		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0037317

Facility Name: Lexington of Elmhurst

Address: 420 W Butterfield Rd (Number) Elmhurst (City) 60126 (Zip Code)

County: DuPage

Telephone Number: 630-832-2300 **Fax #** 630-832-7043

HFS ID Number:

Date of Initial License for Current Owners: 11/12/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.	x			
	Trust		Individual		State
	IRS Exemption Code		Partnership		County
			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 of Elmhurst # 0037317 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	53,070	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	145	TOTALS	145	53,070	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			9,327	9,327	8
9	SNF/PED					9
10	ICF	12,373	4,977	551	17,901	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,373	4,977	9,878	27,228	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.31%

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 11/12/91

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 142 and days of care provided 5,529

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 of Elmhurst # 0037317 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	31,392	11,832	770,263	813,487		813,487	(168)	813,319			1
2	Food Purchase		(1,845)		(1,845)		(1,845)	475	(1,370)			2
3	Housekeeping		181	394,687	394,868		394,868		394,868			3
4	Laundry											4
5	Heat and Other Utilities			187,782	187,782		187,782	17,936	205,718			5
6	Maintenance	46,964	159	136,350	183,473		183,473	78,386	261,859			6
7	Other (specify):*							8,277	8,277			7
8	**TOTAL General Services**	78,356	10,327	1,489,082	1,577,765		1,577,765	104,906	1,682,671			8
	B. Health Care and Programs											
9	Medical Director			54,675	54,675		54,675		54,675			9
10	Nursing and Medical Records	3,644,701	494,934	598,855	4,738,490		4,738,490	19,398	4,757,888			10
10a	Therapy											10a
11	Activities	120,370	23,734		144,104		144,104		144,104			11
12	Social Services	146,937			146,937		146,937		146,937			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,374	2,374			15
16	**TOTAL Health Care and Programs**	3,912,008	518,668	653,530	5,084,206		5,084,206	21,772	5,105,978			16
	C. General Administration											
17	Administrative	149,567		1,332,600	1,482,167		1,482,167	(513,540)	968,627			17
18	Directors Fees											18
19	Professional Services			289,398	289,398		289,398	117,606	407,004			19
20	Dues, Fees, Subscriptions & Promotions			23,658	23,658		23,658	11,479	35,137			20
21	Clerical & General Office Expenses	283,061	18,993	53,370	355,424		355,424	852,757	1,208,181			21
22	Employee Benefits & Payroll Taxes			930,043	930,043		930,043		930,043			22
23	Inservice Training & Education							708	708			23
24	Travel and Seminar							69	69			24
25	Other Admin. Staff Transportation			1,245	1,245		1,245	13,578	14,823			25
26	Insurance-Prop.Liab.Malpractice			622,447	622,447		622,447	4,405	626,852			26
27	Other (specify):*							101,513	101,513			27
28	**TOTAL General Administration**	432,628	18,993	3,252,761	3,704,382		3,704,382	588,575	4,292,957			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,422,992	547,988	5,395,373	10,366,353		10,366,353	715,253	11,081,606			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			69,572	69,572		69,572	188,435	258,007			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,080	10,080		10,080	302,069	312,149			32
33	Real Estate Taxes							91,792	91,792			33
34	Rent-Facility & Grounds			533,548	533,548		533,548	(533,389)	159			34
35	Rent-Equipment & Vehicles			85,233	85,233		85,233	3,906	89,139			35
36	Other (specify):*											36
37	TOTAL Ownership			698,433	698,433		698,433	52,813	751,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		381,791	931,952	1,313,743		1,313,743		1,313,743			39
40	Barber and Beauty Shops			1,320	1,320		1,320	(452)	868			40
41	Coffee and Gift Shops			117	117		117		117			41
42	Provider Participation Fee			209,852	209,852		209,852		209,852			42
43	Other (specify):* nonallowable			967,989	967,989		967,989	(967,839)	150			43
44	TOTAL Special Cost Centers		381,791	2,111,230	2,493,021		2,493,021	(968,291)	1,524,730			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,422,992	929,779	8,205,036	13,557,807		13,557,807	(200,225)	13,357,582			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 of Elmhurst # 0037317 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	(168)	1		4
5	Telephone, TV & Radio in Resident Rooms	(15,908)	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	(2,233)	30		9
10	Interest and Other Investment Income	(5,791)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10,383)	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	(865,615)	43		24
25	Fund Raising, Advertising and Promotional	(23,183)	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	(70,805)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (994,086)		$	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)	793,861		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 793,861		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (200,225)		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

STATE OF ILLINOIS

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$	41	1
2	RADIOLOGY	(21,301)	43	2
3	LABORATORY	(31,533)	43	3
4			19	4
5	PERSONAL ITEM REPLACEMENT	(66)	43	5
6	COLLECTIONS	(7,222)	19	6
7	BARBER/BEAUTY INCOME	(452)	40	7
8	LOBBYING DUES	(638)	20	8
9			21	9
10	SALESFORCE COMPUTER CONSULTING	(6,510)	19	10
11			6	11
12			43	12
13	OFFSET MISC INTEREST	(3,083)	32	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**	(70,805)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(168)	0	0	0	0	0	0	0	0	0	0	(168)	1
2	Food Purchase	0	0	0	475	0	0	0	0	0	0	0	475	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	17,936	0	0	0	0	0	0	0	0	17,936	5
6	Maintenance	0	0	78,386	0	0	0	0	0	0	0	0	78,386	6
7	Other (specify):*	0	0	8,277	0	0	0	0	0	0	0	0	8,277	7
8	**TOTAL General Services**	(168)	0	104,599	475	0	0	0	0	0	0	0	104,906	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	19,398	0	0	0	0	0	0	0	0	19,398	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	2,374	0	0	0	0	0	0	0	0	2,374	15
16	**TOTAL Health Care and Programs**	0	0	21,772	0	0	0	0	0	0	0	0	21,772	16
	C. General Administration													
17	Administrative	0	0	0	(513,540)	0	0	0	0	0	0	0	(513,540)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,732)	(3,518)	134,856	0	0	0	0	0	0	0	0	117,606	19
20	Fees, Subscriptions & Promotions	(638)	0	12,117	0	0	0	0	0	0	0	0	11,479	20
21	Clerical & General Office Expenses	0	0	852,757	0	0	0	0	0	0	0	0	852,757	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	708	0	0	0	0	0	0	0	708	23
24	Travel and Seminar	0	0	0	69	0	0	0	0	0	0	0	69	24
25	Other Admin. Staff Transportation	0	0	0	13,578	0	0	0	0	0	0	0	13,578	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	4,405	0	0	0	0	0	0	0	4,405	26
27	Other (specify):*	0	0	0	101,513	0	0	0	0	0	0	0	101,513	27
28	**TOTAL General Administration**	(14,370)	(3,518)	999,730	(393,267)	0	0	0	0	0	0	0	588,575	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,538)	(3,518)	1,126,101	(392,792)	0	0	0	0	0	0	0	715,253	29

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	(2,233)	155,407	0	35,261	0	0	0	0	0	0	0	188,435	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,874)	268,677	0	42,266	0	0	0	0	0	0	0	302,069	32
33	Real Estate Taxes	0	71,626	0	20,166	0	0	0	0	0	0	0	91,792	33
34	Rent-Facility & Grounds	0	(533,389)	0	0	0	0	0	0	0	0	0	(533,389)	34
35	Rent-Equipment & Vehicles	0	0	0	3,906	0	0	0	0	0	0	0	3,906	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(11,107)	(37,679)	0	101,599	0	0	0	0	0	0	0	52,813	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	(452)	0	0	0	0	0	0	0	0	0	0	(452)	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):*	(967,989)	150	0	0	0	0	0	0	0	0	0	(967,839)	43
44	**TOTAL Special Cost Centers**	(968,441)	150	0	0	0	0	0	0	0	0	0	(968,291)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(994,086)	(41,047)	1,126,101	(291,193)	0	0	0	0	0	0	0	(200,225)	45

Facility Name & ID Number Lexington of Elmhurst # 0037317 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 Elmhurst II Limited Partnership	**	$ (3,518)	$ (3,518)	1
2	V	30	depreciation		Sambell of Elmhurst II Limited Partnership	**	155,407	155,407	2
3	V	32	interest expense		Sambell of Elmhurst II Limited Partnership	**	268,677	268,677	3
4	V	32	amortization of mortgage cost		Sambell of Elmhurst II Limited Partnership	**			4
5	V	33	property taxes		Sambell of Elmhurst II Limited Partnership	**	71,626	71,626	5
6	V	34	rental expense	533,389	Sambell of Elmhurst II Limited Partnership	**		(533,389)	6
7	V	43	trust fees		Sambell of Elmhurst II Limited Partnership	**	150	150	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V				** The owners of Lexington Health Care Center of Elmhurst Inc. own				12
13	V				100% of Sambell of Elmhurst II Limited Partnership				13
14	Total			$ 533,389			$ 492,342	$ * (41,047)	14

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping Supplies	$	Royal Management Corp.	**	$	$	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	17,431	17,431	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	505	505	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**			18
19	V	6	Management Allocation - salaries		Royal Management Corp.	**	67,629	67,629	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	10,757	10,757	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**			21
22	V	7	Management Allocation - empoyee benefits		Royal Management Corp.	**	8,277	8,277	22
23	V	10	Medical consultant		Royal Management Corp.	**			23
24	V	10	Management Allocation - salaries		Royal Management Corp.	**	19,398	19,398	24
25	V	15	Management Allocation - empoyee benefits		Royal Management Corp.	**	2,374	2,374	25
26	V	17	Management Allocation - salaries		Royal Management Corp.	**			26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	36,954	36,954	27
28	V	19	Professional fees		Royal Management Corp.	**	97,902	97,902	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,036	1,036	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	11,081	11,081	30
31	V	21	Management Allocation - salaries		Royal Management Corp.	**	829,468	829,468	31
32	V	21	Bank charges		Royal Management Corp.	**	4,516	4,516	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	2,713	2,713	33
34	V	21	Postage		Royal Management Corp.	**	3,739	3,739	34
35	V	21	Telephone		Royal Management Corp.	**	12,321	12,321	35
36	V								36
37	V								37
38	V		** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp						38
39	Total			$			$ 1,126,101	$ * 1,126,101	39

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	23	Inservice training	$	Royal Management Corp	**	$ 708	$ 708	15
16	V	24	Travel & seminar		Royal Management Corp	**	69	69	16
17	V	25	Auto expense		Royal Management Corp	**	13,578	13,578	17
18	V	26	Insurance general		Royal Management Corp	**	4,405	4,405	18
19	V	27	Management Allocation - employee benefits		Royal Management Corp	**	101,513	101,513	19
20	V	30	Depreciation		Royal Management Corp	**	35,261	35,261	20
21	V	32	Interest		Royal Management Corp	**	42,266	42,266	21
22	V	2	Amortization of mortgage costs		Royal Management Corp	**	475	475	22
23	V	33	Property taxes		Royal Management Corp	**	20,166	20,166	23
24	V	34	Rent expense		Royal Management Corp	**			24
25	V	35	Equipment rental		Royal Management Corp	**	3,906	3,906	25
26	V	17	Management fees	513,540	Royal Management Corp	**		(513,540)	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 Elmhurst, Inc own 100% of Royal Management Corp.						38
39	Total			$ 513,540			$ 222,347	$ * (291,193)	39

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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 Bloomingdale Inc.	Bloomingdale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr of LaGrange Inc.	LaGrange	Lexington Square		Independent and	3
4			Lexington HC Ctr of Lake Zurich Inc.	Lake Zurich	Life Care	Lombard	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		Independent and	6
7			Lexington HC Ctr of Schaumburg Inc.	Schaumburg	Life Care	Elmhurst	Living Facility	7
8					of Elmhurst, LLC			8
9					Vesta Management	Lomardd	Mgmt Company	9
10					Group LLC			10
11					Sambell of		Real Estate	11
12					Elmhurst Ltd.	Elmhurst	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					Curatess LLC	Lombard	Telemedicine	24
25					Repbulic Construction	Lombard	Construction	25
26					of Illinois, Inc.		Company	26
27					Lexington Home	Lombard	Home Health	27
28					Health Care, Inc.			28
29					Lexington Hospice	Lombard	Hospice	29
30					Services, LLC			30

Facility Name & ID Number Lexington of Elmhurst # 0037317 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					Lexington Private	Lombard	Healthcare	1
2					Home Care			2
3					Merit Sleep	Lombard	Mgmt Company	3
4					Management LLC			4
5					Sambell of Chicago	Chicago Ridge	Real Estate	5
6					Ridge Ltd Ptsp		Property	6
7					Sambell of Bloomingda	Bloomingdale	Real Estate	7
8					II Ltd Ptsp		Property	8
9					Sambell of	LaGrangeg	Real Estate	9
10					LaGrange Ltd Ptsp		Property	10
11					Lexington HC Sys	Lake Zurich	Real Estate	11
12					of Lake Zurich Ltd		Property	12
13					Ptsp			13
14					Lexington HC Sys	Lombard	Real Estate	14
15					of Lombard Ltd Ptsp		Property	15
16					Lexington HC Sys	Orland Park	Real Estate	16
17					of Orland Park Ltd		Property	17
18					Ptsp			18
19					Sambell of	Schaumburg	Real Estate	19
20					Schaumburg Ltd Ptsp		Property	20
21					Samvest of Algonquin	Algonquin	Real Estate	21
22					Ltd Ptsp		Property	22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington of Elmhurst # 0037317 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 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 of Elmhurst # 0037317 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 svailable	565,750	8	$	$	52,925	$ 0	1
2	5	Utilities - gas & electric	Bed days svailable	565,750	8	186,333		52,925	17,431	2
3	5	Utilities - water & sewer	Bed days svailable	565,750	8	5,398		52,925	505	3
4	5	Utilities - maintenance office	Bed days svailable	565,750	8			52,925	0	4
5	6	Management Allocation - salaries	Bed days svailable	565,750	8	722,929	722,929	52,925	67,629	5
6	6	Repairs & maintenance	Bed days svailable	565,750	8	114,986		52,925	10,757	6
7	6	Scavenger & exterminating	Bed days svailable	565,750	8			52,925	0	7
8	7	Management Allocation - empoyee ber	Bed days svailable	565,750	8	88,474		52,925	8,277	8
9	10	Medical consultant	Bed days svailable	565,750	8			52,925	0	9
10	10	Management Allocation - salaries	Bed days svailable	565,750	8			52,925	0	10
11	15	Management Allocation - empoyee ber	Bed days svailable	565,750	8	25,377		52,925	2,374	11
12	17	Management Allocation - salaries	Bed days svailable	565,750	8	207,358	207,358	52,925	19,398	12
13	19	Computer consultant & supplies	Bed days svailable	565,750	8	395,029		52,925	36,954	13
14	19	Professional fees	Bed days svailable	565,750	8	1,046,538		52,925	97,902	14
15	20	Dues & subscriptions	Bed days svailable	565,750	8	11,082		52,925	1,037	15
16	20	Advertising - help wanted	Bed days svailable	565,750	8	118,456		52,925	11,081	16
17	21	Management Allocation - salaries	Bed days svailable	565,750	8	8,866,730	8,866,730	52,925	829,468	17
18	21	Bank charges	Bed days svailable	565,750	8	48,277		52,925	4,516	18
19	21	Office supplies & printing	Bed days svailable	565,750	8	29,001		52,925	2,713	19
20	21	Postage	Bed days svailable	565,750	8	39,969		52,925	3,739	20
21	21	Telephone	Bed days svailable	565,750	8	131,703		52,925	12,321	21
22										22
23										23
24										24
25	TOTALS					$ 12,037,640	$ 9,797,017		$ 1,126,102	25

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	$	52,925	$ 708	1
2	24	Travel & seminar	Bed days available	565,750	8	735		52,925	69	2
3	25	Auto expense	Bed days available	565,750	8	145,140		52,925	13,578	3
4	26	Insurance general	Bed days available	565,750	8	47,093		52,925	4,405	4
5	27	Management Allocation - employee be	Bed days available	565,750	8	1,085,139		52,925	101,513	5
6	30	Depreciation	Bed days available	565,750	8	376,924		52,925	35,261	6
7	32	Interest	Bed days available	565,750	8	451,812		52,925	42,266	7
8	2	Amortization of mortgage costs	Bed days available	565,750	8	5,077		52,925	475	8
9	33	Property taxes	Bed days available	565,750	8	215,565		52,925	20,166	9
10	34	Rent expense	Bed days available	565,750	8			52,925		10
11	35	Equipment rental	Bed days available	565,750	8	41,748		52,925	3,905	11
12	17	Management fees	Bed days available	565,750	8			52,925		12
13	35	Auto lease	Bed days available	565,750	8			52,925		13
14	6	Security	Bed days available	565,750	8			52,925		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	$		$ 222,346	25

Facility Name & ID Number Lexington of Elmhurst # 0037317 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**		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	MB Financial		x	Mortgage	varies	9/15/2017	$ 6,506,220	$ 5,725,475	9/15/2019	Libor + 3.5	$ 268,600	1
2												2
3												3
4												4
5												5
	Working Capital											
6	West Suburban Bank		x	PPP loan	none	5/7/20	1,065,469	1,065,469	5/7/22	0.0100	7,074	6
7												7
8												8
9	TOTAL Facility Related						$ 7,571,689	$ 6,790,944			$ 275,674	9
	B. Non-Facility Related*											
10								interest income offset			(5,791)	10
11								allocated from mgmt co			42,266	11
12								Misc interest			3,083	12
13								Offset miscellaneous interst			(3,083)	13
14	TOTAL Non-Facility Related						$	$			$ 36,475	14
15	TOTALS (line 9+line14)						$ 7,571,689	$ 6,790,944			$ 312,149	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 of Elmhurst # 0037317 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	81,864	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.)	$	77,386	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,478)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	76,104	4
allocated from management co		20,166	
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.	$	91,792	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	72,948	8
	2016	73,680	9
	2017	77,955	10
	2018	82,388	11
	2019	77,386	12

FOR BHF USE ONLY

Line	Description		Line
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 of Elmhurst COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0037317

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.	06-14-317-008	Land & Building	$ 77,386.00	$ 77,386.00
2.	Royal Management Corp (Samvest of Lombard II)		$	$
3.	05-01-202-021	Land & Building	$ 215,565.00	$ 20,166.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 292,951.00	$ 97,552.00

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 of Elmhurst # 0037317 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior concrete block Frame steel Number of Stories 3

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 [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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	resident care	55,000	1991	$ 1,277,670	1
2	management company allocations			17,239	2
3	TOTALS	55,000		$ 1,294,909	3

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	133		1991	1991	$ 4,110,586	$	35	$ 117,445	$ 117,445	$ 3,418,680	4
5	12		1995	1995	73,302	2,095	35	2,095		53,736	5
6											6
7											7
8											8
	Improvement Type**										
9	building improvement			1992	693	20	35	20		561	9
10	land improvement			1995	7,500		15			7,500	10
11	fan coil units			1996	4,904	140	35	140		3,432	11
12	patio			1996	2,322		15			2,322	12
13	basement rehab			1997	17,151		10			17,151	13
14	baseboards			1997	3,129		10			3,129	14
15	wiring			1998	3,090		10			3,090	15
16	lobby tile			1999	19,354		10			19,354	16
17	patio			1999	4,196		15			4,196	17
18	automatic door			2000	1,300		10			1,300	18
19	wallpaper			2000	6,853		10			6,853	19
20	patio			2000	1,242		15			1,242	20
21	storage closet for HVAC			2000	3,745		15			3,745	21
22	fire pump system			2001	4,140		10			4,140	22
23	door releases			2001	4,420		10			4,420	23
24	infrared curtains for elevator			2001	3,000		10			3,000	24
25	parking lot			2002	2,532		10			2,532	25
26	kitchen tile and plumbing			2002	9,661		10			9,661	26
27	elevator upgrade			2002	2,596		5			2,596	27
28	facility rehab - painting/wallpaper/carpeting			2003	175,251		10			175,251	28
29	facility rehab - floor tile/room upgrade			2003	38,140	1,907	20	1,907		34,167	29
30	facility rehab - carpeting			2003	7,861		10			7,861	30
31	parking lot			2004	2,000		5			2,000	31
32	roof			2004	15,000	750	20	750		12,313	32
33	landscaping			2005	5,396	270	20	270		4,182	33
34	paint for building			2005	9,000		10			9,000	34
35	roof			2005	14,300	715	20	715		10,844	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 Lexington of Elmhurst # 0037317 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	HVAC upgrade	2005	$ 3,230	$ 162	20	$ 162	$	$ 2,532	37
38	sprinkler system	2005	1,060	53	20	53		808	38
39	lobby, lounge, and reception rehab	2005	27,602	1,380	20	1,380		21,966	39
40	window treatment	2005	1,932		10			1,932	40
41	cubicle curtains	2005	820		5			820	41
42	countertop	2005	845		5			845	42
43	HVAC	2006	3,793	190	20	190		2,673	43
44	automatic door lock	2006	2,784	139	20	139		1,948	44
45	storeroom door lock	2006	1,904	95	20	95		1,348	45
46	service door	2006	2,545	127	20	127		1,781	46
47	landscaping ehancement - patio	2006	2,340	156	15	156		2,249	47
48	PT therapy room	2006	570	14	40	14		196	48
49									49
50									50
51									51
52	transitional unit	2007	1,864	93	20	93		1,281	52
53	employee lunch room	2007	2,827	141	20	141		1,907	53
54	PT room rehab	2007	58,628	2,941	20	2,941		39,018	54
55	landscaping-brick pavers	2008	43,813	2,921	15	2,921		35,781	55
56	parking lot	2008	31,700	1,585	20	1,585		19,945	56
57	roof repairs	2008	4,200	280	15	280		3,547	57
58	HVAC - new chillers	2008	118,557	5,928	20	5,928		73,111	58
59	emergency A/C	2008	5,706	285	20	285		3,517	59
60	building addition	2008			27				60
61	kitchen upgrade	2008	7,214		27	262	262	3,188	61
62	2nd floor remodel-painting, flooring, electrical	2008	561,274		27	20,410	20,410	248,322	62
63	foundation stabilization	2008	66,195		27	2,407	2,407	29,285	63
64	irrigation system	2009	15,485	1,032	15	1,032		11,698	64
65	landscaping enhancements	2009	26,798	1,787	15	1,787		20,398	65
66	patio fence	2009	9,319	466	20	466		5,397	66
67	chiller	2009	82,310	4,115	20	4,115		48,355	67
68	plumbing	2009	4,280	214	20	214		2,354	68
69	2nd floor remodel-MDS office, HR office, nursing call system	2009	6,853	250	27	250		2,760	69
70	TOTAL (lines 4 thru 69)		$ 5,649,112	$ 30,251		$ 170,775	$ 140,524	$ 4,417,220	70

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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		$ 5,649,112	$ 30,251		$ 170,775	$ 140,524	$ 4,417,220	1
2	patio pergola	2009	12,814	641	20	641		7,262	2
3	tub room carpentry, flooring, electrical	2009	5,828	212	27	212		2,331	3
4	2nd floor remodel - carpentry, doors, flooring, electrical	2009	455,801		27	16,575	16,575	194,756	4
5	painting, sprinkler system								5
6	landscaping	2010	3,314	221	15	221		2,265	6
7	physician office remodel-carpetnry, tiling	2010	6,450	235	27	235		2,367	7
8	front entrance door and drain tile	2010	4,418	216	27	216		2,204	8
9	nurse pull cord station	2010	3,256	118	27	118		1,182	9
10	remodel pantry shelves	2010	7,146	260	27	260		2,599	10
11	director of nursing office painting	2010	5,539	201	27	201		2,013	11
12	corridor remodel-flag pole tiling	2010	13,777	550	27	550		5,568	12
13	library/lounge remodel-art,carpentry,electrical	2010	11,870	432	27	432		4,318	13
14	steel frame remodel	2010	6,740	245	27	245		2,573	14
15	2nd floor remodel-carpentry, doors, flooring, electrical	2010	17,168	624	27	624		6,866	15
16	tub room carpentry, plumbing	2010	11,731	427	27	427		4,623	16
17	pergola	2010	8,180		5			8,180	17
18	stamped concrete	2010	17,260	628	27	628		6,487	18
19	landscaping	2011	4,443	296	15	296		2,764	19
20	offices-doors, locks, keys	2011	66,131	2,405	27	2,405		23,047	20
21	seal and stripe parking lot	2011	3,500	127	27	127		1,176	21
22	laundry room electrical, painting	2011	6,412	233	27	233		2,214	22
23	floor install	2011	10,158	369	27	369		3,631	23
24	2nd floor doors	2011	9,654	351	27	351		3,481	24
25									25
26	front entrance door	2012	3,733	136	27	136		1,121	26
27	shower-electrical	2012	4,982	181	27	181		1,479	27
28	fire dampers	2012	7,392	269	27	269		2,174	28
29	low voltage wiring	2012	5,186	189	27	189		1,636	29
30	emr wiring	2012	14,543	529	27	529		4,275	30
31	1st floor doors	2012	8,476	308	27	308		2,593	31
32	back patio fence	2012	3,536	129	27	129		1,137	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,388,550	$ 40,783		$ 197,882	$ 157,099	$ 4,723,542	34

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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		$ 6,388,550	$ 40,783		$ 197,882	$ 157,099	$ 4,723,542	1
2	1st Fl. Rm. Reconfigure. - labor, electrical, drywall, plumbing	2013	39,603	1,440	27	1,440		11,100	2
3									3
4	MDS Office Millwork & Electrical	2014	15,401	560	27	560		3,593	4
5	Automate Front Doors (Front Entrance)	2014	9,593	349	27	349		2,181	5
6	Install LED Lights throughout facility	2014	44,958	1,635	27	1,635		9,810	6
7	Wiring -Fiber connection throughout facility	2014	5,597	204	27	204		1,291	7
8									8
9									9
10	Parking Lot - Replace Aprons and Curbs	2015	27,000	1,800	15	1,800		9,750	10
11	EMR Wiring - Entire Facility	2015	5,087	185	27	185		1,048	11
12									12
13	R&M Reclass: Parking Lot - crack sealing, coating, and striping	2015	3,800		20	190	190	1,045	13
14	R&M Reclas: Landscaping on left and ride side of driveway	2015	8,676		15	578	578	3,179	14
15	and side of building								15
16									16
17	Physical Therapy Room Construction - Surfacing, Equipment	2016	12,981	481	27	481		2,044	17
18	Relocating, Plumbing, Drywalls, Wiring, Painting								18
19	Resident Rooms Remodeling - Chair Rail Installations in First	2016	24,495	907	27	907		3,779	19
20	Floor and Second Floor Rooms								20
21									21
22	Parking Lot - Mill Asphalt and resurface	2018	24,100	1,607	15	1,607		4,285	22
23									23
24	Air compressor	2019	5,511	276	20	276	0	437	24
25	Provide power to touchscreens	2019	2,917	73	40	73	0	128	25
26									26
27	R&M Reclass: tree removal and replanting of trees	2019	3,125		15	208	208	260	27
28	R&M Reclass: Replace sprinklers in kitchen	2019	4,856		25	194	194	243	28
29	R&M Reclass: Elevator repairs	2019	3,041		20	152	152	190	29
30	R&M Reclass: Elevator repairs	2019	4,241		20	212	212	318	30
31	R&M Reclass: Repair damaged downspouts	2019	3,400		10	340	340	510	31
32									32
33	reconcile to book			629			(629)		33
34	TOTAL (lines 1 thru 33)		$ 6,636,932	$ 50,928		$ 209,274	$ 158,345	$ 4,778,733	34

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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		$ 6,636,932	$ 50,928		$ 209,274	$ 158,345	$ 4,778,733	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,636,932	$ 50,928		$ 209,274	$ 158,345	$ 4,778,733	34

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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		$ 6,636,932	$ 50,928		$ 209,274	$ 158,345	$ 4,778,733	1
2									2
3	Building - management company	2002	238,549		40	8,591	8,591	111,544	3
4	HVAC, electrical, security system - management company	2003	2,095		30	104	104	1,672	4
5	Key card system - management company	2004	329		20	27	27	241	5
6	VAV TX controls - management company	2005	100		20	8	8	71	6
7	Interior Signs - management company	2006	73		20	8	8	62	7
8	Building improvements - management company	2008	10,328		20	385	385	4,549	8
9	Building improvements - management company	2009	1,918		20	168	168	1,098	9
10	Building improvements - management company	2010	1,889		20	133	133	981	10
11	Building improvements - management company	2011	1,484		20	113	113	609	11
12	Building improvements - management company	2012	4,367		20	263	263	1,305	12
13	Building improvements - management company	2013	3,875		20	178	178	1,478	13
14	Building improvements - management company	2014	2,097		20	341	341	1,317	14
15	Building improvements - management company	2015	369		20	73	73	244	15
16	Building improvements - management company	2016	6,086		20	735	735	2,029	16
17	Building improvements - management company	2017	3,838		20	270	270	611	17
18	Building improvements - management company	2018	689		20	41	41	75	18
19	Building improvements - management company	2019	12,432		20	337	337	622	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)		$ 6,927,450	$ 50,928		$ 221,049	$ 170,120	$ 4,907,241	34

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	$ 199,803	$ 16,395	$ 16,395	$	5-10	$ 150,984	71
72	Current Year Purchases	19,280	2,249	2,249		5	2,249	72
73	Fully Depreciated Assets	1,247,962					1,247,962	73
74	allocated from mgmt co	461,918		15,421	15,421		357,095	74
75	TOTALS	$ 1,928,963	$ 18,644	$ 34,065	$ 15,421		$ 1,758,290	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			43,508		2,893	2,893		33,398	79
80	TOTALS			$ 43,508	$	$ 2,893	$ 2,893		$ 33,398	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)	$ 10,194,830	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 69,572	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 258,007	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 188,434	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,698,929	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 of Elmhurst # 0037317 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? [x] YES [ ] NO
16. Rental Amount for movable equipment: $ 9,502 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 management company				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 of Elmhurst # 0037317 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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39, 3	hrs	$	8,579	$ 334,414	$	8,579	$ 334,414	1
2	Licensed Speech and Language Development Therapist	39, 3	hrs		2,440	115,545		2,440	115,545	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39, 2 & 3	hrs		9,031	378,074		9,031	378,074	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				361,381		361,381	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): ambulance	39, 3				60,257			60,257	12
13	Other (specify): see Sch. 16a	39, 2					20,412		20,412	13
14	TOTAL			$	20,050	$ 888,290	$ 381,793	20,050	$ 1,270,083	14

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	$ 878,320	$ 982,107	1
2	Cash-Patient Deposits	29,296	29,296	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,064,845)	2,249,758	2,249,758	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,060	43,061	6
7	Other Prepaid Expenses	42,527	43,527	7
8	Accounts Receivable (owners or related parties)	(1,235,619)	550,900	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,007,342	$ 3,898,649	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,319	6,319	12
13	Land		1,277,670	13
14	Buildings, at Historical Cost		4,051,346	14
15	Leasehold Improvements, at Historical Cost	1,240,552	2,331,035	15
16	Equipment, at Historical Cost	786,468	1,454,589	16
17	Accumulated Depreciation (book methods)	(1,429,575)	(5,944,545)	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 ins rec receiv	1,258,196	1,258,196	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,861,960	$ 4,434,610	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,869,302	$ 8,333,259	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,041,410	$ 1,041,410	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,282	42,282	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	201,357	201,357	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,184	11,184	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,104	32
33	Accrued Interest Payable	7,074	102,998	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	see schedule 17a	4,602,293	4,058,922	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,905,600	$ 5,534,257	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,065,469	1,065,469	39
40	Mortgage Payable		5,725,475	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)**	$ 1,065,469	$ 6,790,944	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,971,069	$ 12,325,201	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,101,767)	$ (3,991,942)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,869,302	$ 8,333,259	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (943,436)	1
2	Restatements (describe):		2
3	post closing adjustment	20,730	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (922,706)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,179,061)	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)**	$ (2,179,061)	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)**	$ (3,101,767)	24 *

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

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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	$ 12,288,512	1
2	Discounts and Allowances for all Levels	(6,149,466)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,139,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,047,056	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,047,056	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	452	13
14	Non-Patient Meals	168	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	364,175	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	171,437	19
20	Radiology and X-Ray	292	20
21	Other Medical Services	518,430	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,054,954	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,791	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,791	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	other revenue	(786)	28
28a	provider relief funds	1,132,685	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,131,899	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,378,746	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,577,765	31
32	Health Care	5,084,206	32
33	General Administration	3,704,382	33
	B. Capital Expense		
34	Ownership	698,433	34
	C. Ancillary Expense		
35	Special Cost Centers	2,283,169	35
36	Provider Participation Fee	209,852	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,557,807	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,179,061)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,179,061)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,565,014	44
45	Private Pay - Net Inpatient Revenue	1,244,716	45
46	Medicare - Net Inpatient Revenue	1,500,003	46
47	Other-(specify) mgd care, other	829,313	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,139,046	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,528	2,028	$ 139,952	$ 69.01	1
2	Assistant Director of Nursing	1,212	1,658	69,641	42.00	2
3	Registered Nurses	25,379	33,012	1,165,424	35.30	3
4	Licensed Practical Nurses	16,516	21,622	658,224	30.44	4
5	CNAs & Orderlies	46,106	60,202	1,086,550	18.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,243	1,771	42,859	24.20	9
10	Activity Assistants	3,927	5,394	77,511	14.37	10
11	Social Service Workers	4,821	5,810	146,937	25.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,808	1,940	31,392	16.18	15
16	Dishwashers					16
17	Maintenance Workers	1,794	2,134	46,964	22.01	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,456	2,005	149,567	74.60	20
21	Assistant Administrator					21
22	Other Administrative	4,898	6,408	148,440	23.16	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	3,044	4,005	71,784	17.92	31
32	Other Health Care(specify)					32
33	Other(specify) see sch 20a	13,760	18,042	587,747	32.58	33
34	TOTAL (lines 1 - 33)	127,492	166,031	$ 4,422,992 *	$ 26.64	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	$ 34,756	1-3	35
36	Medical Director	monthly	54,675	9-3	36
37	Medical Records Consultant	monthly	423	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	17,032	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	1,250	19-3	44
45	Social Service Consultant	monthly	2,136	19-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 110,272		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	687	$ 40,974	10-3	50
51	Licensed Practical Nurses	82	3,506	10-3	51
52	Certified Nurse Assistants/Aides	18,364	535,858	10-3	52
53	TOTAL (lines 50 - 52)	19,132	$ 580,338		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tremaine Brown	Administrator	0	$ 149,567
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 149,567

B. Administrative - Other

Description	Amount
Royal Mgmt Fees	$ 513,540
shared services	819,060
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,332,600

C. Professional Services

Vendor/Payee	Type	Amount
Cassiday	Legal	$ 2,648
Markoff	Legal	6,042
Duane Morris	Legal	12,136
Much Shelist	Legal	1,682
Fifth Third	Legal	31,569
Generation	Legal	8,851
Markoff/Much Shelist	Collections	7,222
RSM	accounting	23,393
Wipfli	accounting	5,000
Duane Morris	refinancing	3,373
Personnel planners	u/c consulting	718
see schedule 21c		186,764
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 289,398

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 204,988
Unemployment Compensation Insurance	27,111
FICA Taxes	331,628
Employee Health Insurance	277,148
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Contributions	(20,674)
Uniform	(2,123)
Tuition	6,312
Other Benefits	105,653
TOTAL (agree to Schedule V, line 22, col.8)	$ 930,043

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	$ 3,980
Advertising: Employee Recruitment	7,192
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	1,090
Other License & Fees	716
ICHA	6,034
Other Dues	4,646
Lobbying	(638)
allocated from management co	12,118
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,138

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
allocated from management co	69
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 69

**See instructions.

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 6034**

(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. $ **28,903** 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. $ **209,852**
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.