



Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

# 0035188 Report Period Beginning: 1/1/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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	166	Skilled (SNF)	166	60,590	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			9,640	9,640	8
9	SNF/PED					9
10	ICF	24,644	5,864	2,292	32,800	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,644	5,864	11,932	42,440	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.04%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 05/01/89

J. Was the facility purchased or leased after January 1, 1978?

YES  Date New Construction NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 166 and days of care provided 7,004

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Lexington Health Care Center of Bloomingdal # 0035188 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	414,094	31,602	2,735	448,431		448,431	-	448,431		1
2	Food Purchase		288,842		288,842		288,842	(2,412)	286,430		2
3	Housekeeping	278,972	31,122	154,286	464,380		464,380	227	464,607		3
4	Laundry	-	11,813	-	11,813		11,813	-	11,813		4
5	Heat and Other Utilities			205,863	205,863		205,863	6,452	212,315		5
6	Maintenance	52,904	-	205,265	258,169		258,169	105,205	363,374		6
7	Other (specify):* <b>Mgmt. Co. Alloc. Ben</b>	-	-	-				10,564	10,564		7
8	<b>TOTAL General Services</b>	745,970	363,379	568,149	1,677,498		1,677,498	120,036	1,797,534		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	-	-	26,200	26,200		26,200	-	26,200		9
10	Nursing and Medical Records	4,186,842	262,318	540,313	4,989,473		4,989,473	19,301	5,008,774		10
10a	Therapy	-	-	-				-			10a
11	Activities	130,032	12,730	6,501	149,263		149,263	-	149,263		11
12	Social Services	147,843	-	3,891	151,734		151,734	-	151,734		12
13	CNA Training	-	-	-				-			13
14	Program Transportation	-	-	-				-			14
15	Other (specify):* <b>Mgmt. Co. Alloc. Ben</b>	-	-	-				2,021	2,021		15
16	<b>TOTAL Health Care and Programs</b>	4,464,717	275,048	576,905	5,316,670		5,316,670	21,322	5,337,992		16
	<b>C. General Administration</b>										
17	Administrative	149,182	-	1,398,684	1,547,866		1,547,866	(1,382,607)	165,259		17
18	Directors Fees			-				-			18
19	Professional Services			230,651	230,651		230,651	12,407	243,058		19
20	Dues, Fees, Subscriptions & Promotions			33,935	33,935		33,935	11,398	45,333		20
21	Clerical & General Office Expenses	117,038	24,882	54,146	196,066		196,066	760,590	956,656		21
22	Employee Benefits & Payroll Taxes			783,146	783,146		783,146	-	783,146		22
23	Inservice Training & Education			17,163	17,163		17,163	441	17,604		23
24	Travel and Seminar			-				572	572		24
25	Other Admin. Staff Transportation		-	7,138	7,138		7,138	12,707	19,845		25
26	Insurance-Prop.Liab.Malpractice			423,360	423,360		423,360	2,301	425,661		26
27	Other (specify):* <b>Mgmt. Co. Alloc. Ben</b>	-	-	-				80,651	80,651		27
28	<b>TOTAL General Administration</b>	266,220	24,882	2,948,223	3,239,325		3,239,325	(501,540)	2,737,785		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,476,907	663,309	4,093,277	10,233,493		10,233,493	(360,182)	9,873,311		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 Health Care Center of Bloomingdale, Inc. #0035188 Report Period Beginning: 1/1/18 Ending: 12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			117,683	117,683		117,683	255,027	372,710			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			9,981	9,981		9,981	348,234	358,215			32
33	Real Estate Taxes			-				165,730	165,730			33
34	Rent-Facility & Grounds			881,739	881,739		881,739	(874,085)	7,654			34
35	Rent-Equipment & Vehicles			47,812	47,812		47,812	1,494	49,306			35
36	Other (specify):*			-				-				36
37	<b>TOTAL Ownership</b>			1,057,215	1,057,215		1,057,215	(103,600)	953,615			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	277,082	1,076,924	1,354,006		1,354,006	-	1,354,006			39
40	Barber and Beauty Shops	-	-	13,002	13,002		13,002	-	13,002			40
41	Coffee and Gift Shops	-	-	1,180	1,180		1,180	(1,086)	94			41
42	Provider Participation Fee			303,267	303,267		303,267	-	303,267			42
43	Other (specify):* <b>Non-Allowable Cos</b>	69	-	444,486	444,555		444,555	(444,555)				43
44	<b>TOTAL Special Cost Centers</b>	69	277,082	1,838,859	2,116,010		2,116,010	(445,641)	1,670,369			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,476,976	940,391	6,989,351	13,406,718		13,406,718	(909,423)	12,497,295			45

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

**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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,412)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,127)	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	44,618	30		9
10	Interest and Other Investment Income	(9,981)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9,373)	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	(8,580)	43		18
19	Entertainment				19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(338,389)	43		24
25	Fund Raising, Advertising and Promotional	(31,306)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,327)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See PG5A</u>	(81,709)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (448,786)		\$	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	2	
		Amount	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)	(460,637)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (460,637)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (909,423)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Lexington Health Care Center of Bloomingdale, Inc.

ID# 0035188

Report Period Beginning: 1/1/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Radiology	\$ (27,526)	43	1
2	Laboratory	(17,658)	43	2
3	Non-Allowable Finance Charge	(2,237)	32	3
4	Non-Allowable Marketing Salaries	(69)	43	4
5	Non-allowable legal expense	(70,093)	19	5
6	Unrealized loss on FMV swap	38,432	43	6
7	Disallowed Lobbying	(1,472)	20	7
8	Gift Shop Income	(1,086)	41	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	<b>Total</b>	(81,709)		49

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	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)	
1	V	19 Professional Fees	\$	Sambell of Bloomingdale Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation Expense		Sambell of Bloomingdale Limited Partnership	**	191,333	191,333	2
3	V	32 Amortization of Mortgage Cost		Sambell of Bloomingdale Limited Partnership	**	45,248	45,248	3
4	V	32 Interest	78,104	Sambell of Bloomingdale Limited Partnership	**	379,728	301,624	4
5	V	33 Property Tax		Sambell of Bloomingdale Limited Partnership	**	160,656	160,656	5
6	V	34 Rent	877,539	Sambell of Bloomingdale Limited Partnership	**		(877,539)	6
7	V	43 Unrealized loss on FMV of Swap	70,930	Sambell of Bloomingdale Limited Partnership	**		(70,930)	7
8	V	43 (Gain)/Loss - disposal - mortgage costs		Sambell of Bloomingdale Limited Partnership	**	32,498	32,498	8
9	V	21 Miscellaneous Expense		Sambell of Bloomingdale Limited Partnership	**	3	3	9
10	V	21 Bank Charges		Sambell of Bloomingdale Limited Partnership	**	49	49	10
11	V							11
12	V			** The owners of Lexington Health Care Center of Bloomingdale, Inc.				12
13	V			own 100% of Sambell of Bloomingdale Limited Partnership				13
14	Total		\$ 1,026,573			\$ 809,715	\$ * (216,858)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	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		Royal Management Corp.	**	\$ 227	\$ 227	15	
16	V	5		Royal Management Corp.	**	5,874	5,874	16	
17	V	5		Royal Management Corp.	**	156	156	17	
18	V	5		Royal Management Corp.	**	422	422	18	
19	V	6		Royal Management Corp.	**	98,836	98,836	19	
20	V	6		Royal Management Corp.	**	6,113	6,113	20	
21	V	6		Royal Management Corp.	**	256	256	21	
22	V	7		Royal Management Corp.	**	10,564	10,564	22	
23	V	10		Royal Management Corp.	**	390	390	23	
24	V	10		Royal Management Corp.	**	18,911	18,911	24	
25	V	15		Royal Management Corp.	**	2,021	2,021	25	
26	V	17		Royal Management Corp.	**	16,077	16,077	26	
27	V	19		Royal Management Corp.	**	16,266	16,266	27	
28	V	19		Royal Management Corp.	**	66,034	66,034	28	
29	V	20		Royal Management Corp.	**	1,227	1,227	29	
30	V	20		Royal Management Corp.	**	11,643	11,643	30	
31	V	21		Royal Management Corp.	**	738,462	738,462	31	
32	V	21		Royal Management Corp.	**	2,005	2,005	32	
33	V	21		Royal Management Corp.	**	6,820	6,820	33	
34	V	21		Royal Management Corp.	**	3,377	3,377	34	
35	V	21		Royal Management Corp.	**	9,874	9,874	35	
36	V							36	
37	V			** The owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.					37
38	V							38	
39	Total		\$			\$ 1,015,555	\$ * 1,015,555	39	

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



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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.	**	\$ 441	\$ 441	15
16	V	24	Travel & seminar		Royal Management Corp.	**	572	572	16
17	V	25	Auto expense		Royal Management Corp.	**	12,707	12,707	17
18	V	26	Insurance general		Royal Management Corp.	**	2,301	2,301	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	80,651	80,651	19
20	V	30	Depreciation		Royal Management Corp.	**	19,076	19,076	20
21	V	32	Interest		Royal Management Corp.	**	11,811	11,811	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,769	1,769	22
23	V	33	Property taxes		Royal Management Corp.	**	5,074	5,074	23
24	V	34	Rent expense		Royal Management Corp.	**	3,454	3,454	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,327	1,327	25
26	V	17	Management fees	1,398,684	Royal Management Corp.	**	0	(1,398,684)	26
27	V	35	Auto Lease		Royal Management Corp.	**	167	167	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V		** The owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.						36
37	V								37
38	V								38
39	Total			\$ 1,398,684			\$ 139,350	\$ * (1,259,334)	39

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

Facility Name &amp; ID Number

Lexington Health Care Center of Bloomingdale, Inc.

# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	33.33%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Lexington Square	Lombard	Independent and	3
4			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Life Care		Assisted Living	4
5			Lexington HC Ctr. of Lombard, Inc.	Lombard	of Lombard, LLC		Facility	5
6			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Life Care		Living Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	of Elmhurst, LLC			8
9			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Vesta Management	Lombard	Mgmt. Company	9
10					Group LLC			10
11					Sambell of	Bloomingdale	Real Estate	11
12					Bloomingdale Ltd.		Property	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					Investments, LLC			23
24					Lexington Home	Lombard	Home Health	24
25					Health Care, Inc.			25
26					Lexington Hospice	Lombard	Hospice	26
27					Services, LLC			27
28					Lexington Private	Lombard	Healthcare	28
29					Home Care			29
30								30

Facility Name & ID Number

Lexington Health Care Center of Bloomingdale, Inc.

# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Merit Sleep	Lombard	Mgmt. Company	1
2					Management, LLC			2
3					Sambell of Chicago	Chicago Ridge	Real Estate	3
4					Ridge Ltd. Ptsp.		Property	4
5					Sambell of Elmhurst	Elmhurst	Real Estate	5
6					II Ltd. Ptsp.		Property	6
7					Sambell of	LaGrange	Real Estate	7
8					LaGrange Ltd. Ptsp.		Property	8
9					Lexington HC Sys	Lake Zurich	Real Estate	9
10					of Lake Zurich Ltd.		Property	10
11					Ptsp.			11
12					Lexington HC Sys	Lombard	Real Estate	12
13					of Lombard Ltd. Ptsp.		Property	13
14					Lexington HC Sys	Orland Park	Real Estate	14
15					of Orland Park Ltd.		Property	15
16					Ptsp.			16
17					Sambell of	Schaumburg	Real Estate	17
18					Schaumburg Ltd. Ptsp		Property	18
19					Sambell of	Streamwood	Real Estate	19
20					Streamwood Ltd. Ptsp		Property	20
21					Lexington HC Sys	Wheeling	Real Estate	21
22					of Wheeling Ltd. Ptsp.		Property	22
23					Samvest of Algonquin	Algonquin	Real Estate	23
24					Ltd. Ptsp.		Property	24
25					Curates,LLC	Lombard	Telemedicine	25
26					Republic Construction		Construction	26
27					of Illinois , Inc	Lombard	Company	27
28								28
29								29
30								30

Facility Name & ID Number Lexington Health Care Center of Bloomingd # 0035188 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	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 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 4,130	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,097	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,130	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,097	L17, C7	4
5	Phil Thiem	Executive Committee	Administrative	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	653	L17, C7	5
6	Jeremy Samatas	Executive Committee	Administrative	0	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	971	L17, C7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,078		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 Health Care Center of Bloomingdale, Inc. # 0035188 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping supplies	Bed Days Available	722,335	10	\$ 2,704	\$ 60,590	\$ 227	1	
2	5	Utilities - gas & electric	Bed Days Available	722,335	10	70,024	60,590	5,874	2	
3	5	Utilities - water & sewer	Bed Days Available	722,335	10	1,855	60,590	156	3	
4	5	Utilities - maintenance office	Bed Days Available	722,335	10	5,025	60,590	422	4	
5	6	Management allocation - salaries	Bed Days Available	722,335	10	1,178,292	1,178,292	60,590	98,836	5
6	6	Repairs & maintenance	Bed Days Available	722,335	10	72,883	60,590	6,113	6	
7	6	Scavenger & exterminating	Bed Days Available	722,335	10	3,054	60,590	256	7	
8	7	Management allocation - employees	Bed Days Available	722,335	10	125,945	60,590	10,564	8	
9	10	Medical consultant	Bed Days Available	722,335	10	4,651	60,590	390	9	
10	10	Management allocation - salaries	Bed Days Available	722,335	10	225,449	225,449	60,590	18,911	10
11	15	Management allocation - employees	Bed Days Available	722,335	10	24,098	60,590	2,021	11	
12	17	Management allocation - salaries	Bed Days Available	722,335	10	191,670	191,670	60,590	16,077	12
13	19	Computer consultant & supplies	Bed Days Available	722,335	10	193,924	60,590	16,266	13	
14	19	Professional fees	Bed Days Available	722,335	10	787,232	60,590	66,034	14	
15	20	Dues & subscriptions	Bed Days Available	722,335	10	14,624	60,590	1,227	15	
16	20	Advertising - help wanted	Bed Days Available	722,335	10	138,799	60,590	11,643	16	
17	21	Management allocation - salaries	Bed Days Available	722,335	10	8,803,710	8,803,710	60,590	738,462	17
18	21	Bank charges	Bed Days Available	722,335	10	23,902	60,590	2,005	18	
19	21	Office supplies & printing	Bed Days Available	722,335	10	81,306	60,590	6,820	19	
20	21	Postage	Bed Days Available	722,335	10	40,262	60,590	3,377	20	
21	21	Telephone	Bed Days Available	722,335	10	117,714	60,590	9,874	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 12,107,123	\$ 10,399,121	\$ 1,015,555	25	

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc. # 0035188 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	23	Inservice Training	Bed Days Available	722,335	10	\$ 5,261	\$ 60,590	\$ 441	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	6,817	60,590	572	2
3	25	Auto expense	Bed Days Available	722,335	10	151,483	60,590	12,707	3
4	26	Insurance general	Bed Days Available	722,335	10	27,426	60,590	2,301	4
5	27	Management allocation - employees	Bed Days Available	722,335	10	961,496	60,590	80,651	5
6	30	Depreciation	Bed Days Available	722,335	10	227,415	60,590	19,076	6
7	32	Interest	Bed Days Available	722,335	10	140,807	60,590	11,811	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	21,094	60,590	1,769	8
9	33	Property taxes	Bed Days Available	722,335	10	60,494	60,590	5,074	9
10	34	Rent expense	Bed Days Available	722,335	10	41,178	60,590	3,454	10
11	35	Equipment rental	Bed Days Available	722,335	10	15,819	60,590	1,327	11
12	35	Auto Lease	Bed Days Available	722,335	10	1,993	60,590	167	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,661,283	\$	\$ 139,350	25

Facility Name & ID Number Lexington Health Care Center of Bloomingda # 0035188 Report Period Beginning: 1/1/18 Ending: 12/31/18

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Lexington Financial																			
2	Services, L.L.C.	X		Mortgage	Varies	05/22/08	\$ 6,375,000		01/01/33	Variable	153,679									
3	Midcap Financial Trust		X	Mortgage	Varies	05/29/18	5,058,006	5,058,006	05/29/21	Libor + 5.25%	226,049									
4																				
5				Finance Charge - Insurance Policy							2,237									
<b>Working Capital</b>																				
6	Bank of America		X	Working Capital	None	09/30/13	300,000		01/31/19	Prime/Libor	3,185									
7	LHCS of Lombard LP	X		Working Capital	None	02/20/18	300,000		02/19/20	Libor + 5.25%	4,559									
8																				
9	<b>TOTAL Facility Related</b>						\$ 12,033,006	\$ 5,058,006			\$ 389,709									
<b>B. Non-Facility Related*</b>																				
10										Amortization of mortgage cost	45,248									
11										Interest Income offset	(88,085)									
12										Allocated from Mgmt Co.	13,580									
13										Finance charges	(2,237)									
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (31,494)									
15	<b>TOTALS (line 9+line14)</b>						\$ 12,033,006	\$ 5,058,006			\$ 358,215									

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

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

**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.**

1. Real Estate Tax accrual used on 2017 report.			\$	<u>160680</u>	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.)	2017		\$	<u>144,681</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>(15,999)</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>176,655</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		Alloc Fr. Mgmt Co.		<u>5,074</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>165,730</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2013	<u>169,987</u>	8	<b>FOR BHF USE ONLY</b>	
	2014	<u>172,357</u>	9	13	FROM R. E. TAX STATEMENT FOR 2017 \$
	2015	<u>156,302</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2016	<u>157,740</u>	11	15	LESS REFUND FROM LINE 6 \$
	2017	<u>144,681</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
<a href="#">See attached real estate accrual sheet</a>					

**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.**



**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lexington Health Care Center of Bloomingdale, Inc. COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02-15-401-003</u>	<u>Land &amp; Building</u>	\$ <u>144,680.86</u>	\$ <u>144,680.86</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land &amp; Building</u>	\$ <u>253,394.82</u>	\$ <u>5,074.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>398,075.68</u>	\$ <u>149,754.86</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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 Health Care Center of Bloomingdale, Inc.

# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 34554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

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

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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

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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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>15,828</u>	<u>2</u>
3	<b>TOTALS</b>	<b>43,000</b>		<b>\$ 418,376</b>	<b>3</b>

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82		1989	1989	\$ 2,980,863	\$ -	35	\$ 85,192	\$ 85,192	\$ 2,527,363	4
5	9		1992	1992	178974	-	35	5,114	5,114	138071	5
6	75		1994	1994	2022894	-	35	57,797	57,797	1416025	6
7						-		-			7
8						-		-			8
	<b>Improvement Type**</b>										
9	Capitalized repairs		1989		9,080	-	10	-		9,080	9
10	Building Improvements		1990		3,674	-	10	-		3,674	10
11	Building Improvements		1991		2,586	-	10	-		2,586	11
12	Building Improvements		1992		3,154	-	10	-		2,997	12
13	Building Improvements		1993		1,582	-	10	-		1,503	13
14	Building Improvements		1994		15,734	-	10	-		15,734	14
15	Land Improvements		1994		1,381	-	10	-		1,381	15
16	Land Improvements		1995		1,074	-	15	-		1,068	16
17	Building Improvements		1995		1,288	-	35	37	37	884	17
18	Building Improvements		1995		9,433	270	35	270		6,345	18
19	Building Improvements		1995		43,839	1,252	35	1,252		29,423	19
20	Concrete flooring, fire doors, tile, sprinkler heads, and basement renovation					-		-			20
21			1996		8,706	-	15	-		3,606	21
22	Land improvements		1996		7,858	-	15	-		7,858	22
23						-		-			23
24	Resident room heaters		1997		3,563	102	35	102		2,242	24
25	Automatic doors		1997		12,950	370	35	370		7,801	25
26	Basement renovation		1997		59,358	-	10	-		59,358	26
27	Land Improvement - outdoor flagpoles		1997		1,574	-	15	-		1,574	27
28	1st Floor Remodel (Nurses Station/Lounge)		1998		76,487	-	10	-		76,487	28
29	Wiring for MDS		1998		4,506	-	10	-		4,506	29
30	Flag Pole		1998		787	-	10	-		787	30
31	Resurface/Stripe Parking Lot		1998		9,777	-	10	-		9,777	31
32	Kitchen tile/paint		1999		718	-	10	-		718	32
33	1st Floor Remodel		1999		3,296	-	10	-		3,296	33
34	Roof repairs		2000		5,748	-	15	-		5,748	34
35	Sump pump		2000		2,534	-	10	-		2,534	35
36	Sump pump basin repair		2000		6,307	-	10	-		6,307	36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Lexington Health Care Center of Bloomingdale, Inc.

# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic door closers	2000	\$ 1,300	\$ -	15	\$ -	\$ -	\$ 1,300	37
38	Infrared curtains for elevator doors	2001	3,000	-	10	-	-	3,000	38
39	Ejector pump	2002	3,050	-	5	-	-	3,050	39
40	Lift station pump	2002	3,359	-	5	-	-	3,359	40
41	New asphalt parking lot	2003	16,450	-	10	-	-	16,450	41
42	Roof repairs	2003	2,900	-	10	-	-	2,900	42
43	Freezer/cooler repairs	2003	4,005	200	20	200	-	3,085	43
44	Kitchen remodel	2003	7,188	359	20	359	-	5,537	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976	-	47,614	45
46	Floor tile	2003	16,305	815	20	815	-	13,042	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789	-	57,149	47
48	Rehab-floor tile	2003	8,117	406	20	406	-	6,123	48
49	Dining room remodel	2003	42,698	2,135	20	2,135	-	32,203	49
50	Foundation repair	2003	4,800	240	20	240	-	3,700	50
51	Parking lot	2004	24,550	-	10	-	-	24,550	51
52	Kitchen walk-in cooler floor	2004	7,161	-	10	-	-	7,161	52
53	Old Towne rehab	2004	13,967	698	20	698	-	9,948	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447	-	147,128	54
55	Create first floor therapy room	2004	185	9	20	9	-	108	55
56	Transitional unit	2005	213	11	20	11	-	131	56
57	Landscaping	2005	8,814	441	20	441	-	5,806	57
58	Roof repairs	2005	3,250	163	20	163	-	2,145	58
59	HVAC upgrade	2005	7,048	352	20	352	-	4,695	59
60	Kitchen repair	2005	1,631	82	20	82	-	1,105	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995	-	12,935	61
62	Window treatments	2005	3,606	-	5	-	-	3,606	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358	-	5,013	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107	-	27,392	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799	-	23,688	65
66	Basement renovation	2005	14,176	709	20	709	-	9,216	66
67				-		-			67
68				-		-			68
69				-		-			69
70	TOTAL (lines 4 thru 69)		\$ 6,126,921	\$ 31,085		\$ 179,225	\$ 148,140	\$ 4,831,872	70

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

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,126,921	\$ 31,085		\$ 179,225	\$ 148,140	\$ 4,831,872	1
2	Landscaping Enhancement	2006	7,084	472	15	472		5,822	2
3	Install Kitchen Sink	2006	2,915	146	20	146		1,861	3
4	Common area rehab	2006	2,382	119	20	119		1,508	4
5	Paint Building Exterior	2006	19,500	-	5	-		19,500	5
6	Patio	2006	53,305	3,554	15	3,554		42,943	6
7	Retaining Wall	2007	2,950	197	15	197		2,298	7
8	Roof Repair	2007	17,050	853	20	853		10,022	8
9	Air Conditioning units	2007	4,338	217	20	217		2,586	9
10	Paver walk and stairway	2007	10,500	525	20	525		6,125	10
11	Fire exit stairways	2007	9,379	469	20	469		5,237	11
12	Landscaping	2008	35,147	2,343	15	2,343		23,625	12
13	Parking Lot - Seal & Striping	2008	6,460	323	20	323		3,392	13
14	Roof	2008	15,300	765	20	765		8,160	14
15	HVAC - Spot Coolers	2008	5,589	140	40	140		1,400	15
16	Electrical - Storage Room	2008	4,768	238	20	238		2,479	16
17	Electrical - Fire Alarm Panel	2008	118,395	5,920	20	5,920		59,693	17
18	1st floor remodel-Carpentry, Flooring, Electrical, Parking fixtures	2008	557,202	-	27	20,262	20,262	216,128	18
19	Lawn Irrigation	2009	14,435	962	15	962		8,979	19
20	Landscaping	2009	12,950	863	15	863		7,911	20
21	Roof	2009	49,330	2,467	20	2,467		22,614	21
22	Front Entrance	2009	19,392	485	40	485		4,446	22
23	HVAC-Window unit	2009	41,315	4,131	10	4,131		40,278	23
24	HVAC Quick connectors	2009	7,058	706	10	706		6,883	24
25	Lift pump	2009	14,783	1,478	10	1,478		13,548	25
26	Fire alarm panel	2009	93,279	4,664	20	4,664		42,365	26
27	Pantry Cabinets	2009	3,523	352	10	352		3,227	27
28	Therapy Room counter tops-carpentry	2009	2,500	250	10	250		2,438	28
29	Patio Pergola	2009	7,930	397	20	397		3,705	29
30	Patio Stamped Concrete	2009	13,901	927	15	927		8,729	30
31	Lobby 1st floor remodel-Carpentry, doors frames, electrical	2009	52,018	-	27	1,892	1,892	17,028	31
32	painting, wallpaper			-		-			32
33	OT Remodel-carpentry, electrical	2010	791,224	-	27	62,223	62,223	508,155	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,122,823	\$ 65,048		\$ 297,565	\$ 232,517	\$ 5,934,957	34

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

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12B, Carried Forward</b>	\$ 8,122,823	\$ 65,048		\$ 297,565	\$ 232,517	\$ 5,934,957		1
2			-		-				2
3	Lawn irrigation system	2010	5,503	367	15	367		3,119	3
4	Roof work	2010	15,268	557	27	557		4,734	4
5	HVAC Chiller	2010	84,004	3,064	27	3,064		25,023	5
6	Pantry-shelves	2010	23,805	868	27	868		7,306	6
7	Wanderguard	2010	3,747	137	27	137		1,130	7
8	Concrete work	2010	7,080	258	27	258		2,107	8
9	Automatic Doors	2010	4,903	490	10	490		4,165	9
10	Physician office carpentry and electrical update	2010	4,677	171	27	171		1,382	10
11	Library/Lounge-art, painting	2010	13,763	502	27	502		4,142	11
12	Pergola and patio wall	2010	21,186	57	27	-	(57)	21,186	12
13	Office carpentry and electrical changes	2010	5,744	209	27	209		1,707	13
14	Payroll office-painting, carpentry	2011	18,505	673	27	673		4,823	14
15	Mulch stone and perennials	2011	4,364	291	15	291		2,085	15
16	Admissions office-painting, carpentry	2011	2,868	104	27	104		745	16
17	Parking lot lights	2011	6,070	221	27	221		1,584	17
18	Roof work	2011	93,530	3,401	27	3,401		24,090	18
19	Front entrance-awning, doors	2011	11,869	432	27	432		3,383	19
20	Duct extension	2011	3,476	126	27	126		998	20
21	HVAC unit	2011	23,400	851	27	851		6,099	21
22	Fluid pump	2011	8,400	305	27	305		2,390	22
23	Plumbing valves	2011	9,257	337	27	337		2,387	23
24	Laundry room-painting, electrical, tile	2011	8,386	305	27	305		2,211	24
25	Elevator-electrical work	2011	60,523	2,201	27	2,201		15,774	25
26	VCT Floor OT-painting, electrical, carpentry	2011	49,344	1,794	27	1,794		12,708	26
27				-		-			27
28	Front entrance door	2012	5,387	196	27	196		1,241	28
29	Sprinklers building	2012	6,500	236	27	236		1,455	29
30	Washing machine slab	2012	3,500	127	27	127		836	30
31				-		-			31
32				-		-			32
33				-		-			33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,627,881	\$ 83,328		\$ 315,788	\$ 232,460	\$ 6,093,767	34

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

Facility Name &amp; ID Number Lexington Health Care Center of Bloomingdale, Inc.

# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 8,627,881	\$ 83,328		\$ 315,788	\$ 232,460	\$ 6,093,767	1
2	Generator Exhaust Pipe - Rooftop	2013	9,715	177	27	353	176	1,942	2
3	EMR Wiring - Entire Facility	2013	14,022	42	27	510	468	2,592	3
4				-		-			4
5	A/C GAS UNIT - HVAC mechanical room	2014	30,091	1,094	27	1,094		3,830	5
6	R/M - Remodel and relocating kitchen sink	2014	5,205	-	10	521	521	2,342	6
7	replaced pipes concrete and tile			-		-			7
8	Furnace in Shower Room	2015	11,971	435	27	435		1,450	8
9	EMR Wiring - Entire Facility	2015	6,233	227	27	227		700	9
10	R&M - Asphalt work in the parking lot	2015	5,800	-	20	290	290	1,015	10
11	R&M - PTAC, Heat Pump, Cooling, Heating and	2015	20,633	-	27	764	764	2,675	11
12	Control systems replacement in mechanical			-		-			12
13	room			-		-			13
14	Injections to raise sinking concrete slab for 6 patient rooms &	2016	29,077	1,057	27	1,057		2,114	14
15	Chair Rail Installations in 1st Floor Rooms			-		-			15
16	Furnish/Install Cabinets in Lower Level Activity Room	2016	3,560	712	5	712		1,661	16
17	Furnish & Install 5 Rods/Valances for 8 Windows	2016	3,945	564	7	564		1,550	17
18	- Common Areas / Hallways			-		-			18
19	R&M: Replace Sanitary Line in Kitchen	2016	6,250	-	20	313	313	781	19
20	- Furnish & Install Cast Iron Piping, Lime Stone, Concrete & Ti			-		-			20
21	R&M: Heat Pump - HVAC Mechanical Room	2016	6,190	-	10	619	619	1,548	21
22	R&M: Remove 10 Trees & Install 4 New Trees - Outside NH	2016	9,511	-	20	476	476	1,189	22
23				-		-			23
24	R&M: 4" pipe furnished and installed plumbing work in Kitchen	2017	3,800	-	27	141	141	211	24
25	R&M: Remove asphalt; add concrete & sewer rebuild in parking l	2017	3,000	-	27	111	111	186	25
26	Furnish & Install Air Conditioner in Office & Conf - LL	2018	28,982	483	15	483		483	26
27	Furnish & Install Slide in A/C Units for Resident Rooms	2018	10,047	-	10	-		-	27
28	Install New Key into the Spare Fluid Pump - Mech. Room	2018	4,711	157	5	157		157	28
29	Update Walls in Kitchen Pantries	2018	4,709	275	10	275		275	29
30	Update Electrical (Conduit, Pole & Wires) in Laundry Room	2018	3,910	163	10	163		163	30
31	Replace Copper Lines & Reinstall Tiles - North Corridor	2018	8,869	-	5	-		(0)	31
32	Reconcile to book depreciation			386		-	(386)		32
33				-		-			33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,858,112	\$ 89,100		\$ 325,051	\$ 235,952	\$ 6,120,630	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 8,858,112	\$ 89,100		\$ 325,051	\$ 235,952	\$ 6,120,630	1
2	Building - management company	2002	219,024	-	40	4,782	4,782	107,025	2
3	HVAC, electrical, security system - management company	2003	1,924	-	30	166	166	1,645	3
4	Key card system - management company	2004	302	-	20	15	15	218	4
5	VAV TX controls - management company	2005	92	-	20	5	5	64	5
6	Interior Signs - management company	2006	67	-	20	4	4	54	6
7	Building improvements - management company	2008	9,682	-	20	115	115	4,382	7
8	Building improvements - management company	2009	1,847	-	20	100	100	956	8
9	Building improvements - management company	2010	1,812	-	20	77	77	870	9
10	Building improvements - management company	2011	1,363	-	20	63	63	476	10
11	Building improvements - management company	2012	4,282	-	20	156	156	1,050	11
12	Building improvements - management company	2013	3,558	-	20	203	203	1,312	12
13	Building improvements - management company	2014	1,926	-	20	190	190	868	13
14	Building improvements - management company	2015	338	-	20	41	41	145	14
15	Building improvements - management company	2016	5,588	-	20	409	409	990	15
16	Building improvements - management company	2017	3,574	-	20	152	152	221	16
17	Building improvements - management company	2018	678	-	20	14	14	14	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,114,169	\$ 89,100		\$ 331,543	\$ 242,444	\$ 6,240,920	34

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



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	\$ 143,763	\$ 26,384	\$ 26,384	\$ -	5-10	\$ 94,667	71
72	Current Year Purchases	37,986	2,199	2,199	-	5	2,199	72
73	Fully Depreciated Assets	939,162			-	5-7	939,162	73
74	Allocated from Mgmt. Co.	420,542		11,136	11,136	5-7	385,279	74
75	TOTALS	\$ 1,541,453	\$ 28,583	\$ 39,719	\$ 11,136		\$ 1,421,307	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.			39,804	-	1,448	1,448	5	35,994	79
80	TOTALS			\$ 39,804	\$ -	\$ 1,448	\$ 1,448		\$ 35,994	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,113,802	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,683	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 372,710	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 255,028	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,698,221	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	N/A	\$ -	\$ -	\$ -	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ -	\$ -	\$ -	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$ -	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Parking Space Lease				4,200			5
6	Allocated from Mgmt. Co.				3,454			6
7	TOTAL				\$ 7,654			7

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \_\_\_\_\_ \*

**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: \$ 49,139.00 Description: Copier-\$6,855, Postage machine - \$516, Med Eq.-\$11,478, Oxy Eq.-\$28,963, Mgmt. Co.-\$1327

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Mgmt. Co.			167	20
21	TOTAL		\$	\$ 167	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.

**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	8,227	\$ 424,013	\$	8,227	\$ 424,013	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,860	108,840		3,860	108,840	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		11,103	543,383		11,103	543,383	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 prescripts				261,664		261,664	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Schedule 16A</u>	39(2)					15,418		15,418	12
13	Other (specify): <u>Ambulance</u>	39(3)				688			688	13
14	TOTAL			\$	23,189	\$ 1,076,924	\$ 277,082	23,189	\$ 1,354,006	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:** Lexington Health Care Center of Bloomingdale, Inc.  
**IDPH License ID Number:** 0035188  
**Fiscal Year End:** 12/31/18

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

<b>Description</b>	<b>Amount</b>
Oxygen	6,716
DME	1,433
Rehab Supplies	7,269
<b>Total - Line 12</b>	<b><u>15,418</u></b>

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc. # 0035188 Report Period Beginning: 1/1/18 Ending: 12/31/18  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 23,456	\$ 131,439	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,280,738) )	977,043	977,043	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	184,272	184,272	6
7	Other Prepaid Expenses	29,292	29,292	7
8	Accounts Receivable (owners or related parties)		1,118,160	8
9	Other(specify): <u>Interest Receivable</u>	(9,636)	4,585	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,204,427	\$ 2,444,791	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		418,376	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	2,141,623	3,931,438	15
16	Equipment, at Historical Cost	624,618	1,581,257	16
17	Accumulated Depreciation (book methods)	(1,757,529)	(7,698,221)	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 (sp) <u>Insurance Recovery</u>	732,973	732,973	22
23	Other(specify): <u>Mortgage Cost, net</u>		183,708	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,741,685	\$ 4,332,262	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,946,112	\$ 6,777,053	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 458,461	\$ 458,461	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,262	315,262	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,146	12,146	31
32	Accrued Real Estate Taxes(Sch.IX-B)		176,655	32
33	Accrued Interest Payable		33,099	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	4,302,637	1,220,801	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,088,506	\$ 2,216,424	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,058,006	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,058,006	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,088,506	\$ 7,274,430	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,142,394)	\$ (497,377)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,946,112	\$ 6,777,053	48

\*(See instructions.)

Facility Name: Lexington Health Care Center of Bloomingdale, Inc.  
 IDPH License ID Number: 0035188  
 Fiscal Year End: 12/31/18

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Cash Patient Trust	62,550	62,550
Pa Audit Settlement	91,570	91,570
Rent Receivable	-	(3,114,506)
Due From Lhcs Of Lom	4,325	4,325
Due To Lex Fin Svcs I	-	-
Due To / From Rehab Care Therapy	(2,073)	(2,073)
Due From Llc I	-	-
Due From/(To) Lhcc Bloomingdale	-	32,670
Prepaid Insurance	36,276	36,276
Cobra	3,658	3,658
Withholding - Dental Insurance	612	612
Withholding - Ep/Ci/WI	1,696	1,696
Withholding - Short Term Disab	-	-
Life Insurance Withholding	-	-
Vision Withholding	(3)	(3)
401K Withholding	3,841	3,841
Accrued Expenses	42,128	42,128
Accrued Resident Tax	-	-
Accrued Vesta 3% Management Fees	(32,337)	(32,337)
Accrued Royal Management Fees	(50,256)	(50,256)
Accrued Rent	3,114,506	3,114,506
Accrued Insurance	107,743	107,743
Due To Patient Trust Fund	(62,207)	(62,207)
Advance - Biweekly Part A Paym	19,252	19,252
Uncollectible Part A Co Pvts	-	-
Due To - Royal Operations	20,282	20,282
Due To Sambell Bloomingdale Lp	(32,670)	(32,670)
Due To Lhcc Elmhurst	-	-
Due To Lagrange	-	-
Due To Lhcc Lombard	150,000	150,000
Due To Schaumburg	-	-
Professional Liabilities Claims	837,652	837,652
Interest Rate Swap Liability	-	-
Due From Ins Carrier	(13,908)	(13,908)
<b>Total - Line 36</b>	<b>4,302,637</b>	<b>1,220,801</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(725,053)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post Closing Adjustment</b>	<b>(192,151)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(917,204)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,225,190)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,225,190)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,142,394)</b>	<b>24</b> *

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



**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.**

1		2	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 15,311,926	1
2	Discounts and Allowances for all Levels	(7,619,804)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,692,122	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,754,874	6
7	Oxygen	8,729	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,763,603	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,086	12
13	Barber and Beauty Care	14,505	13
14	Non-Patient Meals	2,412	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	407,859	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	124,733	19
20	Radiology and X-Ray	18,213	20
21	Other Medical Services	136,880	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 705,688	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	19,943	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 19,943	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other revenues</b>	172	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 172	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,181,528	30

1		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,677,498	31
32	Health Care	5,316,670	32
33	General Administration	3,239,325	33
<b>B. Capital Expense</b>			
34	Ownership	1,057,215	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,812,743	35
36	Provider Participation Fee	303,267	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,406,718	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,225,190)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,225,190)	43
<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,552,888	44
45	Private Pay - Net Inpatient Revenue	1,325,458	45
46	Medicare - Net Inpatient Revenue	1,101,062	46
47	Other-(specify) <u>Managed Care</u>	2,712,714	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 7,692,122	49

\* This must agree with page 4, line 45, column 4.  
 \*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.  
 ^ Entity is a cash basis taxpayer

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	1,538	2,001	\$ 125,328	\$ 62.64	1
2	Assistant Director of Nursing	1,788	2,366	103,566	43.78	2
3	Registered Nurses	31,415	40,066	1,342,276	33.50	3
4	Licensed Practical Nurses	18,024	23,114	648,696	28.06	4
5	CNAs & Orderlies	68,209	83,351	1,413,042	16.95	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	1,877	2,282	47,641	20.88	9
10	Activity Assistants	4,992	6,099	82,391	13.51	10
11	Social Service Workers	4,496	5,858	147,843	25.24	11
12	Dietician	1,330	1,559	39,009	25.03	12
13	Food Service Supervisor	1,644	1,908	45,585	23.89	13
14	Head Cook	1,617	2,125	46,742	22.00	14
15	Cook Helpers/Assistants	18,850	22,396	282,758	12.63	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	2,241	2,379	52,904	22.23	17
18	Housekeepers	17,137	20,895	278,972	13.35	18
19	Laundry	-	-	-		19
20	Administrator	1,666	2,166	149,182	68.88	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	-	-	-		23
24	Clerical	5,096	6,521	117,038	17.95	24
25	Vocational Instruction	-	-	-		25
26	Academic Instruction	-	-	-		26
27	Medical Director	-	-	-		27
28	Qualified MR Prof. (QMRP)	-	-	-		28
29	Resident Services Coordinator	-	-	-		29
30	Habilitation Aides (DD Homes)	-	-	-		30
31	Medical Records	1,719	2,241	36,801	16.42	31
32	Other Health C: <u>See Sch 20A</u>	13,930	17,807	517,134	29.04	32
33	Other(specify) <u>Marketing</u>	29	2	69	35.76	33
34	TOTAL (lines 1 - 33)	197,597	245,136	\$ 5,476,976 *	\$ 22.34	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		\$		35
36	Medical Director				36
37	Medical Records Consultant	Monthly	780	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,516	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	2,376	11(3)	44
45	Social Service Consultant	Monthly	3,891	12(3)	45
46	Other(specify) <u>Pulmonary</u>	Monthly	13,601	10(3)	46
47	<u>Medical Consultant</u>	Monthly	390	10(7)	47
48	<u>See Sch 20B</u>	Monthly	12,072	10(3)	48
49	TOTAL (lines 35 - 48)		\$ 46,626		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	17,568	500,344	10(3)	52
53	TOTAL (lines 50 - 52)	17,568	\$ 500,344		53

**Facility Name:** Lexington Health Care Center of Bloomingdale, Inc.  
**IDPH License ID Number:** 0035188  
**Fiscal Year End:** 12/31/18

**Schedule 20A**

**XVIII. Staffing and Salary Costs**  
**Line 32 Other Health Care (specify):**

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Staffing Coordinator	1,999	2,475	47,209	19
Unit Secretary	4,287	5,295	136,176	26
Accounts Coordinator	1,710	2,189	37,931	17
MDS	2,222	2,941	131,661	45
Clinical Coordinator	2,421	3,124	118,464	38
Wound Care Coordinator	1,291	1,782	45,692	26
<b>Total - Line 32 Other Health Care (specify):</b>	<b>13,930</b>	<b>17,807</b>	<b>517,134</b>	

**Facility Name:** Lexington Health Care Center of Bloomingdale, Inc.  
**IDPH License ID Number:** 0035188  
**Fiscal Year End:** 12/31/18

**Schedule 20B**

**XVIII. Staffing and Salary Costs**  
**Line 48**

Description	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
Staffing Coordinator	Monthly	2,947	10(3)
Unit Secretary	Monthly	9,125	10(3)
<b>Total - Line 48</b>		<b>12,072</b>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Anshu Raina</u>	<u>Administrator</u>	<u>0%</u>	\$ <u>149,182</u>	<u>Workers' Compensation Insurance</u>	\$ <u>102,464</u>	<u>IDPH License Fee</u>	\$ <u>5,970</u>	
				<u>Unemployment Compensation Insurance</u>	<u>29,343</u>	<u>Advertising: Employee Recruitment</u>	<u>6,292</u>	
				<u>FICA Taxes</u>	<u>408,877</u>	<u>Health Care Worker Background Check</u>	<u>1,398</u>	
				<u>Employee Health Insurance</u>	<u>208,288</u>	(Indicate # of checks performed <u>126</u> )	<u>1,398</u>	
				<u>Employee Meals</u>	<u>0</u>	<u>Patient Background Checks</u>	<u>428</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Fees</u>	<u>1,416</u>	
				<u>401(k) Contributions</u>	<u>15,673</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>8,986</u>	
				<u>Other Employee Benefits</u>	<u>16,770</u>	<u>IHCA</u>	<u>4,620</u>	
				<u>Uniform Allowance</u>	<u>(585)</u>	<u>Less: Non-Allowable Dues</u>	<u>(1,472)</u>	
				<u>Tuition</u>	<u>2,316</u>	<u>Management Company Allocation</u>	<u>12,870</u>	
						<u>Less: Public Relations Expense</u>	( )	
						<u>Non-allowable advertising</u>	( )	
						<u>Yellow page advertising</u>	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 149,182</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>		<b>\$ 783,146</b>		
<b>(List each licensed administrator separately.)</b>						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		
						<b>\$ 45,333</b>		
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-Royal Operating</u>			\$ <u>781,428</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	\$
<u>Royal-Shared Services</u>			<u>617,256</u>					
							<u>In-State Travel</u>	
							<u>Seminar Expense</u>	
							<u>Allocated from Home Office</u>	<u>572</u>
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 1,398,684</b>	<b>TOTAL</b>		<b>\$</b>	<u>Entertainment Expense</u>	( )
<b>(Attach a copy of any management service agreement)</b>							(agree to Sch. V, line 24, col. 8)	
							<b>TOTAL</b>	<b>\$ 572</b>
C. Professional Services			Amount					
Vendor/Payee	Type							
<u>RSM US LLP</u>	<u>Accounting</u>	\$ <u>33,589.00</u>						
<u>Much Shelist</u>	<u>Legal</u>	<u>11,938.82</u>						
<u>Duane Morris</u>	<u>Legal</u>	<u>1,182.94</u>						
<u>Mcguire Woods</u>	<u>Legal</u>	<u>2,999.01</u>						
<u>Huges Socol Piers</u>	<u>Legal</u>	<u>942.00</u>						
<u>Bert Spilker &amp; Associates</u>	<u>Legal</u>	<u>76.00</u>						
<u>Hinshaw &amp; Culbertson</u>	<u>Legal</u>	<u>234.00</u>						
<u>Midcap Financial</u>	<u>Legal</u>	<u>2,205.22</u>						
<u>Personnel Planners Inc</u>	<u>U/C Consulting</u>	<u>840.00</u>						
<u>Midcap Financial</u>	<u>Financial</u>	<u>3,161.25</u>						
<u>Lexington Financial Services</u>	<u>LLC &amp; 401k audit</u>	<u>2,965.51</u>						
<u>See Sch 21C</u>	<u>See Sch 21C</u>	<u>170,517</u>						
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 230,651</b>					
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name: Lexington Health Care Center of Bloomingdale, Inc.  
 IDPH License ID Number: 0035188  
 Fiscal Year End: 12/31/18

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

Vendor	Type	Amount
Much Shelist	Collections	69,996
Connected For Care Llc	Computer services	8,600
Infor Lawson	Computer services	5,377
Lawson	Computer services	4,325
Ability Network Inc	Computer services	1,872
Relias	Computer services	6,912
Onshift	Computer services	6,297
MHC SW	Computer services	18
ICIMS	Computer services	3,170
Salesforce	Computer services	8,705
Info Control	Computer services	2,173
Royal Management Operation	Computer services	16,659
National Datacare Corp.	Computer services	2,489
Softchoice	Computer services	3,494
Comp Supply	Computer services	1,436
Touch Point	Computer services	2,553
MS Licensing	Computer services	9,937
Microsoft Software	Computer services	464
Netsmart	Computer services	10,616
Health Medx Software	Computer services	531
GP Software	Computer services	3,985
Royal Management Operation	Consulting	911
<b>Total (agree to Schedule V, line 19, column 3)</b>		<b>230,651</b>
Allocated from Real Estate Entity	Professional Services	200
Less: Non-Allowable Legal Fees		(70,093)
		<b>160,758</b>
<b>Allocated from Mgmt. Co.</b>		
Much Shelist	Legal	1,238
Duane Morris	Legal	792
Partridge Partners	Legal	60
RSM	Accounting	1,359
Friedman & Huey	Accounting	409
IL Secretary of State	Filing Fees	4
West Suburban Bank	Banking	5
Personnel Planners	U/C Consultant	8
LaSalle Network	Recruiting / Finance	7,179
Pension Administrators, Inc.	401K Administration	187
Gene Whitehorn	Public Aid Pending Consultant	1,237
Steeley Group LLC	Financial Consulting	2,018
M Werner Consulting	Public Aid Consultant	56
Early Stage Solutions	Financial Consulting	13,686
Objective Arts	Public Aid Pending Consultants	251
Adam Leflon	Financial Consulting	5,804
Brilliant Staffing LLC	Financial Consulting	1,929
Mark J Eenigenburg	Budgeting Consultant	1,806
Deloitte Consulting LLP	Compensation Consulting	846
John Mattone Partners	Workplace Consultant	4,667
Mark Rodeghier	Survey Preparation Consultant	250
JGC Advisors LLC	Contracting Consultant	117
Michel Desjardins	Contracting Consultant	63
Pathway Health Services	Operational & Financial Consulting	(133)
Brandlin & Associates	Banking Consultants	18,002
Steven Wood	Strategy/Operations Consulting	710
Susan Parker	Social Service Consultant	12
Focus Pointe Global	Strategic Planning	196
Andrzej Stankiewicz	General Business Consulting	164
DLC	Financial Planning & Analysis	2,637
Fieldwork	Recruitment Consultant	352
Computer Services	Computer Consulting	16,266
		<b>82,177</b>
Allocated from SV of Lombard II		
Friedman & Huey	Accounting	102
Duane Morris	Legal	19
Illinois Secretary of State	Filing Fees	2
		<b>123</b>
<b>Total (agree to Schedule V, line 19, column 8)</b>		<b>243,058</b>

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.# 0035188

Report Period Beginning:

1/1/18

Ending:

12/31/18**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 - \$4,620
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,208 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 303,267  
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2412
- (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? N/A  
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? Yes  
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.