FOR BHF USE

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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: 0035188

Facility Name: Lexington Hlth Cr Ctr Blmngd

Address: 165 S Bloomingdale (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

Telephone Number: 630-980-8700 **Fax #** 630-980-6170

HFS ID Number:

Date of Initial License for Current Owners: 05/01/89

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Rob Schlicht **Telephone Number:** 414-431-9335
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 01/01/2020 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) Rob Schlicht, Director
(Firm Name & Address) Wipfli LLP, 10000 Innovation Drive, Suite 250, Milwaukee WI 53226
(Telephone) 414-431-9335 Fax # 414-431-9303

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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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 _____

	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	166	Skilled (SNF)	166	60,756	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	166	TOTALS	166	60,756	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			5,523	5,523	8
9	SNF/PED					9
10	ICF	19,684	3,578	2,526	25,788	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,684	3,578	8,049	31,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.54%

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 [x] NO [ ]

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 05/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New Construction NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 166 and days of care provided 3,354

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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		6,490	802,130	808,620		808,620	(208)	808,412			1
2	Food Purchase		(1,345)		(1,345)		(1,345)	544	(801)			2
3	Housekeeping		355	472,381	472,736		472,736		472,736			3
4	Laundry											4
5	Heat and Other Utilities			162,097	162,097		162,097	20,534	182,631			5
6	Maintenance	45,727	694	176,440	222,861		222,861	89,738	312,599			6
7	Other (specify):*							9,475	9,475			7
8	**TOTAL General Services**	45,727	6,194	1,613,048	1,664,969		1,664,969	120,083	1,785,052			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,480,677	483,356	435,847	4,399,880		4,399,880	22,207	4,422,087			10
10a	Therapy											10a
11	Activities	107,100	4,677		111,777		111,777		111,777			11
12	Social Services	146,679			146,679		146,679		146,679			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,718	2,718			15
16	**TOTAL Health Care and Programs**	3,734,456	488,033	471,847	4,694,336		4,694,336	24,925	4,719,261			16
	C. General Administration											
17	Administrative	141,635		1,334,436	1,476,071		1,476,071	(514,248)	961,823			17
18	Directors Fees											18
19	Professional Services			268,794	268,794		268,794	115,060	383,854			19
20	Dues, Fees, Subscriptions & Promotions			24,521	24,521		24,521	13,178	37,699			20
21	Clerical & General Office Expenses	367,791	26,446	60,491	454,728		454,728	976,409	1,431,137			21
22	Employee Benefits & Payroll Taxes			802,811	802,811		802,811		802,811			22
23	Inservice Training & Education							811	811			23
24	Travel and Seminar							79	79			24
25	Other Admin. Staff Transportation			810	810		810	15,544	16,354			25
26	Insurance-Prop.Liab.Malpractice			789,270	789,270		789,270	5,043	794,313			26
27	Other (specify):*							116,215	116,215			27
28	**TOTAL General Administration**	509,426	26,446	3,281,133	3,817,005		3,817,005	728,091	4,545,096			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,289,609	520,673	5,366,028	10,176,310		10,176,310	873,099	11,049,409			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 Lexington Hlth Cr Ctr Blmngd #0035188 Report Period Beginning: 01/01/2020 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			126,359	126,359		126,359	269,777	396,136			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,455	11,455		11,455	388,053	399,508			32
33	Real Estate Taxes							161,000	161,000			33
34	Rent-Facility & Grounds			665,463	665,463		665,463	(665,305)	158			34
35	Rent-Equipment & Vehicles			27,548	27,548		27,548	4,471	32,019			35
36	Other (specify):*											36
37	**TOTAL Ownership**			830,825	830,825		830,825	157,996	988,821			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		233,873	571,192	805,065		805,065		805,065			39
40	Barber and Beauty Shops			1,633	1,633		1,633	(1,633)				40
41	Coffee and Gift Shops			623	623		623	(130)	493			41
42	Provider Participation Fee			259,643	259,643		259,643		259,643			42
43	Other (specify):* **non-allowable**			208,431	208,431		208,431	(208,431)				43
44	**TOTAL Special Cost Centers**		233,873	1,041,522	1,275,395		1,275,395	(210,194)	1,065,201			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,289,609	754,546	7,238,375	12,282,530		12,282,530	820,901	13,103,431			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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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 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	(208)	1		4
5	Telephone, TV & Radio in Resident Rooms	(14,545)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	38,076	30		9
10	Interest and Other Investment Income	(5,577)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,704)	43		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				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	(125,190)	43		24
25	Fund Raising, Advertising and Promotional	(32,508)	43		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	(152,996)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (301,652)		$	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)	1,122,553		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,122,553		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 820,901		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

Lexington Hlth Cr Ctr Blmngd

ID# 0035188

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gift Shop Income	$ (130)	41	1
2	Radiology	(10,018)	43	2
3	Laboratory	(17,112)	43	3
4				4
5	Personal Item Replacement	(354)	43	5
6	Collections	(32,892)	19	6
7	Barber/Beauty Income	(1,633)	40	7
8	Lobbying Dues	(696)	20	8
9	Salesforce Consulting	(6,510)	19	9
10	Miscellaneous interst	(4,047)	32	10
11	Offset partnership/propco interest income	(79,604)	32	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**	(152,996)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	(208)	0	0	0	0	0	0	0	0	0	0	(208)	1
2	Food Purchase	0	0	0	544	0	0	0	0	0	0	0	544	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	20,534	0	0	0	0	0	0	0	0	20,534	5
6	Maintenance	0	0	89,738	0	0	0	0	0	0	0	0	89,738	6
7	Other (specify):*	0	0	9,475	0	0	0	0	0	0	0	0	9,475	7
8	**TOTAL General Services**	(208)	0	119,747	544	0	0	0	0	0	0	0	120,083	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	22,207	0	0	0	0	0	0	0	0	22,207	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	2,718	0	0	0	0	0	0	0	0	2,718	15
16	**TOTAL Health Care and Programs**	0	0	24,925	0	0	0	0	0	0	0	0	24,925	16
	C. General Administration													
17	Administrative	0	0	0	(514,248)	0	0	0	0	0	0	0	(514,248)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(39,402)	75	154,387	0	0	0	0	0	0	0	0	115,060	19
20	Fees, Subscriptions & Promotions	(696)	0	13,874	0	0	0	0	0	0	0	0	13,178	20
21	Clerical & General Office Expenses	0	150	976,259	0	0	0	0	0	0	0	0	976,409	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	811	0	0	0	0	0	0	0	811	23
24	Travel and Seminar	0	0	0	79	0	0	0	0	0	0	0	79	24
25	Other Admin. Staff Transportation	0	0	0	15,544	0	0	0	0	0	0	0	15,544	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	5,043	0	0	0	0	0	0	0	5,043	26
27	Other (specify):*	0	0	0	116,215	0	0	0	0	0	0	0	116,215	27
28	**TOTAL General Administration**	(40,098)	225	1,144,520	(376,556)	0	0	0	0	0	0	0	728,091	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(40,306)	225	1,289,192	(376,012)	0	0	0	0	0	0	0	873,099	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	38,076	191,333	0	40,368	0	0	0	0	0	0	0	269,777	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(89,228)	428,893	0	48,388	0	0	0	0	0	0	0	388,053	32
33	Real Estate Taxes	0	137,914	0	23,086	0	0	0	0	0	0	0	161,000	33
34	Rent-Facility & Grounds	0	(665,305)	0	0	0	0	0	0	0	0	0	(665,305)	34
35	Rent-Equipment & Vehicles	0	0	0	4,471	0	0	0	0	0	0	0	4,471	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(51,152)	92,835	0	116,313	0	0	0	0	0	0	0	157,996	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	(1,633)	0	0	0	0	0	0	0	0	0	0	(1,633)	40
41	Coffee and Gift Shops	(130)	0	0	0	0	0	0	0	0	0	0	(130)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(208,431)	0	0	0	0	0	0	0	0	0	0	(208,431)	43
44	**TOTAL Special Cost Centers**	(210,194)	0	0	0	0	0	0	0	0	0	0	(210,194)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(301,652)	93,060	1,289,192	(259,699)	0	0	0	0	0	0	0	820,901	45

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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
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	19	Professional fees	$	Sambell of Bloomingdale Limited Partnership	**	$ 75	$ 75	1
2	V	30	Depreciation		Sambell of Bloomingdale Limited Partnership	**	191,333	191,333	2
3	V	32	Amortization of mortgage		Sambell of Bloomingdale Limited Partnership	**	76,017	76,017	3
4	V	32	Interest		Sambell of Bloomingdale Limited Partnership	**	352,876	352,876	4
5	V	33	Property tax		Sambell of Bloomingdale Limited Partnership	**	137,914	137,914	5
6	V	34	Rent	665,305	Sambell of Bloomingdale Limited Partnership	**		(665,305)	6
7	V	43	Unrealized loss on FMV of Swap		Sambell of Bloomingdale Limited Partnership	**			7
8	V	43	(Gain)/Loss on disposal		Sambell of Bloomingdale Limited Partnership	**			8
9	V	21	Miscellaneous		Sambell of Bloomingdale Limited Partnership	**	150	150	9
10	V	21	Bank charges		Sambell of Bloomingdale Limited Partnership	**			10
11	V								11
12	V				** The owners of Lexington Health Care Center of Bloomingdale Inc. own				12
13	V				100% of Sambell of Bloomingdale Limited Partnership				13
14	Total			$ 665,305			$ 758,365	$ * 93,060	14

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	3	Housekeeping Supplies	$	Royal Management Corp.	**	$	$	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	19,956	19,956	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	578	578	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**			18
19	V	6	Management Allocation - salaries		Royal Management Corp.	**	77,423	77,423	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	12,315	12,315	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**			21
22	V	7	Management Allocation - empoyee benefits		Royal Management Corp.	**	9,475	9,475	22
23	V	10	Medical consultant		Royal Management Corp.	**			23
24	V	10	Management Allocation - salaries		Royal Management Corp.	**	22,207	22,207	24
25	V	15	Management Allocation - empoyee benefits		Royal Management Corp.	**	2,718	2,718	25
26	V	17	Management Allocation - salaries		Royal Management Corp.	**			26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	42,306	42,306	27
28	V	19	Professional fees		Royal Management Corp.	**	112,081	112,081	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,188	1,188	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	12,686	12,686	30
31	V	21	Management Allocation - salaries		Royal Management Corp.	**	949,598	949,598	31
32	V	21	Bank charges		Royal Management Corp.	**	5,170	5,170	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	3,106	3,106	33
34	V	21	Postage		Royal Management Corp.	**	4,281	4,281	34
35	V	21	Telephone		Royal Management Corp.	**	14,105	14,104	35
36	V								36
37	V								37
38	V		** The owners of Lexington Health Care Center of Bloomingdale Inc. own 100% of Royal Management Corp						38
39	Total			$			$ 1,289,193	$ * 1,289,192	39

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	23	Inservice training	$	Royal Management Corp	**	$ 811	$ 811	15
16	V	24	Travel & seminar		Royal Management Corp	**	79	79	16
17	V	25	Auto expense		Royal Management Corp	**	15,544	15,544	17
18	V	26	Insurance general		Royal Management Corp	**	5,043	5,043	18
19	V	27	Management Allocation - employee benefits		Royal Management Corp	**	116,215	116,215	19
20	V	30	Depreciation		Royal Management Corp	**	40,368	40,368	20
21	V	32	Interest		Royal Management Corp	**	48,388	48,388	21
22	V	2	Amortization of mortgage costs		Royal Management Corp	**	544	544	22
23	V	33	Property taxes		Royal Management Corp	**	23,086	23,086	23
24	V	34	Rent expense		Royal Management Corp	**			24
25	V	35	Equipment rental		Royal Management Corp	**	4,471	4,471	25
26	V	17	Management fees	514,248	Royal Management Corp	**		(514,248)	26
27	V	35	Auto lease		Royal Management Corp	**			27
28	V	6	Security		Royal Management Corp	**			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		** The owners of Lexington Health Care Center of Bloomingdale own 100% of Royal Management Corp.						38
39	Total			$ 514,248			$ 254,549	$ * (259,699)	39

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	James Samatas Discretionary Trust	33.33	Lexington HC Ctr of Chicago Ridge Inc.	Chicago Ridge	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr of Elmhurst Inc.	Elmhurst	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr of LaGrange Inc.	LaGrange	Lexington Square	Lombard	Independent and	3
4			Lexington HC Ctr of Lake Zurich Inc.	Lake Zurich	Life Care		Assisted Living	4
5			Lexington HC Ctr of Lombard Inc.	Lombard	of Lombard LLC		Facility	5
6			Lexington HC Ctr of Orland Park Inc.	Orland Park	Lexington Square	Elmhurst	Independent and	6
7			Lexington HC Ctr of Schaumburg Inc.	Schaumburg	Life Care		Living Facility	7
8					of Elmhurst, LLC			8
9					Vesta Management	Lombard	Mgmt Company	9
10					Group LLC			10
11					Sambell of	Bloomingdale	Real Estate	11
12					Bloomingdale Ltd.		Company	12
13					Ptsp.			13
14					Royal Management	Lombard	Mgmt Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance Company	16
17					Services II LLC			17
18					Heron Point	Lombard	Mgmt Company	18
19					Management Corp			19
20					Samvest of Lombard	Lombard	Lessor	20
21					II, LLC			21
22					North Heron	Lombard	Finance Company	22
23					Inveestments, LLC			23
24					Lexington Home	Lombard	Home Health	24
25					Health Care, Inc.			25
26					Lexington Hospice	Lombard	Hospice	26
27					Services, LLC			27
28					Lexington Private	Lombard	Healthcare	28
29					Home Care			29
30								30

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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					Merit Sleep	Lombard	Mgmt Company	1
2					Management LLC			2
3					Sambell of Chicago	Chicago Ridge	Real Estate	3
4					Ridge Ltd Ptsp		Property	4
5					Sambell of Elmhurst	Elmhurst	Real Estate	5
6					II Ltd Ptsp		Property	6
7					Sambell of	LaGrange	Real Estate	7
8					LaGrange Ltd Ptsp		Property	8
9					Lexington HC Sys	Lake Zurich	Real Estate	9
10					of Lake Zurich Ltd		Property	10
11					Ptsp			11
12					Lexington HC Sys	Lombard	Real Estate	12
13					of Lombard Ltd Ptsp		Property	13
14					Lexington HC Sys		Real Estate	14
15					of Orland Park Ltd	Orland Park	Property	15
16					Ptsp			16
17					Sambell of	Schaumburg	Real Estate	17
18					Schaumburg Ltd Ptsp		Property	18
19					Samvest of Algonquin	Algonquin	Real Estate	19
20					Ltd Ptsp		Property	20
21					Curates, LLC	Lombard	Telemedicine	21
22					Repbulic Construction		Construction	22
23					of Illinois, Inc.	Lombard	Company	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	owners took no salary in 2020								$		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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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: Royal Management Corp
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard IL 60148
Phone Number: (630-458-4700
Fax Number: (630-458-4796

	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	3	Housekeeping Supplies	Bed days available	565,750	8	$	$	60,590	$ 0	1
2	5	Utilities - gas & electric	Bed days available	565,750	8	186,333		60,590	19,956	2
3	5	Utilities - water & sewer	Bed days available	565,750	8	5,398		60,590	578	3
4	5	Utilities - maintenance office	Bed days available	565,750	8			60,590	0	4
5	6	Management Allocation - salaries	Bed days available	565,750	8	722,929	722,929	60,590	77,423	5
6	6	Repairs & maintenance	Bed days available	565,750	8	114,986		60,590	12,315	6
7	6	Scavenger & exterminating	Bed days available	565,750	8			60,590	0	7
8	7	Management Allocation - empoyee ber	Bed days available	565,750	8	88,474		60,590	9,475	8
9	10	Medical consultant	Bed days available	565,750	8			60,590	0	9
10	10	Management Allocation - salaries	Bed days available	565,750	8			60,590	0	10
11	15	Management Allocation - empoyee ber	Bed days available	565,750	8	25,377		60,590	2,718	11
12	17	Management Allocation - salaries	Bed days available	565,750	8	207,358	207,358	60,590	22,207	12
13	19	Computer consultant & supplies	Bed days available	565,750	8	395,029		60,590	42,306	13
14	19	Professional fees	Bed days available	565,750	8	1,046,538		60,590	112,081	14
15	20	Dues & subscriptions	Bed days available	565,750	8	11,082		60,590	1,187	15
16	20	Advertising - help wanted	Bed days available	565,750	8	118,456		60,590	12,686	16
17	21	Management Allocation - salaries	Bed days available	565,750	8	8,866,730	8,866,730	60,590	949,598	17
18	21	Bank charges	Bed days available	565,750	8	48,277		60,590	5,170	18
19	21	Office supplies & printing	Bed days available	565,750	8	29,001		60,590	3,106	19
20	21	Postage	Bed days available	565,750	8	39,969		60,590	4,281	20
21	21	Telephone	Bed days available	565,750	8	131,703		60,590	14,105	21
22										22
23										23
24										24
25	TOTALS					$ 12,037,640	$ 9,797,017		$ 1,289,192	25

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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: Royal Management Corp
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard IL 60148
Phone Number: (630-458-4700
Fax Number: (630-458-4796

	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	23	Inservice training	Bed days available	565,750	8	$ 7,573	$	60,590	$ 811	1
2	24	Travel & seminar	Bed days available	565,750	8	735		60,590	79	2
3	25	Auto expense	Bed days available	565,750	8	145,140		60,590	15,544	3
4	26	Insurance general	Bed days available	565,750	8	47,093		60,590	5,044	4
5	27	Management Allocation - employee be	Bed days available	565,750	8	1,085,139		60,590	116,215	5
6	30	Depreciation	Bed days available	565,750	8	376,924		60,590	40,367	6
7	32	Interest	Bed days available	565,750	8	451,812		60,590	48,388	7
8	2	Amortization of mortgage costs	Bed days available	565,750	8	5,077		60,590	544	8
9	33	Property taxes	Bed days available	565,750	8	215,565		60,590	23,086	9
10	34	Rent expense	Bed days available	565,750	8			60,590		10
11	35	Equipment rental	Bed days available	565,750	8	41,748		60,590	4,471	11
12	17	Management fees	Bed days available	565,750	8			60,590		12
13	35	Auto lease	Bed days available	565,750	8			60,590		13
14	6	Security	Bed days available	565,750	8			60,590		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,376,806	$		$ 254,549	25

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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** 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	Midcap financial		x	mortgage	varies	5/29/18	$ 5,058,006	$ 4,908,212	5/29/21	libor +5.2	$ 352,876	1
2												2
3												3
4								Offset miscellaneous interst			(4,047)	4
5								Miscellaneous interest			4,047	5
	Working Capital											
6												6
7	West Suburban Bank		x	PPP Loan	none	5/7/20	1,115,824	1,115,824		0.0100	7,408	7
8												8
9	TOTAL Facility Related						$ 6,173,830	$ 6,024,036			$ 360,284	9
	B. Non-Facility Related*											
10								interest income offset			(5,577)	10
11								amotization			76,017	11
12								allocated from management co			48,388	12
13								offset propco interest income			(79,604)	13
14	TOTAL Non-Facility Related						$	$			$ 39,224	14
15	TOTALS (line 9+line14)						$ 6,173,830	$ 6,024,036			$ 399,508	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* 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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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.**	$ 137,760	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.)		$ 139,642	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,882	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 136,032	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
	allocated from mgmt co	23,086	
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.		$ 161,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	156,302	8
	2016	157,740	9
	2017	144,681	10
	2018	149,755	11
	2019	139,642	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

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 Lexington Hlth Cr Ctr Blmngd COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Christine Thompson

TELEPHONE 630-458-4700 FAX #: 630-458-4796

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.	02-15-401-003	land and building	$ 139,642.00	$ 139,642.00
2.	Royal Management Corp (Samvest of Lombard II)		$	$
3.	05-01-202-021	land and building	$ 215,565.00	$ 23,086.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 355,207.00	$ 162,728.00

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 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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior concrete block Frame 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? [ ] (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).

n/a

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: n/a
2. Number of Years Over Which it is Being Amortized: n/a
3. Current Period Amortization: n/a
4. Dates Incurred: n/a

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	Resident care	43,000	1987	$ 402,548	1
2	Management Company Allocation			19,746	2
3	TOTALS	43,000		$ 422,294	3

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	82		1989	1989	$ 2,980,863	$	35	$ 85,192	$ 85,192	$ 2,697,747	4
5	9		1992	1992	178,974		35	5,114	5,114	148,299	5
6	75		1994	1994	2,022,894		35	57,797	57,797	1,531,619	6
7											7
8											8
	Improvement Type**										
9	Capitalized repairs			1989	9,080		10			9,080	9
10	Building Improvements			1990	3,674		10			3,674	10
11	Building Improvements			1991	2,586		10			2,586	11
12	Building Improvements			1992	3,154		10			2,997	12
13	Building Improvements			1993	1,582		10			1,503	13
14	Building Improvements			1994	15,734		10			15,734	14
15	Land Improvements			1994	1,381		10			1,381	15
16	Land Improvements			1995	1,074		15			1,074	16
17	Building Improvements			1995	1,288		35	37	37	958	17
18	Building Improvements			1995	9,433	270	35	270		6,885	18
19	Building Improvements			1995	43,839	1,252	35	1,252		31,927	19
20	Concrete flooring, fire doors, tile sprinkler heads										20
21	and basement renovations			1996	8,706		15			3,606	21
22	Land Improvements			1996	7,858		15			7,858	22
23											23
24	Resident room heaters			1997	3,563	102	35	102		2,446	24
25	Automatic doors			1997	12,950	370	35	370		8,541	25
26	Basement renovation			1997	59,358		10			59,358	26
27	Land Improvements - outdoor flagpole			1997	1,574		15			1,574	27
28	1st floor remodel (nurses station/lounge)			1998	76,487		10			76,487	28
29	Wiring for MDS			1998	4,506		10			4,506	29
30	Flag pole			1998	787		10			787	30
31	Resurface/Stripe parking lot			1998	9,777		10			9,777	31
32	Kitchen tile/paint			1999	718		10			718	32
33	1st floor remodel (nurses station/lounge)			1999	3,296		10			3,296	33
34	Roof repairs			2000	5,748		15			5,748	34
35	Sump pump			2000	2,534		10			2,534	35
36	Sump pump basin repair			2000	6,307		10			6,307	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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	automatic door closers	2000	$ 1,300	$	15	$	$	$ 1,300	37
38	infrared curtains for elevator doors	2001	3,000		10			3,000	38
39	ejector pump	2002	3,050		5			3,050	39
40	lift station pump	2002	3,359		5			3,359	40
41	new asphalt parking lot	2003	16,450		10			16,450	41
42	roof repairs	2003	2,900		10			2,900	42
43	freezer/cooler repairs	2003	4,005	200	20	200		3,485	43
44	kitchen remodel	2003	7,188	359	20	359		6,255	44
45	painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		53,566	45
46	floor tile	2003	16,305	815	20	815		14,672	46
47	rehab-painting & decorating	2003	75,774	3,789	20	3,789		64,727	47
48	rehab-floor tile	2003	8,117	406	20	406		6,935	48
49	dining room remodel	2003	42,698	2,135	20	2,135		36,473	49
50	foundation repair	2003	4,800	240	20	240		4,180	50
51	parking lot	2004	24,550		10			24,550	51
52	kitchen walk-in cooler floor	2004	7,161		10			7,161	52
53	old towne rehab	2004	13,967	698	20	698		11,344	53
54	alzheimers remodel	2004	208,935	10,447	20	10,447		168,022	54
55	create first fllor therapy room	2004	185	9	20	9		126	55
56	trnsitional unit	2005	213	11	20	11		153	56
57	landscaping	2005	8,814	441	20	441		6,688	57
58	roof repairs	2005	3,250	163	20	163		2,471	58
59	HVAC upgrade	2005	7,048	352	20	352		5,399	59
60	kitchen repair	2005	1,631	82	20	82		1,269	60
61	lobby, reception and office rehabilitation	2005	19,900	995	20	995		14,925	61
62	window treatments	2005	3,606		5			3,606	62
63	lower level therapy rehabilitation	2005	7,167	358	20	358		5,729	63
64	therapy room rehabilitation	2005	42,149	2,107	20	2,107		31,606	64
65	alzheimers remodel	2005	35,986	1,799	20	1,799		27,286	65
66	basement renovation	2005	14,176	709	20	709		10,634	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,126,921	$ 31,085		$ 179,225	$ 148,140	$ 5,190,328	70

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	
1	Totals from Page 12A, Carried Forward		$ 6,126,921	$ 31,085		$ 179,225	$ 148,140	$ 5,190,328	1
2	Landscaping enhancement	2006	7,084	472	15	472		6,766	2
3	install kitchen sink	2006	2,915	146	20	146		2,153	3
4	common area rehab	2006	2,382	119	20	119		1,746	4
5	paint building exterior	2006	19,500		5			19,500	5
6	patio	2006	53,305	3,554	15	3,554		50,051	6
7	retaining wall	2007	2,950	197	15	197		2,692	7
8	roof repair	2007	17,050	853	20	853		11,728	8
9	air conditionng units	2007	4,338	217	20	217		3,020	9
10	paverr walk and stairway	2007	10,500	525	20	525		7,175	10
11	fire exit stairways	2007	9,379	469	20	469		6,175	11
12	Landscaping	2008	35,147	2,343	15	2,343		28,311	12
13	parking lot seal & striping	2008	6,460	323	20	323		4,038	13
14	roof repair	2008	15,300	765	20	765		9,690	14
15	HVAC spot coolers	2008	5,589	140	40	140		1,680	15
16	electrical storage rooms	2008	4,768	238	20	238		2,955	16
17	electrical fire alarm panel	2008	118,395	5,920	20	5,920		71,533	17
18	1st floor remodel - carpentry, flooring, electrical, parking	2008	557,202		27	20,262	20,262	256,652	18
19	lawn irrigation	2009	14,435	962	15	962		10,903	19
20	landscaping	2009	12,950	863	15	863		9,637	20
21	roof	2009	49,330	2,467	20	2,467		27,548	21
22	front entrance	2009	19,392	485	40	485		5,416	22
23	HVAC Window unit	2009	41,315		10			41,315	23
24	HVAC quick connectors	2009	7,058		10			7,058	24
25	lift pump	2009	14,783		10			14,783	25
26	fire alarm panel	2009	93,279	4,664	20	4,664		51,693	26
27	pantry cabinets	2009	3,523		10			3,523	27
28	therapy room counter tops carpentry	2009	2,500		10			2,500	28
29	patio pergola	2009	7,930	397	20	397		4,499	29
30	patio stamped concrete	2009	13,901	927	15	927		10,583	30
31	lobby 1st floor remodel - carpentry, doors, frames, electrical	2009	52,018		27	1,892	1,892	20,812	31
32	painting, wallpaper								32
33	OT remodel, carpentry, electrical	2010	791,224		27	62,223	62,223	633,601	33
34	TOTAL (lines 1 thru 33)		$ 8,122,823	$ 58,131		$ 290,648	$ 232,517	$ 6,520,064	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	
1	Totals from Page 12B, Carried Forward		$ 8,122,823	$ 58,131		$ 290,648	$ 232,517	$ 6,520,064	1
2									2
3	lawn irrigation system	2010	5,503	367	15	367		3,853	3
4	roof work	2010	15,268	557	27	557		5,848	4
5	HVAC Chiller	2010	84,004	3,064	27	3,064		31,151	5
6	Pantry shelves	2010	23,805	868	27	868		9,042	6
7	Wanderguard	2010	3,747	137	27	137		1,404	7
8	Concrete work	2010	7,080	258	27	258		2,623	8
9	automatic doors	2010	4,903	490	10	490		5,145	9
10	Phsycian office carpentry and electrical update	2010	4,677	171	27	171		1,724	10
11	Library/Lounge art, painting	2010	13,763	502	27	502		5,146	11
12	Pergola and patio work	2010	21,186		27			21,186	12
13	Office carpentry and electrical changes	2010	5,744	209	27	209		2,125	13
14	Payroll office painting carpentry	2011	18,505	673	27	673		6,169	14
15	Mulch stone and perennials	2011	4,364	291	15	291		2,667	15
16	Admissions office painting carpentry	2011	2,868	104	27	104		953	16
17	Parking lot lights	2011	6,070	221	27	221		2,026	17
18	roof work	2011	93,530	3,401	27	3,401		30,892	18
19	Frunt entrance, awning, doors	2011	11,869	432	27	432		4,247	19
20	Duct extension	2011	3,476	126	27	126		1,250	20
21	HVAC unit	2011	23,400	851	27	851		7,801	21
22	Fluid pump	2011	8,400	305	27	305		3,000	22
23	Plumbing valves	2011	9,257	337	27	337		3,061	23
24	Laundry room - painting, electical, tile	2011	8,386	305	27	305		2,821	24
25	Elevator electrical work	2011	60,523	2,201	27	2,201		39,976	25
26	VCT floor OT Painting, electrical, carpentry	2011	49,344	1,794	27	1,794		16,296	26
27									27
28	Front entrance door	2012	5,387	196	27	196		1,633	28
29	Sprinklers building	2012	6,500	236	27	236		1,927	29
30	Washing machine slab	2012	3,500	127	27	127		1,090	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,627,882	$ 76,354		$ 308,871	$ 232,517	$ 6,735,120	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	
1	Totals from Page 12C, Carried Forward		$ 8,627,882	$ 76,354		$ 308,871	$ 232,517	$ 6,735,120	1
2	gnerator exhaust pipe rooftop	2013	9,715	177	27	353	176	2,294	2
3	EMR wiring entire facility	2013	14,022	42	27	510	468	3,528	3
4									4
5	A/C gas unit - HVAC mechanical room	2014	30,091	1,094	27	1,094		6,018	5
6	R/M Remodel and relocating kitchen sink	2014	5,205		10	521	521	3,384	6
7	replaced pipes, concrete and tile								7
8	Furnace in shower room	2015	11,971	435	27	435		2,320	8
9	EMR wiring entire facility	2015	6,233	227	27	227		1,154	9
10	R&M Asphalt work in the parking lot	2015	5,800		20	290	290	1,595	10
11	R&M PTAC Heat pump, cooling and heating and	2015	20,633		27	764	764	4,203	11
12	Control systems replacement in mechanical								12
13	room								13
14	Injections to raise sinking concrete slab for 6 patient rooms	2016	29,077	1,057	27	1,057		4,228	14
15	Chair rail installations in 1st floor rooms								15
16	Funish/Install cabinets in lower level activity room	2016	3,560	712	5	712		3,085	16
17	Furnish & install 5 rods/valances for 8 windows	2016	3,945	564	7	564		2,678	17
18	common areas/hallways								18
19	R&M Replace sanitary line in kitchen	2016	6,250		20	313	313	1,407	19
20	Furnish and isntall cast iron piping, limestone, concrete								20
21	R&M Heat pump HVAC mechanical room	2016	6,190		10	619	619	2,786	21
22	R&M Remove 10 trees and install 4 new trees outside NH	2016	9,511		20	476	476	2,141	22
23									23
24	R&M 4" nine furnishened and installed plumbing work in kitchen	2017	3,800		27	141	141	493	24
25	R&M Remove asphalt, add concrete and sewer rebuild parking lot	2017	3,000		27	111	111	408	25
26	Funish and install air conditioner in office and conf room LL	2018	28,982	1,932	15	1,932		4,347	26
27	Furnish & Install slide in ACUnits resident rooms	2018	10,047	1,005	10	1,005		2,010	27
28	Install new Key into spare fluid pum mechanical room	2018	4,711	942	5	942		2,041	28
29	Update walls in kitchen pantries	2018	4,709	471	10	471		1,217	29
30	Update electrical (conduit, pole, wires) in laundry room	2018	3,910	391	10	391		945	30
31	Replace conner lines and reinstall tiles north corridor	2018	8,869	887	5	887		1,774	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,858,113	$ 86,290		$ 322,686	$ 236,396	$ 6,789,176	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	
1	Totals from Page 12D, Carried Forward		$ 8,858,113	$ 86,290		$ 322,686	$ 236,396	$ 6,789,176	1
2	Mill and resurface pavement	2019	45,600	1,824	25	1,824		2,736	2
3	Drainage project & refuse container in rear of building	2019	4,000	267	15	267	0	311	3
4	Repair damaged exterior wall	2019	32,545	1,627	20	1,627	(0)	2,305	4
5	Concrete work in parking lot, curbs, sidewalk	2019	6,100	244	25	244		325	5
6	Old Town HVAC installation project	2019	20,336	2,034	10	2,034	0	2,712	6
7	Replacement pump	2019	8,840	1,768	5	1,768		3,094	7
8	Provide power to touch screens	2019	3,720	93	40	93		147	8
9	AC/Heat Gas unit (10)	2020	19,792	1,649	10	1,649		1,649	9
10	Outdoor Lift Station Upgrade	2020	21,528	478	15	478		478	10
11									11
12	reconcile to books			1,087			(1,087)		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)		$ 9,020,574	$ 97,361		$ 332,670	$ 235,309	$ 6,802,933	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	
1	Totals from Page 12E, Carried Forward		$ 9,020,574	$ 97,361		$ 332,670	$ 235,309	$ 6,802,933	1
2	Building - management company	2002	273,248		40	9,841	9,841	127,651	2
3	HVAC electrical, security system, mgmt company	2003	2,400		30	119	119	1,913	3
4	key card system, management company	2004	377		20	31	31	276	4
5	VAV TX controls management company	2005	115		20	9	9	81	5
6	interior signs - management company	2006	84		20	9	9	71	6
7	Building improvements - management company	2008	11,829		20	440	440	5,204	7
8	Building improvements - management company	2009	2,196		20	193	193	1,258	8
9	Building improvements - management company	2010	2,165		20	152	152	1,122	9
10	Building improvements - management company	2011	1,700		20	129	129	697	10
11	Building improvements - management company	2012	5,004		20	302	302	1,495	11
12	Building improvements - management company	2013	4,439		20	204	204	1,692	12
13	Building improvements - management company	2014	2,402		20	391	391	1,508	13
14	Building improvements - management company	2015	422		20	84	84	280	14
15	Building improvements - management company	2016	6,968		20	842	842	2,322	15
16	Building improvements - management company	2017	4,396		20	310	310	701	16
17	Building improvements - management company	2018	790		20	47	47	86	17
18	Building improvements - management company	2019	14,240		20	386	386	712	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)		$ 9,353,349	$ 97,361		$ 346,159	$ 248,798	$ 6,950,002	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	$ 234,256	$ 27,764	$ 27,764	$	5-10	$ 152,237	71
72	Current Year Purchases	10,576	1,234	1,234		5	1,234	72
73	Fully Depreciated Assets	939,162					939,162	73
74	allocated from mgmt co	529,104		17,665	17,665		408,644	74
75	TOTALS	$ 1,713,098	$ 28,998	$ 46,663	$ 17,665		$ 1,501,277	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	allocated from mgmt co			49,837		3,314	3,314		38,220	79
80	TOTALS			$ 49,837	$	$ 3,314	$ 3,314		$ 38,220	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)	$ 11,538,578	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 126,359	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 396,136	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 269,777	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,489,499	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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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: $ 9,166 Description: See Sch. 14a
(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	allocated from mgmt co				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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39, 3	hrs	$	4,743	$ 204,178	$	4,743	$ 204,178	1
2	Licensed Speech and Language Development Therapist	39, 3	hrs		905	47,030		905	47,030	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39, 3	hrs		6,332	283,549		6,332	283,549	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				215,236		215,236	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39, 3				6,293			6,293	12
13	Other (specify): see sch 16a	39, 2					18,637		18,637	13
14	TOTAL			$	11,980	$ 541,050	$ 233,873	11,980	$ 774,923	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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	$ 22,773	$ 266,165	1
2	Cash-Patient Deposits	29,313	29,313	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,139,287)	2,171,209	2,171,209	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(12,287)	(12,287)	6
7	Other Prepaid Expenses	46,780	46,780	7
8	Accounts Receivable (owners or related parties)	(471,434)	790,340	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,786,354	$ 3,291,520	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,548	13
14	Buildings, at Historical Cost		5,183,589	14
15	Leasehold Improvements, at Historical Cost	2,315,815	3,717,546	15
16	Equipment, at Historical Cost	676,003	1,172,295	16
17	Accumulated Depreciation (book methods)	(2,014,170)	(7,365,012)	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 (spe insur recov rec	427,181	427,181	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,404,829	$ 3,538,147	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,191,183	$ 6,829,667	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 563,941	$ 563,941	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,065	40,065	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,773	195,773	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,797	9,797	31
32	Accrued Real Estate Taxes(Sch.IX-B)		136,032	32
33	Accrued Interest Payable	7,408	29,586	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	see workpaper 17a	6,714,511	3,628,396	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,531,495	$ 4,603,590	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,115,824	1,115,824	39
40	Mortgage Payable		4,908,212	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)**	$ 1,115,824	$ 6,024,036	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,647,319	$ 10,627,626	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,456,136)	$ (3,797,959)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,191,183	$ 6,829,667	48

*(See instructions.)

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,250,181)	1
2	Restatements (describe):		2
3	post closing adjustments	944	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,249,237)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,206,899)	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)**	$ (2,206,899)	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)**	$ (5,456,136)	24 *

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

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	$ 12,596,540	1
2	Discounts and Allowances for all Levels	(6,012,781)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,583,759	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,837,348	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,837,348	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	130	12
13	Barber and Beauty Care	2,771	13
14	Non-Patient Meals	208	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	199,508	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	93,920	19
20	Radiology and X-Ray		20
21	Other Medical Services	130,348	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 426,885	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,577	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,577	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	miscellaneous	17,350	28
28a	provider relief funds	1,204,712	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,222,062	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,075,631	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,664,969	31
32	Health Care	4,694,336	32
33	General Administration	3,817,005	33
	B. Capital Expense		
34	Ownership	830,825	34
	C. Ancillary Expense		
35	Special Cost Centers	1,015,752	35
36	Provider Participation Fee	259,643	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,282,530	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,206,899)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,206,899)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,038,798	44
45	Private Pay - Net Inpatient Revenue	646,990	45
46	Medicare - Net Inpatient Revenue	904,417	46
47	Other-(specify)	993,554	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,583,759	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 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	1,496	2,044	$ 126,357	$ 61.82	1
2	Assistant Director of Nursing	1,352	1,808	85,421	47.25	2
3	Registered Nurses	22,478	33,300	1,217,693	36.57	3
4	Licensed Practical Nurses	7,100	10,954	351,284	32.07	4
5	CNAs & Orderlies	43,451	60,678	1,261,910	20.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,559	2,032	45,687	22.48	9
10	Activity Assistants	3,372	4,304	61,413	14.27	10
11	Social Service Workers	4,925	5,990	146,679	24.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,304	1,927	45,727	23.73	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,607	1,912	141,635	74.08	20
21	Assistant Administrator					21
22	Other Administrative	6,862	8,133	249,926	30.73	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,189	3,104	54,802	17.66	31
32	Other Health Care(specify)					32
33	Other(specify) see sched 20a	11,170	15,057	501,075	33.28	33
34	TOTAL (lines 1 - 33)	108,865	151,243	$ 4,289,609 *	$ 28.36	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	$ 50,241	1-3	35
36	Medical Director	monthly	36,000	9-3	36
37	Medical Records Consultant	monthly	390	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	14,547	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	monthly	1,525	19-3	44
45	Social Service Consultant	monthly	4,572	19-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 107,275		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,302	$ 98,031	10-3	50
51	Licensed Practical Nurses	257	14,904	10-3	51
52	Certified Nurse Assistants/Aides	8,941	304,810	10-3	52
53	TOTAL (lines 50 - 52)	10,500	$ 417,745		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anshu Raina	Administrator	0	$ 141,635
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 141,635

B. Administrative - Other

Description	Amount
Royal mmgt fees	$ 514,248
shared services	820,188
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,334,436
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	legal fees	$ 20,812
Much Shelist	legal fees	20,897
Midcap Financial	legal fees	2,250
Markoff	legal fees	830
Lauhoff	legal fees	100
Much Shelist	Collections	32,385
Markoff	Collections	507
Wipfli	Accounting	5,000
RSM	Accounting	27,489
Personnel Planners	u/c consulting	1,065
Midcap Financial	DDS Exam Fees	13,345
see schedule 21c		144,114
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 268,794

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 210,208
Unemployment Compensation Insurance	23,043
FICA Taxes	312,227
Employee Health Insurance	253,986
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K CONTRIBUTION	(30,260)
UNIFORM ALLOWANCE	7,542
TUITION	7,217
OTHER BENEITS	18,848
TOTAL (agree to Schedule V, line 22, col.8)	$ 802,811

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,351
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	2,563
Misc License, Permits, Inspection	1,676
IHCA	6,436
Miscellaneous Dues	9,931
Lobbying portion of IHCA dues	(696)
allocated from mgmt co	13,873
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,134

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
allocated from management co	79
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 79

**See instructions.

Facility Name & ID Number Lexington Hlth Cr Ctr Blmngd # 0035188 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IHCA 6436**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,119** Line **10(2)**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **259,643**
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? **no** 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? **0**
d. Have vehicle usage logs been maintained? **adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
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:

(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.