		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: 0038083

Facility Name: Lexington of LaGrange

Address: 4735 Willow Springs (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: 708-352-6900 **Fax #** 708-482-0239

HFS ID Number:

Date of Initial License for Current Owners: 7/31/92

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 of LaGrange # 0038083 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	120	Skilled (SNF)	120	43,920	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	120	TOTALS	120	43,920	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			10,906	10,906	8
9	SNF/PED					9
10	ICF	7,459	3,295	900	11,654	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,459	3,295	11,806	22,560	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.37%

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 7/31/92

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 120 and days of care provided 6,248

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 LaGrange # 0038083 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		6,309	709,205	715,514		715,514		715,514			1
2	Food Purchase		(887)		(887)		(887)	(755)	(1,642)			2
3	Housekeeping	96	101	368,726	368,923		368,923		368,923			3
4	Laundry											4
5	Heat and Other Utilities			167,170	167,170		167,170	14,844	182,014			5
6	Maintenance	45,145	725	116,779	162,649		162,649	64,871	227,520			6
7	Other (specify):*							6,850	6,850			7
8	**TOTAL General Services**	45,241	6,248	1,361,880	1,413,369		1,413,369	85,810	1,499,179			8
	B. Health Care and Programs											
9	Medical Director			31,876	31,876		31,876		31,876			9
10	Nursing and Medical Records	3,579,773	374,196	46,278	4,000,247		4,000,247	16,054	4,016,301			10
10a	Therapy											10a
11	Activities	97,651	4,125	23	101,799		101,799		101,799			11
12	Social Services	94,366			94,366		94,366		94,366			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							1,965	1,965			15
16	**TOTAL Health Care and Programs**	3,771,790	378,321	78,177	4,228,288		4,228,288	18,019	4,246,307			16
	C. General Administration											
17	Administrative	142,539		1,432,584	1,575,123		1,575,123	(552,072)	1,023,051			17
18	Directors Fees											18
19	Professional Services			238,242	238,242		238,242	74,296	312,538			19
20	Dues, Fees, Subscriptions & Promotions			30,622	30,622		30,622	9,453	40,075			20
21	Clerical & General Office Expenses	249,773	20,405	98,019	368,197		368,197	705,730	1,073,927			21
22	Employee Benefits & Payroll Taxes			837,593	837,593		837,593		837,593			22
23	Inservice Training & Education							586	586			23
24	Travel and Seminar							57	57			24
25	Other Admin. Staff Transportation			543	543		543	11,237	11,780			25
26	Insurance-Prop.Liab.Malpractice			478,389	478,389		478,389	3,646	482,035			26
27	Other (specify):*							84,011	84,011			27
28	**TOTAL General Administration**	392,312	20,405	3,115,992	3,528,709		3,528,709	336,944	3,865,653			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,209,343	404,974	4,556,049	9,170,366		9,170,366	440,773	9,611,139			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 of LaGrange #0038083 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			61,493	61,493		61,493	238,290	299,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,572	6,572		6,572	235,716	242,288			32
33	Real Estate Taxes			43,579	43,579		43,579	454,159	497,738			33
34	Rent-Facility & Grounds			775,421	775,421		775,421	(775,263)	158			34
35	Rent-Equipment & Vehicles			44,370	44,370		44,370	3,232	47,602			35
36	Other (specify):*											36
37	**TOTAL Ownership**			931,435	931,435		931,435	156,134	1,087,569			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		414,117	1,013,773	1,427,890		1,427,890		1,427,890			39
40	Barber and Beauty Shops			1,553	1,553		1,553	(1,553)				40
41	Coffee and Gift Shops			2	2		2		2			41
42	Provider Participation Fee			162,576	162,576		162,576		162,576			42
43	Other (specify):* **non-allowable**			1,030,138	1,030,138		1,030,138	(1,029,988)	150			43
44	**TOTAL Special Cost Centers**		414,117	2,208,042	2,622,159		2,622,159	(1,031,541)	1,590,618			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,209,343	819,091	7,695,526	12,723,960		12,723,960	(434,634)	12,289,326			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 LaGrange # 0038083 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	(755)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,531)	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	(21,074)	30		9
10	Interest and Other Investment Income	(3,573)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,558)	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	(887,858)	43		24
25	Fund Raising, Advertising and Promotional	(30,367)	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	(117,088)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,080,804)		$	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)	646,170		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 646,170		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (434,634)		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 of LaGrange

ID# 0038083

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Laboratory	$ (60,372)	43	1
2	Radiology	(31,016)	43	2
3				3
4	Personal Item Replacement	(436)	43	4
5	Collections	(16,625)	19	5
6	Barber & Beauty Income	(1,553)	40	6
7	Lobbying	(576)	20	7
8	Salesforce Computer Consulting	(6,510)	19	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(117,088)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of LaGrange # 0038083 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(755)	0	0	0	0	0	0	0	0	0	0	(755)	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	14,844	0	0	0	0	0	0	0	0	14,844	5
6	Maintenance	0	0	64,871	0	0	0	0	0	0	0	0	64,871	6
7	Other (specify):*	0	0	6,850	0	0	0	0	0	0	0	0	6,850	7
8	**TOTAL General Services**	(755)	0	86,565	0	0	0	0	0	0	0	0	85,810	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	16,054	0	0	0	0	0	0	0	0	16,054	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	1,965	0	0	0	0	0	0	0	0	1,965	15
16	**TOTAL Health Care and Programs**	0	0	18,019	0	0	0	0	0	0	0	0	18,019	16
	C. General Administration													
17	Administrative	0	0	0	(552,072)	0	0	0	0	0	0	0	(552,072)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,135)	(14,174)	111,605	0	0	0	0	0	0	0	0	74,296	19
20	Fees, Subscriptions & Promotions	(576)	0	10,029	0	0	0	0	0	0	0	0	9,453	20
21	Clerical & General Office Expenses	0	0	705,730	0	0	0	0	0	0	0	0	705,730	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	586	0	0	0	0	0	0	0	586	23
24	Travel and Seminar	0	0	0	57	0	0	0	0	0	0	0	57	24
25	Other Admin. Staff Transportation	0	0	0	11,237	0	0	0	0	0	0	0	11,237	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,646	0	0	0	0	0	0	0	3,646	26
27	Other (specify):*	0	0	0	84,011	0	0	0	0	0	0	0	84,011	27
28	**TOTAL General Administration**	(23,711)	(14,174)	827,364	(452,535)	0	0	0	0	0	0	0	336,944	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,466)	(14,174)	931,948	(452,535)	0	0	0	0	0	0	0	440,773	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of LaGrange # 0038083 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	(21,074)	230,182	0	29,182	0	0	0	0	0	0	0	238,290	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,573)	203,917	0	35,372	0	0	0	0	0	0	0	235,716	32
33	Real Estate Taxes	0	437,470	0	16,689	0	0	0	0	0	0	0	454,159	33
34	Rent-Facility & Grounds	0	(775,263)	0	0	0	0	0	0	0	0	0	(775,263)	34
35	Rent-Equipment & Vehicles	0	0	0	3,232	0	0	0	0	0	0	0	3,232	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,647)	96,306	0	84,475	0	0	0	0	0	0	0	156,134	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	(1,553)	0	0	0	0	0	0	0	0	0	0	(1,553)	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):*	(1,030,138)	150	0	0	0	0	0	0	0	0	0	(1,029,988)	43
44	**TOTAL Special Cost Centers**	(1,031,691)	150	0	0	0	0	0	0	0	0	0	(1,031,541)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,080,804)	82,282	931,948	(368,060)	0	0	0	0	0	0	0	(434,634)	45

Facility Name & ID Number Lexington of LaGrange # 0038083 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. ☐ 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 LaGrange Limited Partnership	**	$ (14,174)	$ (14,174)	1
2	V	30	depreciation		Sambell of LaGrange Limited Partnership	**	230,182	230,182	2
3	V	32	interest expesne		Sambell of LaGrange Limited Partnership	**	203,917	203,917	3
4	V	32	amortization of mortgage cost		Sambell of LaGrange Limited Partnership	**			4
5	V	33	property taxes		Sambell of LaGrange Limited Partnership	**	437,470	437,470	5
6	V	34	rental income	775,263	Sambell of LaGrange Limited Partnership	**		(775,263)	6
7	V	43	Trust fees		Sambell of LaGrange Limited Partnership	**	150	150	7
8	V	43	unrealized loss on FMV swap		Sambell of LaGrange Limited Partnership	**			8
9	V	43	gain/loss on sale on disposal		Sambell of LaGrange Limited Partnership	**			9
10	V								10
11	V								11
12	V				** The owners of Lexington Health Care Center of LaGrange, Inc. own				12
13	V				100% of Sambell of LaGrange Limited Partnership				13
14	Total			$ 775,263			$ 857,545	$ * 82,282	14

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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.	**	14,426	14,426	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	418	418	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**			18
19	V	6	Management Allocation - salaries		Royal Management Corp.	**	55,969	55,969	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	8,902	8,902	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**			21
22	V	7	Management Allocation - empoyee benefits		Royal Management Corp.	**	6,850	6,850	22
23	V	10	Medical consultant		Royal Management Corp.	**			23
24	V	10	Management Allocation - salaries		Royal Management Corp.	**	16,054	16,054	24
25	V	15	Management Allocation - empoyee benefits		Royal Management Corp.	**	1,965	1,965	25
26	V	17	Management Allocation - salaries		Royal Management Corp.	**			26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	30,583	30,583	27
28	V	19	Professional fees		Royal Management Corp.	**	81,022	81,022	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	858	858	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	9,171	9,171	30
31	V	21	Management Allocation - salaries		Royal Management Corp.	**	686,457	686,457	31
32	V	21	Bank charges		Royal Management Corp.	**	3,738	3,738	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	2,245	2,245	33
34	V	21	Postage		Royal Management Corp.	**	3,094	3,094	34
35	V	21	Telephone		Royal Management Corp.	**	10,196	10,196	35
36	V								36
37	V								37
38	V		** The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp						38
39	Total			$			$ 931,948	$ * 931,948	39

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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	**	$ 586	$ 586	15
16	V	24	Travel & seminar		Royal Management Corp	**	57	57	16
17	V	25	Auto expense		Royal Management Corp	**	11,237	11,237	17
18	V	26	Insurance general		Royal Management Corp	**	3,646	3,646	18
19	V	27	Management Allocation - employee benefits		Royal Management Corp	**	84,011	84,011	19
20	V	30	Depreciation		Royal Management Corp	**	29,182	29,182	20
21	V	32	Interest		Royal Management Corp	**	34,979	34,979	21
22	V	32	Amortization of mortgage costs		Royal Management Corp	**	393	393	22
23	V	33	Property taxes		Royal Management Corp	**	16,689	16,689	23
24	V	34	Rent expense		Royal Management Corp	**			24
25	V	35	Equipment rental		Royal Management Corp	**	3,232	3,232	25
26	V	17	Management fees	552,072	Royal Management Corp	**		(552,072)	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 LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 552,072			$ 184,012	$ * (368,060)	39

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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	NameJames Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Bloomindale, Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	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	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	LaGrange	Real Estate	11
12					LaGrange Ltd. Ptsp.		Property	12
13					Royal Management	Lombard	Mgmt. Company	13
14					Corporation			14
15					Lexington Financial	Lombard	Finance Company	15
16					Services II, LLC			16
17					Heron Point	Lombard	Mgmt. Company	17
18					Management Corp			18
19					Samvest of Lombard	Lombard	Lessor	19
20					II, LLC			20
21					North Heron	Lombard	Finance Company	21
22					Investments, LLC			22
23					Curatess, LLC	Lombard	Telemedicine	23
24					Republic	Lombard	Construction	24
25					Construction of		Company	25
26					Illinois, Inc.			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 LaGrange # 0038083 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	Bloomingdale	Real Estate	5
6					Bloomingdale Ltd.		Property	6
7					Ptsp.			7
8					Sambell of Chicago	Chicago Ridge	Real Estate	8
9					Ridge Ltd. Ptsp.		Property	9
10					Sambell of Elmhurst	Elmhurst	Real Estate	10
11					II Ltd. Ptsp.		Property	11
12					Lexington HC Sys	Lake Zurich	Real Estate	12
13					of Lake Zurich Ltd.		Property	13
14					Ptsp.			14
15					Lexington HC Sys	Lombard	Real Estate	15
16					of Lombard Ltd. Ptsp.		Property	16
17					Lexington HC Sys	Orland Park	Real Estate	17
18					of Orland Park Ltd.		Property	18
19					Ptsp.			19
20					Sambell of	Schaumburg	Real Estate	20
21					Schaumburg Ltd. Ptsp		Property	21
22					Samvest of Algonquin	Algonquin	Real Estate	22
23					Ltd. Ptsp.			23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington of LaGrange # 0038083 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 of LaGrange # 0038083 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	$	$	43,800	$ 0	1
2	5	Utilities - gas & electric	Bed days available	565,750	8	186,333		43,800	14,426	2
3	5	Utilities - water & sewer	Bed days available	565,750	8	5,398		43,800	418	3
4	5	Utilities - maintenance office	Bed days available	565,750	8			43,800	0	4
5	6	Management Allocation - salaries	Bed days available	565,750	8	722,929	722,929	43,800	55,969	5
6	6	Repairs & maintenance	Bed days available	565,750	8	114,986		43,800	8,902	6
7	6	Scavenger & exterminating	Bed days available	565,750	8			43,800	0	7
8	7	Management Allocation - empoyee ber	Bed days available	565,750	8	88,474		43,800	6,850	8
9	10	Medical consultant	Bed days available	565,750	8			43,800	0	9
10	10	Management Allocation - salaries	Bed days available	565,750	8			43,800	0	10
11	15	Management Allocation - empoyee ber	Bed days available	565,750	8	25,377		43,800	1,965	11
12	17	Management Allocation - salaries	Bed days available	565,750	8	207,358	207,358	43,800	16,054	12
13	19	Computer consultant & supplies	Bed days available	565,750	8	395,029		43,800	30,583	13
14	19	Professional fees	Bed days available	565,750	8	1,046,538		43,800	81,022	14
15	20	Dues & subscriptions	Bed days available	565,750	8	11,082		43,800	858	15
16	20	Advertising - help wanted	Bed days available	565,750	8	118,456		43,800	9,171	16
17	21	Management Allocation - salaries	Bed days available	565,750	8	8,866,730	8,866,730	43,800	686,457	17
18	21	Bank charges	Bed days available	565,750	8	48,277		43,800	3,738	18
19	21	Office supplies & printing	Bed days available	565,750	8	29,001		43,800	2,245	19
20	21	Postage	Bed days available	565,750	8	39,969		43,800	3,094	20
21	21	Telephone	Bed days available	565,750	8	131,703		43,800	10,196	21
22										22
23										23
24										24
25	TOTALS					$ 12,037,640	$ 9,797,017		$ 931,948	25

Facility Name & ID Number Lexington of LaGrange # 0038083 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	$	43,800	$ 586	1
2	24	Travel & seminar	Bed days available	565,750	8	735		43,800	57	2
3	25	Auto expense	Bed days available	565,750	8	145,140		43,800	11,237	3
4	26	Insurance general	Bed days available	565,750	8	47,093		43,800	3,646	4
5	27	Management Allocation - employee be	Bed days available	565,750	8	1,085,139		43,800	84,011	5
6	30	Depreciation	Bed days available	565,750	8	376,924		43,800	29,181	6
7	32	Interest	Bed days available	565,750	8	451,812		43,800	34,979	7
8	2	Amortization of mortgage costs	Bed days available	565,750	8	5,077		43,800	393	8
9	33	Property taxes	Bed days available	565,750	8	215,565		43,800	16,689	9
10	34	Rent expense	Bed days available	565,750	8			43,800		10
11	35	Equipment rental	Bed days available	565,750	8	41,748		43,800	3,232	11
12	17	Management fees	Bed days available	565,750	8			43,800		12
13	35	Auto lease	Bed days available	565,750	8			43,800		13
14	6	Security	Bed days available	565,750	8			43,800		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	$		$ 184,011	25

Facility Name & ID Number Lexington of LaGrange # 0038083 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	MB Financial		x	Mortgage	varies	9/15/17	$ 4,481,325	$ 3,943,569	9/15/19	libor+3.5	$ 199,809	1
2												2
3	Sambell of Elmhurst II LLP	x		Loan	varies	9/15/17	329,288	300,179	9/15/19	libor+3.5	4,431	3
4												4
5												5
	Working Capital											
6	West Suburban Bank		x	PPP loan	none	5/7/20	987,615	987,615	5/7/22	0.0100	6,642	6
7												7
8												8
9	TOTAL Facility Related						$ 5,798,228	$ 5,231,363			$ 210,882	9
	B. Non-Facility Related*											
10								interest income offset			(3,573)	10
11								allocated from mgmt co			34,979	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 31,406	14
15	TOTALS (line 9+line14)						$ 5,798,228	$ 5,231,363			$ 242,288	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 LaGrange # 0038083 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.**	$ 444,144	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.)		$ 420,062	2
3. Under or (over) accrual (line 2 minus line 1).		$ (24,082)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 530,004	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.)**		$ 43,579	5
	allocated from mgmt company	16,689	
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** $ 68,452 **For** 2017 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (68,452)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 497,738	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	369,109	8
	2016	386,004	9
	2017	400,968	10
	2018	404,635	11
	2019	420,062	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 of LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Christine Thompson

TELEPHONE 630-458-47000 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.	18-08-207-017-0000	land & building	$ 239,790.00	$ 239,790.00
2.	18-08-207-018-0000	land & building	$ 180,272.00	$ 180,272.00
3.	Royal Management Corp (Samvest of Lombard II)		$	$
4.	05-01-202-021	land & building	$ 215,565.00	$ 16,689.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 635,627.00	$ 436,751.00

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 LaGrange # 0038083 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,072 B. General Construction Type: Exterior concrete brick Frame steel Number of Stories

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 [ ] 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	40,000	1991	$ 500,000	1
2	management company allocation			14,270	2
3	TOTALS	40,000		$ 514,270	3

Facility Name & ID Number Lexington of LaGrange # 0038083 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	120		1992	1992	$ 2,661,448	$	35	$ 76,041	$ 76,041	$ 2,167,174	4
5			1995	1995	79,363		10			79,363	5
6			2005	2005	2,321,014		21	110,524	110,524	1,713,124	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1992	1,152		20			1,152	9
10	Building Improvements			1992	2,714		31			2,714	10
11	Building Improvements			1993	2,901		35	83	83	2,322	11
12	Leasehold Improvements			1994	6,402		10			6,402	12
13	Leasehold Improvements - Corner Guard			1996	2,195		10			2,122	13
14	Wiring			1998	3,378		10			3,378	14
15	Resurface & Restripe Parking Lot			1998	3,753		10			3,753	15
16	Lobby Tile			1998	19,488		10			19,488	16
17	Resurface & Restripe Parking Lot			2000	1,997		10			1,997	17
18	Automatic Door			2000	1,300		10			1,300	18
19	Kitchen Rehab			2001	1,441		10			1,441	19
20	Infrared curtains for elevator			2001	3,000		10			3,000	20
21	Dining room, resident rooms, and corridors renovation			2002	150,083	7,505	20	7,505		135,711	21
22	Elevator upgrade			2002	5,398		10			5,398	22
23	Air conditioner compressor			2003	9,218		10			9,218	23
24	Sidewalk and fencing			2005	46,701	2,335	20	2,335		35,414	24
25	HVAC			2005	8,141	407	20	407		6,139	25
26	Wiring			2005	4,506	225	20	225		3,432	26
27	Lobby, lounge and reception renovations			2005	24,362	1,218	20	1,218		18,676	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors			2005	326,862		20			326,862	28
29	Wallcoverings			2005	10,822		5			10,822	29
30	Medical records room rehab			2006	19,739	987	20	987		13,818	30
31	Activity/PT Room Rehab			2006	1,158	58	20	58		812	31
32	Land scape enhancemen			2006	8,726	582	15	582		8,342	32
33	Roof			2006	29,700	1,980	15	1,980		28,380	33
34	HVAC			2006	3,254	163	20	163		2,336	34
35	Plumbing and sprinkler system			2006	20,725	1,036	20	1,036		15,541	35
36	Laundry Combustion Air			2006	16,814	841	20	841		12,404	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 LaGrange # 0038083 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	Lobby/Lounge/Reception rehab	2006	$ 14,033	$	10	$	$	$ 14,033	37
38	Cubicle curtains/drapery	2006	6,955		5			6,955	38
39	Cabinets/counters for 2nd FI library	2006	2,665		10			2,665	39
40	TCU rehab	2006	2,402	120	20	120		1,690	40
41	First floor remodel	2006	212,084		20	10,604	10,604	148,456	41
42	Kitchen rehab	2006	8,165	408	20	408		5,917	42
43	Bath fixtures-2nd foor	2006	2,076		10			2,076	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		2,465	44
45	Landscaping	2007	3,862	257	15	257		3,491	45
46	HVAC	2007	58,326	2,916	20	2,916		39,123	46
47	Common Areas Remodel	2007	2,059		10			2,059	47
48	First Floor Remodel	2007	6,517		20	326	326	4,481	48
49	Garage	2007	16,487	824	20	824		10,781	49
50	Land Improvements	2008	3,745	250	15	250		3,021	50
51	Parking lot-paving	2008	8,720	436	20	436		5,414	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		1,680	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	16,260	16,260	208,670	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		42,427	55
56	Irrigation System	2009	16,740	1,116	15	1,116		12,555	56
57	Landscaping	2009	10,321	688	15	688		7,740	57
58	Parking lot repairs	2009	3,500	175	20	175		2,027	58
59	HVAC Chiller	2009	2,594	130	20	130		1,484	59
60	Patio Pergola	2009	6,760	338	20	338		4,000	60
61	Stamped Concrete	2009	16,658	833	20	833		9,441	61
62	Fence	2009	4,084	204	20	204		2,261	62
63	Patio Wall	2009	8,212	411	20	411		4,624	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		3,092	64
65									65
66	Brick Replacement	2010	16,578	603	27	603		6,432	66
67	Office Carpentry,flooring,electrical,painting,signs, HVAC	2010	17,565	641	27	641		6,410	67
68	Landscaping enhancements	2010	15,258	1,017	15	1,017		10,679	68
69	Drain tile, sewer, concrete	2010	3,221	214	15	214		2,186	69
70	TOTAL (lines 4 thru 69)		$ 6,882,020	$ 33,327		$ 247,165	$ 213,838	$ 5,220,370	70

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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		$ 6,882,020	$ 33,327		$ 247,165	$ 213,838	$ 5,220,370	1
2	Retaining wall	2010	15,736	1,049	15	1,049		10,490	2
3	Canopy Installation	2010	4,466	163	27	163		1,657	3
4	Dining Room HVAC	2010	4,169	152	27	152		1,596	4
5	Pantry carpentry,flooring,plumbing	2010	2,911	106	27	106		1,095	5
6	Director of Nursing office painting	2010	4,245	155	27	155		1,550	6
7	Remodel Library/Lounge-art,painting,flooring	2010	6,477	236	27	236		2,360	7
8	2nd floor doors	2010	3,046	111	27	111		1,193	8
9	Office changes-carpentry, painting, flooring	2011	2,487	90	27	90		863	9
10	Fence	2011	2,750	183	15	183		1,678	10
11	Mulch and stone	2011	2,662	177	15	177		1,623	11
12	Laundry Room-Tile, Painting	2011	7,311	266	27	266		2,483	12
13	Locker Room - Installation of 6 tier box lockers	2011	2,573	94	27	94		901	13
14	Place beds back into service - Carpentry, Flooring, Electrical,	2011	117,350	4,267	27	4,267		40,892	14
15	-Painting and Plumbing								15
16									16
17									17
18	Electrical wiring for EMR	2012	13,699	498	27	498		4,026	18
19									19
20	Landscaping (Planting roses and day lilies Main Entrance)	2014	10,648	177	15	177		1,239	20
21	Install Automatic Doors (Front Entrance)	2014	6,859	83	15	83		581	21
22	Install LED Lights throughout facility	2014	22,200	67	27	67		469	22
23	R/M Reclass: Elevator door restrictor (Front Entrance)	2014	3,500		10	350	350	2,275	23
24									24
25	Install LED Lights throughout facility	2015	22,799	829	27	829		4,214	25
26	Electrical wiring throughout facility	2015	5,832	212	27	212		1,184	26
27	R/M Reclass: asphalt and concrete work in parking lot	2015	15,650		20	783	783	4,306	27
28									28
29	Private Room Rehab - 1st floor install of chair rails	2016	17,444	634	27	634		2,642	29
30									30
31	Provide power to touchscreens	2018	2,595	65	40	65	0	103	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,179,429	$ 42,941		$ 257,912	$ 214,971	$ 5,309,790	34

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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		$ 7,179,429	$ 42,941		$ 257,912	$ 214,971	$ 5,309,790	1
2									2
3	Pavement - Mill and resurface	2020	61,100	1,629	25	1,629		1,629	3
4									4
5	reconcile to book			1,592			(1,592)		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)		$ 7,240,529	$ 46,162		$ 259,541	$ 213,379	$ 5,311,419	34

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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		$ 7,240,529	$ 46,162		$ 259,541	$ 213,379	$ 5,311,419	1
2	Building - management company	2002	197,473			7,112	7,112	92,342	2
3	HVAC, electrical, security system - management company	2003	1,734			86	86	1,384	3
4	Key card system - management company	2004	273			22	22	199	4
5	VAV TX controls - management company	2005	83			7	7	59	5
6	Interior Signs-management company	2006	60			7	7	52	6
7	Building - management company	2008	8,549			319	319	3,766	7
8	Building - management company	2009	1,587			140	140	910	8
9	Building - management company	2010	1,565			110	110	811	9
10	Building - management company	2011	1,229			93	93	504	10
11	Building - management company	2012	3,616			219	219	1,082	11
12	Building - management company	2013	3,208			147	147	1,223	12
13	Building - management company	2014	1,736			282	282	1,090	13
14	Building - management company	2015	305			61	61	203	14
15	Building - management company	2016	5,037			608	608	1,678	15
16	Building - management company	2017	3,177			224	224	506	16
17	Building - management company	2018	571			34	34	63	17
18	Building - management company	2019	10,291			279	279	515	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)		$ 7,481,023	$ 46,162		$ 269,291	$ 223,129	$ 5,417,806	34

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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	$ 187,577	$ 14,097	$ 14,097	$	5-10	$ 149,821	71
72	Current Year Purchases	10,576	1,234	1,234		5	1,234	72
73	Fully Depreciated Assets	593,234					593,234	73
74	allocated from mgmt co	382,380		12,766	12,766		295,620	74
75	TOTALS	$ 1,173,767	$ 15,331	$ 28,097	$ 12,766		$ 1,039,909	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			36,016		2,395	2,395		27,648	79
80	TOTALS			$ 36,016	$	$ 2,395	$ 2,395		$ 27,648	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)	$ 9,205,076	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 61,493	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 299,783	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 238,290	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,485,363	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 LaGrange # 0038083 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: $ 6,778 Description: see schedule 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 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 of LaGrange # 0038083 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	$	8,330	$ 351,837	$	8,330	$ 351,837	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,122	114,928		2,122	114,928	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		10,787	428,641		10,787	428,641	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				386,135		386,135	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): ambulance	39(3)				23,983			23,983	12
13	Other (specify): see sch 16a	39(2)					27,982		27,982	13
14	TOTAL			$	21,239	$ 919,389	$ 414,117	21,239	$ 1,333,506	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 LaGrange # 0038083 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	$ 1,201,724	$ 1,206,064	1
2	Cash-Patient Deposits	19,022	19,022	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,874,242)	1,416,643	1,416,643	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(29,757)	(29,757)	6
7	Other Prepaid Expenses	37,544	37,544	7
8	Accounts Receivable (owners or related parties)	(339,589)	(432,187)	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,305,587	$ 2,217,329	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		500,000	13
14	Buildings, at Historical Cost		2,664,349	14
15	Leasehold Improvements, at Historical Cost	1,218,398	4,542,850	15
16	Equipment, at Historical Cost	473,524	947,048	16
17	Accumulated Depreciation (book methods)	(1,142,215)	(5,952,607)	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 recov receiv	895,728	895,728	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,452,487	$ 3,604,420	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,758,074	$ 5,821,749	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 773,584	$ 773,584	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,752	19,752	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,836	198,836	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,210	10,210	31
32	Accrued Real Estate Taxes(Sch.IX-B)		530,004	32
33	Accrued Interest Payable	6,557	65,701	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	see schedule 17a	4,767,652	3,917,606	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,776,591	$ 5,515,693	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	987,615	987,615	39
40	Mortgage Payable		3,943,569	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)**	$ 987,615	$ 4,931,184	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,764,206	$ 10,446,877	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,006,132)	$ (4,625,128)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,758,074	$ 5,821,749	48

***(See instructions.)**

Facility Name & ID Number Lexington of LaGrange # 0038083 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**	$ 663,630	1
2	Restatements (describe):		2
3	post closing adjustment	(1,251,190)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (587,560)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,418,572)	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)**	$ (2,418,572)	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)**	$ (3,006,132)	24 *

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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	$ 10,646,489	1
2	Discounts and Allowances for all Levels	(5,768,511)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,877,978	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,416,898	6
7	Oxygen	24,548	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,441,446	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	1,499	13
14	Non-Patient Meals	755	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	350,732	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	259,405	19
20	Radiology and X-Ray	449	20
21	Other Medical Services	385,747	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 998,587	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,573	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,573	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other income		28
28a	provider relief funds	983,804	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 983,804	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,305,388	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,413,369	31
32	Health Care	4,228,288	32
33	General Administration	3,528,709	33
	B. Capital Expense		
34	Ownership	931,435	34
	C. Ancillary Expense		
35	Special Cost Centers	2,459,583	35
36	Provider Participation Fee	162,576	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,723,960	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,418,572)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,418,572)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,752,123	44
45	Private Pay - Net Inpatient Revenue	787,412	45
46	Medicare - Net Inpatient Revenue	1,476,446	46
47	Other-(specify) managed care/other	861,997	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,877,978	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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,419	2,019	$ 127,575	$ 63.19	1
2	Assistant Director of Nursing	1,366	2,019	95,542	47.32	2
3	Registered Nurses	21,831	31,012	1,119,848	36.11	3
4	Licensed Practical Nurses	13,312	19,039	567,285	29.80	4
5	CNAs & Orderlies	40,814	56,265	1,053,806	18.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,698	2,177	43,846	20.14	9
10	Activity Assistants	3,185	4,029	53,806	13.35	10
11	Social Service Workers	3,375	4,027	94,366	23.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,559	2,088	45,145	21.62	17
18	Housekeepers		8	96	12.00	18
19	Laundry					19
20	Administrator	1,868	2,203	142,539	64.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,180	5,021	104,940	20.90	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	3,184	4,448	78,358	17.62	31
32	Other Health Care(specify)					32
33	Other(specify) see sch 20a	16,147	21,720	682,191	31.41	33
34	TOTAL (lines 1 - 33)	113,938	156,075	$ 4,209,343 *	$ 26.97	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	$ 44,533	1-3	35
36	Medical Director	monthly	31,865	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	15,529	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	6,297	19-3	44
45	Social Service Consultant	monthly	3,556	19-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 101,780		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	40	$ 2,386	10-3	50
51	Licensed Practical Nurses	26	1,238	10-3	51
52	Certified Nurse Assistants/Aides	973	26,273	10-3	52
53	TOTAL (lines 50 - 52)	1,039	$ 29,897		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonny Mundt	Administrator	0	$ 142,539
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,539

B. Administrative - Other

Description	Amount
Royal mgmt fees	$ 552,072
shared services	880,512
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,432,584
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cassiday	legal	$ 2,648
Markoff	legal	3,647
Duane Morris	legal	11,909
Much Shelist	legal	2,711
Fifth Third	legal	23,365
Markoff	collections	7,259
Much Shelist	collections	9,365
Duane Morris	refinancing	2,611
Personnel Planners	u/c consulting	780
RSM/Wipfli	Accounting	25,022
see sche 21c		148,925
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 238,242

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 186,473
Unemployment Compensation Insurance	18,840
FICA Taxes	318,282
Employee Health Insurance	278,299
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k contribution	(25,417)
tuition	4,970
uniform	2,625
other fringes	53,521
TOTAL (agree to Schedule V, line 22, col.8)	$ 837,593

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	9,088
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	6,579
miscellaneous licenses and fees	2,768
IHCA dues	6,316
lobbying portion of IHCA dues	(576)
miscellaneous dues and subs	1,890
allocated from mgmt company	10,029
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,074

G. Schedule of Travel and Seminar**

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

**See instructions.

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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 6316**

(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. $ **16,158** 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. $ **162,576**
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.