93,466	99,443	1,310,034	13.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,683	9,157	179,864	19.64	8
9	Activity Director	2,139	2,360	45,988	19.49	9
10	Activity Assistants	8,721	9,230	100,635	10.90	10
11	Social Service Workers	10,469	11,068	243,496	22.00	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,080	46,023	22.13	13
14	Head Cook	10,054	10,770	148,300	13.77	14
15	Cook Helpers/Assistants	28,102	31,450	378,691	12.04	15
16	Dishwashers					16
17	Maintenance Workers	4,696	5,036	97,454	19.35	17
18	Housekeepers	22,255	23,844	265,862	11.15	18
19	Laundry	8,973	9,761	113,449	11.62	19
20	Administrator	3,704	4,012	225,691	56.25	20
21	Assistant Administrator	640	656	16,338	24.91	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,089	19,442	312,372	16.07	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	4,724	5,073	106,563	21.01	31
32	Other Health Care(specify)					32
33	Other(specify)	1,885	2,078	42,139	20.28	33
34	TOTAL (lines 1 - 33)	309,099	331,945	$ 6,350,156 *	$ 19.13	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	28,785	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	240	10-03	38
39	Pharmacist Consultant	Monthly	15,226	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	4,133	11-03	44
45	Social Service Consultant	76	4,348	12-03	45
46	Other(specify) MDS Consultant	Monthly	49,463	10-03	46
47	Clergy	Monthly	600	12-03	47
48	Psychologist	Monthly	500	12-03	48
49	TOTAL (lines 35 - 48)	76	$ 103,295		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	19	480	10-03	52
53	TOTAL (lines 50 - 52)	19	$ 480		53

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Abbey Davis	Administrator	0	$ 97,833
Joanne Ventrella	Administrator	0	10,933
Scott Schayer	Administrator	0	116,925
Yaakov Karsh	Assistant Admin	0	16,338
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 242,029

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
ProPay HR	Payroll Services	$ 48,326
Achieve Accreditation	Accreditation	7,474
MTS Consulting	Tax Consulting	4,106
Personnel Planners	Unemployment Consulting	1,734
PSD Solutions	Technology Consulting	1,144
Strauss' Data Consulting	Management Consulting	31
BlueOrange Compliance	Cyber Security Solutions	2,011
McCabe Kirshner	Insurance Solutions Consulting	1,334
IIT/Sourcetech	Data Processing	630
Lexis Nexis	Data Processing	75
Chicago Title Land Trust Co	Estate Planning	375
See Supplemental Schedule		169,288
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 236,529

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,351
Unemployment Compensation Insurance	68,849
FICA Taxes	459,369
Employee Health Insurance	241,055
Employee Meals	80,592
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	32,720
401K	8,064
Other Employee Benefits	26,834
Employee Physical Exams	15,704
Voluntary Benefit Contributions	7,353
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,085,891

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 429)	8,567
Patient Background Checks	
Dues and Subscriptions	32,081
License and Permits	13,763
Allocated from Legacy HC	1,324
Allocated from Progressive HC	278
See Supplemental Schedule	4
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,018

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,116
Allocated from Legacy HC	1,749
Allocated from Progressive HC	1,251
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,116

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Carlton Skilled Nursing Facility # 0053934 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. **ICLTC - $35,380**

(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. $ **50,703** 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. $ **544,223**
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. $ **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