		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0056655

Facility Name: Thrive of Lake County

Address: 850 E US Highway 45 (Number) Mundelein (City) 60060 (Zip Code)

County: Lake

Telephone Number: (847) 377-7200 **Fax #** (480) 436-5749

HFS ID Number:

Date of Initial License for Current Owners: 7/20/2020

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: Andrew B. Cutler **Telephone Number:** (847) 940-3269
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 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)
(Print Name and Title) Andrew B. Cutler, Managing Director, Healthcare
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr. 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 940-3269 Fax # (847) 964-5469

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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	185	Skilled (SNF)	185	67,710	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	185	TOTALS	185	67,710	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	8,840	5,522	25,625	39,987	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,840	5,522	25,625	39,987	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.06%

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 7/7/2020

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/7/2020 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 185 and days of care provided 2,295

Medicare Intermediary Wisconsin Phyisican Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	528,724	38,592	13,238	580,554		580,554		580,554			1
2	Food Purchase		308,087		308,087		308,087		308,087			2
3	Housekeeping	146,521	27,921	183,123	357,565		357,565		357,565			3
4	Laundry		3,683	119,708	123,391		123,391		123,391			4
5	Heat and Other Utilities			137,987	137,987		137,987		137,987			5
6	Maintenance	88,939		73,683	162,622		162,622		162,622			6
7	Other (specify):*											7
8	**TOTAL General Services**	764,184	378,283	527,739	1,670,206		1,670,206		1,670,206			8
	B. Health Care and Programs											
9	Medical Director			17,800	17,800		17,800		17,800			9
10	Nursing and Medical Records	3,989,048	463,514	13,819	4,466,381		4,466,381		4,466,381			10
10a	Therapy											10a
11	Activities	154,566	2,230		156,796		156,796		156,796			11
12	Social Services	133,016			133,016		133,016		133,016			12
13	CNA Training											13
14	Program Transportation			9,669	9,669		9,669		9,669			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,276,630	465,744	41,288	4,783,662		4,783,662		4,783,662			16
	C. General Administration											
17	Administrative	156,878		571,065	727,943		727,943	69,150	797,093			17
18	Directors Fees											18
19	Professional Services			266,286	266,286		266,286	(15,898)	250,388			19
20	Dues, Fees, Subscriptions & Promotions			161,972	161,972		161,972	(41,307)	120,665			20
21	Clerical & General Office Expenses	481,913	260,944	277,848	1,020,705		1,020,705	(3,977)	1,016,728			21
22	Employee Benefits & Payroll Taxes			1,619,761	1,619,761		1,619,761		1,619,761			22
23	Inservice Training & Education											23
24	Travel and Seminar			22,046	22,046		22,046	8,143	30,189			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			475,334	475,334		475,334	3,571	478,905			26
27	Other (specify):*							78,459	78,459			27
28	**TOTAL General Administration**	638,791	260,944	3,394,312	4,294,047		4,294,047	98,141	4,392,188			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,679,605	1,104,971	3,963,339	10,747,915		10,747,915	98,141	10,846,056			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 Thrive of Lake County #0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,000	12,000		12,000	1,421,869	1,433,869			30
31	Amortization of Pre-Op. & Org.			1,076	1,076		1,076	3,060	4,136			31
32	Interest							389,269	389,269			32
33	Real Estate Taxes							8,500	8,500			33
34	Rent-Facility & Grounds			817,629	817,629		817,629	(804,848)	12,781			34
35	Rent-Equipment & Vehicles			26,302	26,302		26,302		26,302			35
36	Other (specify):*											36
37	**TOTAL Ownership**			857,007	857,007		857,007	1,017,850	1,874,857			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	698,239	154,998	123,568	976,805		976,805		976,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			338,951	338,951		338,951		338,951			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	698,239	154,998	462,519	1,315,756		1,315,756		1,315,756			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,377,844	1,259,969	5,282,865	12,920,678		12,920,678	1,115,991	14,036,669			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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Reference	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				9
10	Interest and Other Investment Income	(1,466)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(351)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(154,786)	21		24
25	Fund Raising, Advertising and Promotional	(39,241)	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	(182,081)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (377,925)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (377,925)		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

Thrive of Lake County

ID# 0056655

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable IHCA/Lobbying Fees	$ (2,758)	20	1
2	Non-Allowable Marketing Expense	(134,580)	21	2
3	Bank Fess	(10,001)	21	3
4	Credit Card Fees	(269)	21	4
5	Penalties	(3,175)	21	5
6	Non-Allowable Professional Fees	(23,831)	19	6
7	Non-Allowable Marketing Mileage	(7,467)	24	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				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**	(182,081)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	69,150	0	0	0	0	0	0	0	0	0	69,150	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,831)	7,634	299	0	0	0	0	0	0	0	0	(15,898)	19
20	Fees, Subscriptions & Promotions	(41,999)	692	0	0	0	0	0	0	0	0	0	(41,307)	20
21	Clerical & General Office Expenses	(303,162)	365,673	0	(66,488)	0	0	0	0	0	0	0	(3,977)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,467)	15,610	0	0	0	0	0	0	0	0	0	8,143	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,571	0	0	0	0	0	0	0	0	0	3,571	26
27	Other (specify):*	0	78,459	0	0	0	0	0	0	0	0	0	78,459	27
28	**TOTAL General Administration**	(376,459)	540,789	299	(66,488)	0	0	0	0	0	0	0	98,141	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(376,459)	540,789	299	(66,488)	0	0	0	0	0	0	0	98,141	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Thrive of Lake County # 0056655 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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	0	920	1,420,949	0	0	0	0	0	0	0	0	1,421,869	30
31	Amortization of Pre-Op. & Org.	0	0	3,060	0	0	0	0	0	0	0	0	3,060	31
32	Interest	(1,466)	0	390,735	0	0	0	0	0	0	0	0	389,269	32
33	Real Estate Taxes	0	0	8,500	0	0	0	0	0	0	0	0	8,500	33
34	Rent-Facility & Grounds	0	12,421	(817,269)	0	0	0	0	0	0	0	0	(804,848)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,466)	13,341	1,005,975	0	0	0	0	0	0	0	0	1,017,850	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(377,925)	554,130	1,006,274	(66,488)	0	0	0	0	0	0	0	1,115,991	45

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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
IH KCB Mundelein, LLC	100%	Thrive of Lisle	Lisle	Transitional Care Management		MGMT Co.
		Thrive of Fox Valley	Aurora	IH KCB Mundelein Owner, LLC		Bldg. Ptrshp.

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	17	Owner Salary - Allocated	$	Transitional Care Management, LLC		$ 69,150	$ 69,150	1
2	V	19	Professional Fees		Transitional Care Management, LLC		7,634	7,634	2
3	V	20	Dues, Subscriptions		Transitional Care Management, LLC		692	692	3
4	V	21	A&G		Transitional Care Management, LLC		99,661	99,661	4
5	V	21	A&G Salary - Non Owner		Transitional Care Management, LLC		266,012	266,012	5
6	V	27	Employee Benefits		Transitional Care Management, LLC		78,459	78,459	6
7	V	24	Travel & Seminar		Transitional Care Management, LLC		15,610	15,610	7
8	V	26	Insurance		Transitional Care Management, LLC		3,571	3,571	8
9	V	30	Depreciation		Transitional Care Management, LLC		920	920	9
10	V	34	Building Rent		Transitional Care Management, LLC		12,421	12,421	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 554,130	$ * 554,130	14

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	34	Rent	$ 817,269	IH KCB Mundelein Owner, LLC		$	$ (817,269)	15
16	V	33	Real Estate Tax		IH KCB Mundelein Owner, LLC		8,500	8,500	16
17	V	30	Depreciation		IH KCB Mundelein Owner, LLC		1,420,949	1,420,949	17
18	V	31	Amortization		IH KCB Mundelein Owner, LLC		3,060	3,060	18
19	V	32	Interest Expense		IH KCB Mundelein Owner, LLC		390,735	390,735	19
20	V	19	Professional Fees		IH KCB Mundelein Owner, LLC		299	299	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			$ 817,269			$ 1,823,543	$ * 1,006,274	39

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	21	Administration	$ 66,488	IH Asset Management		$	$ (66,488)	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			$ 66,488			$ 0	$ * (66,488)	39

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Brian Cloch	Owner	Administrative	0.07		5	0.13	Alloc. Salary	$ 69,150	17-7	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	$ 69,150		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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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: Transitional Care Management, LLC
Street Address: 3333 Warrenville Rd., Ste. 200
City / State / Zip Code: Lisle, IL 60532
Phone Number: (847) 720-8700
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	17	Owner Salary Allocated	Revenue	3,632,382	4	$ 439,842	$ 422,230	571,065	$ 69,150	1
2	19	Professional Fees	Revenue	3,632,382	4	48,554		571,065	7,633	2
3	20	Dues& Subscriptions	Revenue	3,632,382	4	4,400		571,065	692	3
4	21	A&G	Revenue	3,632,382	4	633,908		571,065	99,660	4
5	21	A&G Salary - Non Owner	Revenue	3,632,382	4	1,692,030	1,692,030	571,065	266,013	5
6	27	Employee Benefits	Revenue	3,632,382	4	499,053		571,065	78,459	6
7	24	Travel & Seminar	Revenue	3,632,382	4	99,292		571,065	15,610	7
8	26	Insurance	Revenue	3,632,382	4	22,716		571,065	3,571	8
9	30	Depreciation	Revenue	3,632,382	4	5,855		571,065	920	9
10	34	Rent	Revenue	3,632,382	4	79,004		571,065	12,421	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					$ 3,524,654	$ 2,114,260		$ 554,129	25

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage			$	$ 22,786,857			$ 390,735	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 22,786,857			$ 390,735	9
	B. Non-Facility Related*											
10	Interst Income Offset		X								(1,466)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,466)	14
15	TOTALS (line 9+line14)						$	$ 22,786,857			$ 389,269	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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 55,587	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.)		$ 64,087	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,500	3
4. Real Estate Tax accrual used for 2020 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.)**		$	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.		$ 8,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019	64,087	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Real estate tax accrual used was an estimate for unimproved land. Real estate tax bill included in an actual bill for unimproved land. The provider does not expect a full tax bill for 2 additional tax years due to recent completion of construction.

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Thrive of Lake County COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0056655

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-06-203-032	Unimproved Land - Facility Site	$ 4,529.62	$ 4,529.62
2.	15-06-203-033	Unimproved Land - Facility Site	$ 8,099.32	$ 8,099.32
3.	15-06-203-034	Unimproved Land - Facility Site	$ 51,457.98	$ 51,457.98
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,086.92	$ 64,086.92

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 93,071 B. General Construction Type: Exterior Brick/Stone/Siding Frame Wood/Steel Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 38,254 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 1,076 4. Dates Incurred:

Nature of Costs: Organization 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	Long-Term Care Property	469,311	2016	$ 2,275,000	1
2					2
3	TOTALS	469,311		$ 2,275,000	3

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	185		2020	2020	$ 26,892,593	$ 1,452,254	27.5	$ 977,912	$ (474,342)	$ 390,524	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 Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 26,892,593	$ 1,452,254		$ 977,912	$ (474,342)	$ 390,524	70

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 38,383	$	$ 5,512	$ 5,512	5	$ 20,095	71
72	Current Year Purchases	1,668,562		166,856	166,856	10	117,725	72
73	Fully Depreciated Assets							73
74	Equipment purchases after capital report	122,216		6,488	6,488		6,488	74
75	TOTALS	$ 1,829,161	$	$ 178,856	$ 178,856		$ 144,308	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)	$ 30,996,754	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,452,254	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,156,768	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (295,486)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 534,832	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 26,302 Description: Copier/Fax Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

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	39-01	hrs	$ 188,197		$	$		$ 188,197	1
2	Licensed Speech and Language Development Therapist	39-01	hrs	140,419					140,419	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01	hrs	369,623					369,623	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				91,025		91,025	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab/Xray/ RT/Other E	39-03				123,568			123,568	12
13	Other (specify): O2/Therapy Supplies	39-02					63,973		63,973	13
14	TOTAL			$ 698,239		$ 123,568	$ 154,998		$ 976,805	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 Thrive of Lake County **#** 0056655 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2020 **(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	$ 1,265,895	$ 1,933,577	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (247,193))	620,568	620,568	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	197,030	197,030	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	23,936	1,544,369	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,107,429	$ 4,295,544	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,275,000	13
14	Buildings, at Historical Cost		26,892,593	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	160,599	1,829,161	16
17	Accumulated Depreciation (book methods)	(26,583)	(1,478,837)	17
18	Deferred Charges	16,303	16,303	18
19	Organization & Pre-Operating Costs	38,254	167,854	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(28,119)	(31,179)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	(175,000)	(175,000)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (14,546)	$ 29,495,895	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,092,883	$ 33,791,439	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 575,176	$ 575,176	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,972	47,972	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	602,345	602,345	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		8,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,225,493	$ 1,233,993	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		22,786,857	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capital Leases/Due to Prop Co	689,619	689,619	43
44	PPP Loan Payable	1,364,000	1,364,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,053,619	$ 24,840,476	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,279,112	$ 26,074,469	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,186,229)	$ 7,716,970	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,092,883	$ 33,791,439	48

***(See instructions.)**

Line #	Other Current Assets:	Amount	Amount
9	Deposits	9,825	9,825
9	Due To/From Prior Owner	14,111	14,111
9	HUD Escrows-CBRE		917,633
9	Due from TCLC		602800
9			
9			
	Total Line 9	23,936	1,544,369

Line #	Other Non-Current Assets:	Amount	Amount
23	Lake County Needs Deposit	(175,000)	-175,000
	Total Line 23	(175,000)	(175,000)

Line #	Other Non-Current Liabilities:	Amount	Amount
36			
36			
36			
36			
36			
36			
36			
	Total Line 36		

Line #	Other Non-Current Liabilities:	Amount	Amount
43			
43			
43			
	Total Line 43		

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 154,873	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 154,872	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,343,101)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	2,000	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)**	$ (1,341,101)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,186,229)	24 *

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 17,853,233	1
2	Discounts and Allowances for all Levels	(9,921,070)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,932,163	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,038,513	6
7	Oxygen	744	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,039,257	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	201,784	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,130	19
20	Radiology and X-Ray	17,490	20
21	Other Medical Services	82,541	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 346,945	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,466	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,466	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	HHS PRF	1,257,746	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,257,746	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,577,577	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,670,206	31
32	Health Care	4,783,662	32
33	General Administration	4,294,047	33
	B. Capital Expense		
34	Ownership	857,007	34
	C. Ancillary Expense		
35	Special Cost Centers	976,805	35
36	Provider Participation Fee	338,951	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,920,678	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,343,101)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,343,101)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,648,794	44
45	Private Pay - Net Inpatient Revenue	1,763,515	45
46	Medicare - Net Inpatient Revenue	588,918	46
47	Other-(specify) Managed Care	3,329,588	47
48	Other-(specify) Hospice	601,348	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,932,163	49

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

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

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

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

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	2,049	2,145	$ 114,963	$ 53.60	1
2	Assistant Director of Nursing	933	1,038	43,019	41.44	2
3	Registered Nurses	35,011	37,382	1,420,217	37.99	3
4	Licensed Practical Nurses	15,981	16,678	792,044	47.49	4
5	CNAs & Orderlies	67,196	73,345	1,576,302	21.49	5
6	CNA Trainees					6
7	Licensed Therapist	14,963	16,026	698,239	43.57	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,054	2,234	50,798	22.74	9
10	Activity Assistants	5,511	6,197	103,768	16.74	10
11	Social Service Workers	2,423	2,628	133,016	50.61	11
12	Dietician					12
13	Food Service Supervisor	1,584	1,663	57,708	34.70	13
14	Head Cook	14,395	15,765	287,655	18.25	14
15	Cook Helpers/Assistants	8,162	9,014	183,361	20.34	15
16	Dishwashers					16
17	Maintenance Workers	2,285	2,389	88,939	37.23	17
18	Housekeepers	5,805	8,081	146,521	18.13	18
19	Laundry					19
20	Administrator	2,128	2,256	156,878	69.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,229	21,797	481,913	22.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,597	1,784	42,503	23.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,306	220,422	$ 6,377,844 *	$ 28.93	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	Monthly	$ 13,238	1-3	35
36	Medical Director	Monthly	17,800	9-3	36
37	Medical Records Consultant	Monthly	1,947	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,872	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 44,857		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				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Prestel	Administrator	0	$ 156,878
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 156,878

B. Administrative - Other

Description	Amount
Management Fee - Transitional Care Management	$ 571,065
TOTAL (agree to Schedule V, line 17, col. 3)	$ 571,065
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alison Consulting	Marketing	$ 5,787
Why8, Inc.	Marketing	14,045
Much Shellist	Legal	13,687
FGMK, LLC	Accounting/Consulting	88,134
Paycom	Payroll Processing	64,737
Stone, McGuire	Compliance Program	7,400
Ben Lazare	Legislative Liason	4,000
Nicole Cartier	Clinical IT	64,971
Quarles & Brady	Legal	2,485
Benesch	Legal	1,040
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 266,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 220,412
Unemployment Compensation Insurance	
FICA Taxes	498,995
Employee Health Insurance	723,350
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	9,853
Uniform Expense	13,975
Employee Welfare	141,342
Pre Employment Screening	11,834
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,619,761

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	$ 3,980
Advertising: Employee Recruitment	95,827
Health Care Worker Background Check	
(Indicate # of checks performed 13)	
Patient Background Checks	137
Dues & Subscriptions	20,029
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 119,973

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,617
Seminar Expense	6,962
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,579

* Attach copy of IMRF notifications

**See instructions.

Thrive of Lake County
0056655
Travel Schedule
1/1/2020-12/31/2020

DATE	EMPLOYEE NAME	JOB DESCRIPTIO	DESTINATION	PURPOSE OF TRIP	Expense	ADJ	TOTAL	ADJ
06/29/20	Nicole Cartier	Clinical IT	Lodging		474.28		474.28	
07/01/20	Nicole Cartier	Clinical IT	Lodging		474.28		474.28	
07/24/20	Nicole Cartier	Clinical IT	Lodging		384.47		384.47	
07/31/20	Nicole Cartier	Clinical IT	Lodging		135.42		135.42	
08/07/20	Nicole Cartier	Clinical IT	Mileage		133.37		133.37	
01/01/20	Linda R	Administratior	Mileage	Operations	586.57		586.57	ADJ
01/17/20	Heidi & Lisa At	Marketing	Hospital	Marketing	543.96	(543.96)	-	ADJ
01/31/20	Heidi & Lisa At	Marketing	Hospital	Marketing	461.54	(461.54)	-	ADJ
02/14/20	Heidi & Lisa At	Marketing	Hospital	Marketing	461.54	(461.54)	-	ADJ
02/28/20	Heidi & Lisa At	Marketing	Hospital	Marketing	461.54	(461.54)	-	ADJ
03/13/20	Heidi & Lisa At	Marketing	Hospital	Marketing	461.54	(461.54)	-	ADJ
03/27/20	Heidi & Lisa At	Marketing	Hospital	Marketing	461.54	(461.54)	-	ADJ
03/31/20	Linda & Olivia	Administratior	Mileage	Operations	199.32		199.32	
04/10/20	Heidi & Lisa At	Marketing	Hospital	Marketing	461.54	(461.54)	-	ADJ
04/24/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
05/10/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
05/24/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
05/31/20	Heidi Allowan	Marketing	Hospital	Meetings/Wo	230.77	(230.77)	-	ADJ
06/29/20	Nicole Cartier	Clinical IT	Mileage		316.68		316.68	
06/19/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
06/30/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
06/30/20	Manny		Mileage		190.9		190.9	
07/01/20	Nicole Cartier	Clinical IT	Mileage		542.41		542.41	
07/24/20	Nicole Cartier	Clinical IT	Mileage		215.34		215.34	
07/31/20	Nicole Cartier	Clinical IT	Mileage		129.45		129.45	
07/07/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
07/31/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
08/07/20	Nicole Cartier	Clinical IT	Mileage	Mileage	195.36		195.36	
08/28/20	Nicole Cartier	Clinical IT	Mileage	Mileage	437.34		437.34	
08/31/20	Nicole Cartier	Clinical IT	Mileage	Mileage	293.6		293.6	
08/18/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
08/31/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
09/04/20	Nicole Cartier	Clinical IT	Mileage	Mileage	223.11		223.11	
09/18/20	Nicole Cartier	Clinical IT	Mileage	Mileage	153.18		153.18	
09/30/20	Nicole Cartier	Clinical IT	Mileage	Mileage	547.23		547.23	
09/11/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
09/25/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
10/18/20	Nicole Cartier	Clinical IT	Mileage	Mileage	523.92		523.92	
10/30/20	Nicole Cartier	Clinical IT	Mileage	Mileage	444.56		444.56	
10/09/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
10/23/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
10/31/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
11/13/20	Nicole Cartier	Clinical IT	Mileage	Mileage	152.07		152.07	
11/27/20	Nicole Cartier	Clinical IT	Mileage	Mileage	223.11		223.11	
11/14/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
11/30/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
12/14/20	Nicole Cartier	Clinical IT	Mileage	Mileage	328.56		328.56	
12/25/20	Nicole Cartier	Clinical IT	Mileage	Mileage	157.07		157.07	
12/31/20	Nicole Cartier	Clinical IT	Mileage	Mileage	155.4		155.4	
12/18/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
12/31/20	Heidi Allowan	Marketing	Hospital	Marketing	230.77	-230.77	0	ADJ
12/31/20	Heidi Allowan	Marketing	Hospital	Marketing	82.42	-82.42	0	ADJ
	Totals				**15397.25**	**-7780.25**	**7617**	
							-	

Thrive of Lake County
0056655
Seminar Schedule
1/1/2020-12/31/2020

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
01/31/20	CE Solutions	On-line	Various	Various	Online	348.26
02/29/20	CE Solutions	On-line	Various	Various	Online	348.26
02/29/20		Case Mgmt. Conf.	Various	Various	Online	325.00
03/31/20	CE Solutions	On-line	Various	Various	Online	348.26
04/30/20	CE Solutions	On-line	Various	Various	Online	348.26
04/01/20	AMDA	AMDA Conf.		Clinical	Online	595.00
05/31/20	CE Solutions	On-line	Various	Various	Online	348.26
06/30/20	CE Solutions	On-line	Various	Various	Online	348.26
07/31/20	C. Chow	Dietary	Dietary	Dietary	Online	99.98
07/31/20	CE Solutions	On-line	Various	Various	Online	348.26
08/31/20	CE Solutions	On-line	Various	Various	Online	348.26
09/30/20	CE Solutions	On-line	Various	Various	Online	348.26
10/31/20	CE Solutions	On-line	Various	Various	Online	432.38
11/30/20	CE Solutions	On-line	Various	Various	Online	376.30
12/31/20	Jackie Prestel	Tuition Reimb.	Jackie Prestel	Administrator	Online	1,623.00
12/31/20	CE Solutions	On-line	Various	Various	Online	376.36
						6,962.36

Thrive of Lake County
0056655
Legal Schedule
1/1/2020-12/31/2020

DATE	G/L ACCT. #	PAYEE/VENDOR	ADJ	AMOUNT	ADJ Amount	Adjusted Balance
6/30/2020	80,550	Benesch		495		495
5/19/2020	80,550	Quarles & Brady, LLC		2,485		2,485
10/19/2020	80,550	Benesch		545		545
8/31/2020	80,550	Much Shelist - 8/31		236		236
8/31/2020	80,550	Much Shelist - Credit		(791)		(791)
9/30/2020	80,550	Much Shelist - 9/30		4,330		4,330
10/30/2020	80,550	Much Shelist - November		9,912		9,912
11/30/2020	80,550	Much Shelist - DEC 2019				-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
		Total		17,212		5,526

Facility Name & ID Number Thrive of Lake County # 0056655 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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. **IHCA - $2145**

(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? **5 Year**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** 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. $ **338,951**
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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(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? **LN 14**
d. Have vehicle usage logs been maintained? **No**
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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.