

		FOR BHF USE					

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2019
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2019)

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.

<p>I. IDPH License ID Number: <u>0036095</u></p> <p>Facility Name: <u>Lexington Health Care Center of Schaumburg Inc.</u></p> <p>Address: <u>675 South Roselle Road</u> <u>Schaumburg</u> <u>60193</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>847-351-5500</u> Fax # <u>847-352-8592</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/3/90</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Rob Schlicht</u> Telephone Number: <u>414-431-9335</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2019</u> to <u>12/31/2019</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Rob Schlicht</u> <u>Director</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee WI 53226</u></td> </tr> <tr> <td>(Telephone) <u>414-431-9335</u> Fax # <u>414-431-9303</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____		(Title) _____	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Rob Schlicht</u> <u>Director</u>	(Firm Name & Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee WI 53226</u>	(Telephone) <u>414-431-9335</u> Fax # <u>414-431-9303</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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Facility Name & ID Number Lexington Health Care Center of Schaumburg Inc.

0036095 Report Period Beginning: 01/01/2019 Ending: 12/31/2019

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	214	Skilled (SNF)	214	78,110	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	214	TOTALS	214	78,110	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			10,444	10,444	8
9	SNF/PED					9
10	ICF	36,436	7,745	1,758	45,939	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,436	7,745	12,202	56,383	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.18%

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

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 4/1/90

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 214 and days of care provided 7,165

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: 12/31/19 Fiscal Year: 12/31/19

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

Facility Name & ID Number Lexington Health Care Center of Schaumbur # 0036095 Report Period Beginning: 01/01/2019 Ending: 12/31/2019

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
	A. General Services										
1	Dietary	205,934	13,059	641,696	860,689	860,689		860,689			1
2	Food Purchase		163,519		163,519	163,519	(738)	162,781			2
3	Housekeeping	177,700	16,964	292,196	486,860	486,860	613	487,473			3
4	Laundry		9,619		9,619	9,619		9,619			4
5	Heat and Other Utilities			254,278	254,278	254,278	18,956	273,234			5
6	Maintenance	48,611		197,699	246,310	246,310	140,504	386,814			6
7	Other (specify):* Mgmt Co Alloc						18,240	18,240			7
8	TOTAL General Services	432,245	203,161	1,385,869	2,021,275	2,021,275	177,575	2,198,850			8
	B. Health Care and Programs										
9	Medical Director			49,850	49,850	49,850		49,850			9
10	Nursing and Medical Records	5,831,428	391,451	84,193	6,307,072	6,307,072	28,842	6,335,914			10
10a	Therapy										10a
11	Activities	181,199	13,844	12,161	207,204	207,204		207,204			11
12	Social Services	198,131		3,091	201,222	201,222		201,222			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co Alloc						3,703	3,703			15
16	TOTAL Health Care and Programs	6,210,758	405,295	149,295	6,765,348	6,765,348	32,545	6,797,893			16
	C. General Administration										
17	Administrative	142,608		1,548,859	1,691,467	1,691,467	(1,548,859)	142,608			17
18	Directors Fees										18
19	Professional Services			183,493	183,493	183,493	126,580	310,073			19
20	Dues, Fees, Subscriptions & Promotions			32,616	32,616	32,616	4,641	37,257			20
21	Clerical & General Office Expenses	125,432	58,041	47,153	230,626	230,626	867,801	1,098,427			21
22	Employee Benefits & Payroll Taxes			1,201,272	1,201,272	1,201,272		1,201,272			22
23	Inservice Training & Education			7,053	7,053	7,053		7,053			23
24	Travel and Seminar						90	90			24
25	Other Admin. Staff Transportation			661	661	661	15,124	15,785			25
26	Insurance-Prop.Liab.Malpractice			719,377	719,377	719,377	12,383	731,760			26
27	Other (specify):* Mgmt Co Alloc						108,684	108,684			27
28	TOTAL General Administration	268,040	58,041	3,740,484	4,066,565	4,066,565	(413,556)	3,653,009			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,911,043	666,497	5,275,648	12,853,188	12,853,188	(203,436)	12,649,752			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			114,758	114,758		114,758	290,612	405,370			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			78,812	78,812		78,812	572,755	651,567			32
33	Real Estate Taxes							718,965	718,965			33
34	Rent-Facility & Grounds			1,345,315	1,345,315		1,345,315	(1,345,315)				34
35	Rent-Equipment & Vehicles			59,862	59,862		59,862	4,401	64,263			35
36	Other (specify):*											36
37	TOTAL Ownership			1,598,747	1,598,747		1,598,747	241,418	1,840,165			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		340,636	1,127,046	1,467,682		1,467,682		1,467,682			39
40	Barber and Beauty Shops			14,860	14,860		14,860	(14,860)				40
41	Coffee and Gift Shops			696	696		696	(144)	552			41
42	Provider Participation Fee			412,478	412,478		412,478		412,478			42
43	Other (specify):*			467,998	467,998		467,998	(467,998)				43
44	TOTAL Special Cost Centers		340,636	2,023,078	2,363,714		2,363,714	(483,002)	1,880,712			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,911,043	1,007,133	8,897,473	16,815,649		16,815,649	(445,020)	16,370,629			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	(738)	2		4
5	Telephone, TV & Radio in Resident Rooms	(20,292)	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	20,951	30		9
10	Interest and Other Investment Income	(4,435)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,641)	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	(34,986)	43		18
19	Entertainment				19
20	Contributions	(102)	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	(322,857)	43		24
25	Fund Raising, Advertising and Promotional	(41,963)	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 See Pg 5a	(119,549)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (536,612)		\$	30

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)	91,592		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 91,592		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (445,020)		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.			\$	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

BHF USE ONLY							
48		49		50		51	52

Lexington Health Care Center of Schaumburg Inc.

ID# 0036095

Report Period Beginning: 01/01/2019

Ending: 12/31/2019

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	captialized repairs and maintenance	\$ (16,802)	6	1
2	labs part a	(21,187)	43	2
3	xray part a	(13,087)	43	3
4	personal item replacement	(883)	43	4
5				5
6	collections	(6,401)	19	6
7	barber and beauty	(14,860)	40	7
8	lobbying portion of dues	(1,608)	20	8
9	Salesforce Computer Consulting	(7,859)	19	9
10	gift shop income	(144)	41	10
11	misc income	(5,945)	21	11
12	trust fees	(50)	43	12
13	offset shareholder interest	(30,723)	32	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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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	(119,549)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington Health Care Center of Schaumburg Inc.# 0036095

Report Period Beginning:

01/01/2019

Ending:

12/31/2019

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(738)	0	0	0	0	0	0	0	0	0	0	(738)	2
3	Housekeeping	0	0	613	0	0	0	0	0	0	0	0	613	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	18,956	0	0	0	0	0	0	0	0	18,956	5
6	Maintenance	(16,802)	0	157,231	75	0	0	0	0	0	0	0	140,504	6
7	Other (specify):*	0	0	18,240	0	0	0	0	0	0	0	0	18,240	7
8	TOTAL General Services	(17,540)	0	195,040	75	0	0	0	0	0	0	0	177,575	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	28,842	0	0	0	0	0	0	0	0	28,842	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	3,703	0	0	0	0	0	0	0	0	3,703	15
16	TOTAL Health Care and Programs	0	0	32,545	0	0	0	0	0	0	0	0	32,545	16
	C. General Administration													
17	Administrative	0	0	0	(1,548,859)	0	0	0	0	0	0	0	(1,548,859)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,260)	200	140,640	0	0	0	0	0	0	0	0	126,580	19
20	Fees, Subscriptions & Promotions	(1,608)	0	6,249	0	0	0	0	0	0	0	0	4,641	20
21	Clerical & General Office Expenses	(5,945)	0	873,746	0	0	0	0	0	0	0	0	867,801	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	90	0	0	0	0	0	0	0	90	24
25	Other Admin. Staff Transportation	0	0	0	15,124	0	0	0	0	0	0	0	15,124	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	12,383	0	0	0	0	0	0	0	12,383	26
27	Other (specify):*	0	0	0	108,684	0	0	0	0	0	0	0	108,684	27
28	TOTAL General Administration	(21,813)	200	1,020,635	(1,412,578)	0	0	0	0	0	0	0	(413,556)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(39,353)	200	1,248,220	(1,412,503)	0	0	0	0	0	0	0	(203,436)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center of Schaumburg Inc.# 0036095

Report Period Beginning:

01/01/2019

Ending:

12/31/2019

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	20,951	246,090	0	23,571	0	0	0	0	0	0	0	290,612	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35,158)	568,636	0	39,277	0	0	0	0	0	0	0	572,755	32
33	Real Estate Taxes	0	701,096	0	17,869	0	0	0	0	0	0	0	718,965	33
34	Rent-Facility & Grounds	0	(1,345,315)	0	0	0	0	0	0	0	0	0	(1,345,315)	34
35	Rent-Equipment & Vehicles	0	0	0	4,401	0	0	0	0	0	0	0	4,401	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,207)	170,507	0	85,118	0	0	0	0	0	0	0	241,418	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	(14,860)	0	0	0	0	0	0	0	0	0	0	(14,860)	40
41	Coffee and Gift Shops	(144)	0	0	0	0	0	0	0	0	0	0	(144)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(468,048)	50	0	0	0	0	0	0	0	0	0	(467,998)	43
44	TOTAL Special Cost Centers	(483,052)	50	0	0	0	0	0	0	0	0	0	(483,002)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(536,612)	170,757	1,248,220	(1,327,385)	0	0	0	0	0	0	0	(445,020)	45

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Fees	\$	Sambell of Schaumburg Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation Expense		Sambell of Schaumburg Limited Partnership	**	246,090	246,090	2
3	V	32 Amortization of Mortgage Cost		Sambell of Schaumburg Limited Partnership	**	93,137	93,137	3
4	V	32 Interest		Sambell of Schaumburg Limited Partnership	**	475,499	475,499	4
5	V	33 Property Tax		Sambell of Schaumburg Limited Partnership	**	701,096	701,096	5
6	V	34 Rent	1,345,315	Sambell of Schaumburg Limited Partnership	**		(1,345,315)	6
7	V	43 Trust fees		Sambell of Schaumburg Limited Partnership	**	50	50	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of Schaumburg Inc. own				12
13	V			100% of Sambell of Schaumburg Limited Partnership				13
14	Total		\$ 1,345,315			\$ 1,516,072	\$ * 170,757	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 Housekeeping Supplies	\$	Royal Management Corp.	**	\$ 613	\$	613	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	17,862		17,862	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	608		608	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	486		486	18
19	V	6 Management Allocation - salaries		Royal Management Corp.	**	142,061		142,061	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	15,001		15,001	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	169		169	21
22	V	7 Management Allocation - employee benefits		Royal Management Corp.	**	18,240		18,240	22
23	V	10 Medical consultant		Royal Management Corp.	**				23
24	V	10 Management Allocation - salaries		Royal Management Corp.	**	28,842		28,842	24
25	V	15 Management Allocation - employee benefits		Royal Management Corp.	**	3,703		3,703	25
26	V	17 Management Allocation - salaries		Royal Management Corp.	**				26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	47,512		47,512	27
28	V	19 Professional fees		Royal Management Corp.	**	93,128		93,128	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,024		1,024	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	5,225		5,225	30
31	V	21 Management Allocation - salaries		Royal Management Corp.	**	846,467		846,467	31
32	V	21 Bank charges		Royal Management Corp.	**	2,939		2,939	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	6,266		6,266	33
34	V	21 Postage		Royal Management Corp.	**	3,790		3,790	34
35	V	21 Telephone		Royal Management Corp.	**	14,284		14,284	35
36	V								36
37	V								37
38	V	** The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 1,248,220	\$ *	1,248,220	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	23 Inservice training	\$	Royal Management Corp	**	\$		15	
16	V	24 Travel & seminar		Royal Management Corp	**	90	90	16	
17	V	25 Auto expense		Royal Management Corp	**	15,124	15,124	17	
18	V	26 Insurance general		Royal Management Corp	**	12,383	12,383	18	
19	V	27 Management Allocation - employee benefits		Royal Management Corp	**	108,684	108,684	19	
20	V	30 Depreciation		Royal Management Corp	**	23,571	23,571	20	
21	V	32 Interest		Royal Management Corp	**	38,824	38,824	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp	**	453	453	22	
23	V	33 Property taxes		Royal Management Corp	**	17,869	17,869	23	
24	V	34 Rent expense		Royal Management Corp	**			24	
25	V	35 Equipment rental		Royal Management Corp	**	3,493	3,493	25	
26	V	17 Management fees	1,548,859	Royal Management Corp	**		(1,548,859)	26	
27	V	35 Auto lease		Royal Management Corp	**	908	908	27	
28	V	6 Security Service		Royal Management Corp	**	75	75	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 Schaumburg own 100% of Royal Management Corp.							38
39	Total		\$ 1,548,859			\$ 221,474	\$ * (1,327,385)	39	

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

Facility Name & ID Number

Lexington Health Care Center of Schaumburg Inc.

0036095

Report Period Beginning:

01/01/2019

Ending:

12/31/2019

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 Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Lexington Square	Lombard	Independent	3
4			Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Life Care of		and Assisted	4
5			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Lombard, LLC		Living Facility	5
6			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Life Care of		Living Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Elmhurst, LLC			8
9			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Vesta Management	Lombard	Mgmt. Company	9
10					Group, LLC			10
11					Sambell of	Schaumburg	Real Estate	11
12					Schaumburg		Property	12
13					Ltd. Ptsp.			13
14					Royal Management	Lombard	Mgmt. Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance	16
17					Services, LLC		Company	17
18					Heron Point	Lombard	Mgmt. Company	18
19					Management Corp.			19
20					Samvest of	Lombard	Lessor	20
21					Lombard 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					Merit Sleep Mgmt, LL	Lombard	Mgmt. Company	30

Facility Name & ID Number Lexington Health Care Center of Schaumburg # 0036095 Report Period Beginning: 01/01/2019 Ending: 12/31/2019

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	owners took no salaries in 2019								\$		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 Health Care Center of Schaumburg Inc. # 0036095 Report Period Beginning: 01/01/2019 Ending: 2/31/2019

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	669,997	10	\$ 5,256	\$ 78,110	\$ 613	1	
2	5	Utilities - gas & electric	Bed days available	669,997	10	153,206	78,110	17,861	2	
3	5	Utilities - water & sewer	Bed days available	669,997	10	5,210	78,110	607	3	
4	5	Utilities - maintenance office	Bed days available	669,997	10	4,168	78,110	486	4	
5	6	Management Allocation - salaries	Bed days available	669,997	10	1,218,541	1,218,541	78,110	142,061	5
6	6	Repairs & maintenance	Bed days available	669,997	10	128,674	78,110	15,001	6	
7	6	Scavenger & exterminating	Bed days available	669,997	10	1,449	78,110	169	7	
8	7	Management Allocation - employee be	Bed days available	669,997	10	156,456	78,110	18,240	8	
9	10	Medical consultant	Bed days available	669,997	10		78,110	0	9	
10	10	Management Allocation - salaries	Bed days available	669,997	10	247,396	247,396	78,110	28,842	10
11	15	Management Allocation - employee be	Bed days available	669,997	10	31,764	78,110	3,703	11	
12	17	Management Allocation - salaries	Bed days available	669,997	10		78,110	0	12	
13	19	Computer consultant & supplies	Bed days available	669,997	10	407,540	78,110	47,512	13	
14	19	Professional fees	Bed days available	669,997	10	798,815	78,110	93,128	14	
15	20	Dues & subscriptions	Bed days available	669,997	10	8,782	78,110	1,024	15	
16	20	Advertising - help wanted	Bed days available	669,997	10	44,822	78,110	5,225	16	
17	21	Management Allocation - salaries	Bed days available	669,997	10	7,260,666	7,260,666	78,110	846,467	17
18	21	Bank charges	Bed days available	669,997	10	25,210	78,110	2,939	18	
19	21	Office supplies & printing	Bed days available	669,997	10	53,750	78,110	6,266	19	
20	21	Postage	Bed days available	669,997	10	32,511	78,110	3,790	20	
21	21	Telephone	Bed days available	669,997	10	122,542	78,110	14,286	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 10,706,758	\$ 8,726,603	\$ 1,248,220	25	

Facility Name & ID Number Lexington Health Care Center of Schaumburg Inc. # _____ Report Period Beginning: 01/01/2019 Ending: 2/31/2019

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	669,997	10	\$	\$ 78,110	\$	1
2	24	Travel & seminar	Bed days available	669,997	10	770	78,110	90	2
3	25	Auto expense	Bed days available	669,997	10	129,730	78,110	15,124	3
4	26	Insurance general	Bed days available	669,997	10	106,220	78,110	12,383	4
5	27	Management Allocation - employee b	Bed days available	669,997	10	932,246	78,110	108,684	5
6	30	Depreciation	Bed days available	669,997	10	202,177	78,110	23,570	6
7	32	Interest	Bed days available	669,997	10	333,015	78,110	38,824	7
8	2	Amortization of mortgage costs	Bed days available	669,997	10	3,885	78,110	453	8
9	33	Property taxes	Bed days available	669,997	10	153,272	78,110	17,869	9
10	34	Rent expense	Bed days available	669,997	10		78,110		10
11	35	Equipment rental	Bed days available	669,997	10	29,955	78,110	3,492	11
12	17	Management fees	Bed days available	669,997	10		78,110		12
13	35	Auto lease	Bed days available	669,997	10	7,784	78,110	907	13
14	6	Security Service	Bed days available	669,997	10	672	78,110	78	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,899,726	\$	\$ 221,474	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Midcap Financial Trust		x	Mortgage	varies	5/29/2018	\$ 5,058,006	\$ 6,024,276	5/29/2021	libor+5.25	\$ 475,499	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	LHCS of Lombard LP	x		working capital	none	2/20/18	300,000	698,900	2/19/20	libor+5.25%	48,089	6								
7	Shareholder	x		working capital	varies	5/11/12	452,000	500,536	demand	variable	30,723	7								
8												8								
9	TOTAL Facility Related						\$ 5,810,006	\$ 7,223,712			\$ 554,311	9								
B. Non-Facility Related*																				
10										Amortization of mortgage costs	93,137	10								
11										Interest Income offset	(4,435)	11								
12										Allocated from Mgmt Co	38,824	12								
13										Offset shareholder interest	(30,723)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ 96,803	14								
15	TOTALS (line 9+line14)						\$ 5,810,006	\$ 7,223,712			\$ 651,114	15								

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 2018 report.		\$	<u>637,273</u>	1
	2018			
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.)		\$	<u>628,604</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(8,669)</u>	3
4. Real Estate Tax accrual used for 2019 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>710,244</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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
	allocated from mgmt co		<u>17,869</u>	
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 \$ <u>(479)</u> For <u>###</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	<u>(479)</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>718,965</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2014	<u>565,184</u>	8
	2015	<u>571,449</u>	9
	2016	<u>578,572</u>	10
	2017	<u>618,691</u>	11
	2018	<u>628,604</u>	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2018	\$	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.

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Schaumburg Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036095

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 2018 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 2018.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>07-27-201-039-0000</u>	<u>nursing facility</u>	\$ <u>628,604.00</u>	\$ <u>628,604.00</u>
2.	<u>Ryaol Management Corp (Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>249,182.00</u>	\$ <u>17,869.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>877,786.00</u>	\$ <u>646,473.00</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? 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 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

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 Schaumburg Inc.

0036095

Report Period Beginning:

01/01/2019 Ending:

12/31/2019

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,541 B. General Construction Type: Exterior concrete Frame steel Number of Stories 3

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>resident care</u>	<u>230,000</u>	<u>1988</u>	<u>\$ 211,532</u>	<u>1</u>
2	<u>Management Company allocation</u>			<u>21,498</u>	<u>2</u>
3	TOTALS	230,000		\$ 233,030	3

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	214		1990	1990	\$ 6,091,126	\$	35	\$ 174,032	\$ 174,032	\$ 5,174,632	4
5			1995	1995	146,217	4,178	35	4,178		98,178	5
6											6
7											7
8											8
	Improvement Type**										
9		Building improvements	1991		3,521		10			3,491	9
10		Building improvements	1992		860	25	35	25		681	10
11		Land improvements	1992		5,764		20			5,764	11
12		Land improvements	1992		5,000		20			5,000	12
13		Fan coil units in offices	1996		5,149	147	35	147		3,456	13
14		Basement rehab	1997		14,697		10			14,697	14
15		Brick	1997		1,500	43	35	43		962	15
16		Dining room rehab	1997		6,422		10			6,422	16
17		Parking lot repave and restripe	1998		2,777		10			2,777	17
18		Wiring	1998		3,667		10			3,667	18
19		Retile 2nd and 3rd floor corridors	1998		10,100		10			10,100	19
20		Plumbing for HVAC	1998		2,263		5			2,263	20
21		Lobby-floor tile	1999		7,478		10			7,478	21
22		Wallpaper-labor	1999		9,705		10			9,705	22
23		New patio	1999		19,039		15			19,039	23
24		New pay phone/wiring	1999		2,975		10			2,975	24
25		Roof repairs	2000		9,625		10			9,625	25
26		Water heater	2000		6,688		10			6,688	26
27		Automatic door	2000		1,300		10			1,300	27
28		Rehab project - paint resident rooms, carpet hallways, and tile	2000		52,760		10			52,760	28
29		Water heater and storage tanks	2001		12,102		10			12,102	29
30		Garbage area	2001		4,788		20			4,788	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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

0036095

Report Period Beginning:

01/01/2019 Ending: 12/31/2019

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	Roof	2002	\$ 25,600	\$	10	\$	\$	\$ 25,600	37
38	Facility rehab - paint resident rooms, carpet hallways, and tile	2002	327,253	16,363	20	16,363		300,905	38
39	Elevator electronic curtain	2002	4,500		10			4,500	39
40	Elevator upgrade	2002	5,471		10			5,471	40
41	Painting and decorating	2003	13,477		10			13,477	41
42	Electrical improvements	2003	844	42	20	42		676	42
43	Repave parking lot	2004	28,840	721	40	721		11,115	43
44	Dining room remodel - paint	2004	11,387	569	20	569		8,916	44
45	Landscaping	2005	593	30	20	30		432	45
46	HVAC upgrade	2005	17,734	887	20	887		12,491	46
47	Generator upgrade	2005	19,650	983	20	983		14,744	47
48	Window replacement	2005	3,899	195	20	195		2,795	48
49	Flooring replacement	2005	1,483	74	20	74		1,061	49
50	Lobby, lounge and reception rehab	2005	27,180	1,359	20	1,359		19,026	50
51	Therapy room rehab	2005	35,135	1,757	20	1,757		24,889	51
52	Create first floor therapy room	2005	32,045	1,602	20	1,602		23,764	52
53	Create transitional care unit	2005	29,170	1,458	20	1,458		20,535	53
54	Basement renovation	2005	5,996	300	20	300		4,200	54
55	Countertops	2005	845		5			845	55
56	Interior signs	2005	4,412		5			4,412	56
57	Window treatments	2005	912		5			912	57
58	Wall covering	2005	439		5			439	58
59	Panel Brick Replacement	2006	17,387	869	20	869		11,442	59
60	Landscaping Enhancement	2006	7,608	507	15	507		6,718	60
61	HVAC	2006	12,232	612	20	612		8,007	61
62	Sink	2006	2,331	117	20	117		1,598	62
63	TCU Units	2006	16,379	819	20	819		10,852	63
64	Employee lunch room rehab	2006	8,127	406	20	406		5,482	64
65	Dining room rehab	2006	2,357	118	20	118		1,593	65
66	Basement renovation	2006	9,465	473	20	473		6,307	66
67	Oxygen room rehab	2006	2,664	133	20	133		1,774	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,100,938	\$ 34,787		\$ 208,819	\$ 174,032	\$ 6,013,528	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 Schaumburg Inc.

0036095

Report Period Beginning:

01/01/2019 Ending: 12/31/2019

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	Totals from Page 12A, Carried Forward		\$ 7,100,938	\$ 34,787		\$ 208,819	\$ 174,032	\$ 6,013,528	1
2	Replace Sidewalk	2007	14,625	731	20	731		9,077	2
3	Landscaping	2007	15,700	785	20	785		9,616	3
4	Emergency A/C	2007	15,545	777	20	777		9,777	4
5	1st Floor Remodel - Carpentry, Flooring, Plumbing, Paint	2007	676,072		40	16,902	16,902	208,458	5
6	Bathroom Faucets	2007	12,358	618	20	618		7,467	6
7	Landscaping	2008	10,000	667	15	667		7,781	7
8	Roofing	2008	11,950	598	20	598		6,777	8
9	HVAC-Air tank	2008	2,671	67	40	67		765	9
10	HVAC-Spot Cooler	2008	3,790	95	40	95		1,045	10
11	Electrical-Fire panel upgrade	2008	71,077	1,777	40	1,777		20,732	11
12	Electrical-Replace Gasket	2008	6,125	613	10	302	(311)	6,125	12
13	2nd floor remodel-carpentry, painting, plumbing,electrical	2008	558,949		27	20,325	20,325	226,963	13
14	Panel Brick Replacement	2009	184,595	9,230	20	9,230		92,300	14
15	Land Improvements	2009	12,400	620	20	620		6,510	15
16	Parking Lot	2009	4,600	230	20	230		2,415	16
17	Front Entrance Improvements	2009	28,660	717	40	717		7,409	17
18	HVAC Quick Connectors	2009	5,591	140	40	140		1,458	18
19	HVAC Spot Cooler	2009	4,254	106	40	106		1,104	19
20	1st floor Admin-Tile,electical	2009	11,679	292	40	292		2,920	20
21	Kitchen Plumbing	2009	8,210	821	10	821		8,621	21
22	Fire Alarm Electrical	2009	31,710	793	40	793		8,194	22
23	Glass & Mirror Med Room	2009	2,836	284	10	284		3,053	23
24	2nd Floor Remodel -Carpentry	2009	14,592	730	20	730		7,918	24
25	Patio Pergola	2009	9,505	475	20	475		4,869	25
26	Patio Fence	2009	5,100	255	20	255		2,571	26
27	Landscaping	2009	17,332	1,155	15	1,155		12,128	27
28	3rd Floor Remodel-Carpentry, flooring,electrical,painting	2009	627,866		27	22,832	22,832	234,028	28
29	Landscaping Enhancement	2010	14,885	992	15	992		9,590	29
30	Physician Office carpentry	2010	4,849	177	27	177		1,608	30
31	Kitchen Pantries construction	2010	5,676	207	27	207		1,863	31
32	HVAC Admin Office	2010	7,357	268	27	268		2,446	32
33	Loading Ramp/Foundation Wall	2010	3,000	200	15	200		1,983	33
34	TOTAL (lines 1 thru 33)		\$ 9,504,497	\$ 59,207		\$ 292,987	\$ 233,780	\$ 6,941,099	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 Schaumburg Inc.

0036095

Report Period Beginning:

01/01/2019 Ending: 12/31/2019

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	Totals from Page 12B, Carried Forward		\$ 9,504,497	\$ 59,207		\$ 292,987	\$ 233,780	\$ 6,941,099	1
2	Hallway doors	2010	14,916	1,492	10	1,492		13,552	2
3	Library/Lounge carpentry,electrical,painting,signs	2010	5,009	183	27	183		1,647	3
4	Basement carpentry	2010	3,945	144	27	144		1,416	4
5	Patio/Pergola	2010	12,005	1,201	10	1,201		11,009	5
6	Office carpentry, flooring, electrical, painting, signs, HVAC	2010	50,935	2,091	27	2,091		28,325	6
7									7
8	Fire Dampers	2011	65,681		27	2,388	2,388	19,306	8
9	Parking Lot Remodel (Adjusted for Capital Audit)	2011	141,596		27	6,173	6,173	49,384	9
10	Kitchen Hood/duct work	2011	22,604	822	27	822		6,781	10
11	Payroll Office Remodel - Electrical and Wiring	2011	2,696	98	27	98		841	11
12	Metal edging & drain tile	2011	5,442	363	27	363		2,934	12
13	Repair doors on 1st floor	2011	39,986	1,454	27	1,454		11,632	13
14	Office Remodel - carpentry, flooring, electrical, painting, signs	2011	22,584	821	27	821		6,636	14
15	Exhaust Study HVAC	2011	5,736	209	27	209		1,828	15
16	Pipe and fitting	2011	4,375	159	27	159		1,312	16
17	Laundry Room Remodel - Flooring, Ceiling Tiles and Painting	2011	9,388	341	27	341		2,870	17
18	New Marker Boards	2011	9,887	360	27	360		3,210	18
19	Interior Doors	2011	6,183	225	27	225		1,856	19
20	2nd Floor Doors	2011	27,318	993	27	993		8,275	20
21									21
22	End Air Louvers	2012	3,744		27	136	136	1,054	22
23	Parking Lot (Adjusted for Capital Audit)	2012	-					-	23
24	Kitchen steel hood, floor, sink, drywall and tile	2012	7,307	266	27	266		2,055	24
25	Fire Pump basement	2012	3,461	126	27	126		976	25
26	Replace holding tank	2012	21,985	799	27	799		6,126	26
27	1st floor door opener	2012	8,646	314	27	314		2,329	27
28									28
29	EMR Wiring - Entire Facility	2013	20,058	729	27	729		4,496	29
30	Landscaping - Stump Removal/Trees	2013	42,118		15	2,808	2,808	17,378	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,062,102	\$ 72,397		\$ 317,682	\$ 245,285	\$ 7,148,327	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 Schaumburg Inc.

0036095

Report Period Beginning:

01/01/2019 Ending: 12/31/2019

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	Totals from Page 12C, Carried Forward		\$ 10,062,102	\$ 72,397		\$ 317,682	\$ 245,285	\$ 7,148,327	1
2									2
3	Elevator Renovation - Centrally located	2014	183,936	6,689	27	6,689		34,559	3
4	R/M Reclass: Adding Double Egress Doors (Basement)	2014	3,279		27	121	121	666	4
5	R/M Reclass: Install container fence & garbage container	2014	5,674		15	378	378	2,079	5
6	R/M Reclass: Cast iron waste line for grease trap (kitchen)	2014	8,000		27	296	296	1,628	6
7	R/M Reclass: Patching and crack sealing (parking lot)	2014	9,700		20	485	485	2,668	7
8	Kitchen Sewer Line Addition	2014	7,075	193	27	193		1,158	8
9									9
10	EMR Wiring - Entire Facility	2015	5,896	214	6	214		981	10
11	R/M Reclass: Decorating & Tile for Service Ramp	2015	3,503		20	176	176	790	11
12	R/M Reclass: Striping & Sealing Parking Lot	2015	5,400		20	270	270	1,217	12
13	R/M Reclass: Landscaping to the Entire property	2015	13,693		15	913	913	4,108	13
14									14
15	Electrical Wiring - Entire Facility	2016	4,474	447	10	447		1,567	15
16	Chair Rail Installation in First Floor Rooms	2016	11,516	419	27.5	419		1,362	16
17	R/M Reclass: Underground sanitary pipe replacement in the lower level entrance to ramp area and back elevator hallway	2016	10,500		15	700	700	2,450	17
18									18
19	R/M: Rusted end dome caps repair (cutting, grinding, welding) in the mechanical room	2016	2,750		15	183	183	641	19
20									20
21									21
22	Window replacement's	2017	20,739	1,037	20	1,037		2,160	22
23	R/M Reclass : Furnish and install freeze door - kitchen	2017	2,845		27	105	105	263	23
24	R/M Reclass : Removal of Trees and Stumps	2017	5,225		15	348	348	870	24
25	R/M Reclass : Cooling Water Treatment, Water Biocide	2017	5,571		10	557	557	1,393	25
26	R/M Reclass : Furnish, Remove & Install 15 doors across the building (1st floor utility room 2nd floor staff restroom, 2nd floor tub/shower room 2nd floor lounge, Room 310, Room 316, 3rd floor servery, 3rd floor linen room, 3rd floor tub/shower, 3rd floor staff restroom, LL Equip room, 1st floor staff restroom)	2017	4,187		27	155	155	388	26
27									27
28									28
29									29
30									30
31									31
32									32
33	Reconcile to book								33
34	TOTAL (lines 1 thru 33)		\$ 10,376,065	\$ 81,396		\$ 331,368	\$ 249,972	\$ 7,209,275	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,376,065	\$ 81,396		\$ 331,368	\$ 249,972	\$ 7,209,275	1
2									2
3	Mill and resurface pavement - building exterior	2019	50,150	1,003	25	1,003		1,003	3
4	HVAC - York Chiller #2 - Compressor & suction filter dryer	2019	23,387	835	7	835		835	4
5									5
6	R&M reclass - Removal of trees and branches	2019	2,800		15	62	62	62	6
7	R&M reclass - removal of trees and planting of new trees	2019	3,310		15	74	74	74	7
8	R&M reclass - replace and install new trees	2019	8,005		15	133	133	133	8
9	R&M reclass - replace sprinklers/sprinkler heads hallways	2019	2,687		25	45	45	45	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	reconcile to book			(2,001)			2,001		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,466,404	\$ 81,233		\$ 333,520	\$ 252,287	\$ 7,211,427	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	Totals from Page 12E, Carried Forward		\$ 10,466,404	\$ 81,233		\$ 333,520	\$ 252,287	\$ 7,211,427	1
2	Building - management company	2002	297,485		40	10,714	10,714	151,954	2
3	HVAC, electrical, security system - management company	2003	2,613		30	129	129	2,314	3
4	Key card system - management company	2004	411		20	33	33	316	4
5	VAV TX controls - management company	2005	125		20	10	10	93	5
6	Interior Signs - management company	2006	91		20	10	10	80	6
7	Building improvements - management company	2008	12,879		20	480	480	6,145	7
8	Building improvements - management company	2009	2,391		20	211	211	1,373	8
9	Building improvements - management company	2010	2,357		20	166	166	1,251	9
10	Building improvements - management company	2011	1,852		20	140	140	733	10
11	Building improvements - management company	2012	5,447		20	328	328	1,537	11
12	Building improvements - management company	2013	4,833		20	222	222	1,919	12
13	Building improvements - management company	2014	2,615		20	425	425	1,441	13
14	Building improvements - management company	2015	460		20	91	91	253	14
15	Building improvements - management company	2016	7,590		20	916	916	1,909	15
16	Building improvements - management company	2017	4,787		20	337	337	503	16
17	Building improvements - management company	2018	860		20	51	51	51	17
18	Building improvements - management company	2019	15,503		20	420	420	420	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)		\$ 10,828,703	\$ 81,233		\$ 348,203	\$ 266,970	\$ 7,383,719	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	\$ 202,178	\$ 27,237	\$ 27,237	\$	5-20	\$ 141,376	71
72	Current Year Purchases	83,608	6,289	6,289		5	6,289	72
73	Fully Depreciated Assets	852,301					852,301	73
74	allocated from mgmt co	564,342		20,034	20,034		504,294	74
75	TOTALS	\$ 1,702,429	\$ 33,526	\$ 53,560	\$ 20,034		\$ 1,504,260	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			54,257		3,607	3,607		45,023	79
80	TOTALS			\$ 54,257	\$	\$ 3,607	\$ 3,607		\$ 45,023	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)	\$ 12,818,419	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 114,759	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 405,370	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 290,611	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,933,002	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 Health Care Center of Schaumburg Inc.

0036095

Report Period Beginning: 01/01/2019

Ending: 12/31/2019

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

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.	_____ /2020	\$ _____
13.	_____ /2021	\$ _____
14.	_____ /2022	\$ _____

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: \$ 63,354 Description: see attachment 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	<u>allocated from management company</u>			<u>907</u>	20
21	TOTAL		\$	\$ <u>907</u>	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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	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	\$	7,343	\$ 487,629	\$	7,343	\$ 487,629	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,731	102,284		1,731	102,284	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2 & 3)	hrs		12,841	529,611	1,764	12,841	531,375	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				314,704		314,704	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs			7,523			7,523	11
12	Other (specify): <u>ambulance</u>	39(3)								12
13	Other (specify): <u>see sch 16a</u>	39(2)					24,167		24,167	13
14	TOTAL			\$	21,915	\$ 1,127,047	\$ 340,635	21,915	\$ 1,467,682	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 Health Care Center of Schaumburg Inc.# 0036095Report Period Beginning: 01/01/2019Ending: 12/31/2019

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2019

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 665,904	\$ 711,762	1
2	Cash-Patient Deposits	979	979	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>848,082</u>)	1,071,041	1,071,041	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	229,794	229,794	6
7	Other Prepaid Expenses	20,222	20,222	7
8	Accounts Receivable (owners or related parties)	(195,004)	(390,880)	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,792,936	\$ 1,642,918	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		211,532	13
14	Buildings, at Historical Cost		6,091,126	14
15	Leasehold Improvements, at Historical Cost	2,094,469	4,262,987	15
16	Equipment, at Historical Cost	648,397	1,141,524	16
17	Accumulated Depreciation (book methods)	(1,708,641)	(8,144,088)	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 (specify: <u>CIP/Ins Rec.</u>)	343,693	343,693	22
23	Other(specify): <u>mortgage costs - net</u>		131,944	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,377,918	\$ 4,038,718	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,170,854	\$ 5,681,636	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,284,936	\$ 1,284,936	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,184	1,184	28
29	Short-Term Notes Payable		349,450	29
30	Accrued Salaries Payable	470,486	470,486	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,308	18,308	31
32	Accrued Real Estate Taxes(Sch.IX-B)		710,244	32
33	Accrued Interest Payable		36,315	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>see schedule 17a</u>	11,104,536	4,921,834	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 12,879,450	\$ 7,792,757	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,199,436	849,986	39
40	Mortgage Payable		6,024,276	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,199,436	\$ 6,874,262	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,078,886	\$ 14,667,019	46
47	TOTAL EQUITY(page 18, line 24)	\$ (10,908,032)	\$ (8,985,383)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,170,854	\$ 5,681,636	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (9,233,367)	1
2	Restatements (describe):		2
3	post closing adjustments	(36,244)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,269,611)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,638,421)	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)	\$ (1,638,421)	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)	\$ (10,908,032)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington Health Care Center of Schaumburg Inc. # 0036095 Report Period Beginning: 01/01/2019Ending: 12/31/2019**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 21,087,509	1
2	Discounts and Allowances for all Levels	(11,208,441)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,879,068	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,766,255	6
7	Oxygen	60,248	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,826,503	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	144	12
13	Barber and Beauty Care	16,081	13
14	Non-Patient Meals	738	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	685,586	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	173,709	19
20	Radiology and X-Ray	15,690	20
21	Other Medical Services	569,329	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,461,277	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,435	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,435	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>miscellaneous</u>	5,945	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,945	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,177,228	30

1		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,021,275	31
32	Health Care	6,765,348	32
33	General Administration	4,066,565	33
B. Capital Expense			
34	Ownership	1,598,747	34
C. Ancillary Expense			
35	Special Cost Centers	1,951,236	35
36	Provider Participation Fee	412,478	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,815,649	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,638,421)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,638,421)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,162,876	44
45	Private Pay - Net Inpatient Revenue	1,649,710	45
46	Medicare - Net Inpatient Revenue	849,665	46
47	Other-(specify) <u>managed care</u>	3,216,817	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,879,068	49

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

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

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

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

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

0036095

Report Period Beginning: 01/01/2019

Ending: 12/31/2019

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	1,715	2,141	\$ 149,579	\$ 69.86	1
2	Assistant Director of Nursing	850	982	45,407	46.24	2
3	Registered Nurses	41,803	56,589	1,958,281	34.61	3
4	Licensed Practical Nurses	21,434	28,337	771,958	27.24	4
5	CNAs & Orderlies	108,716	139,975	2,215,470	15.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,871	2,161	49,339	22.83	9
10	Activity Assistants	8,097	9,980	131,860	13.21	10
11	Social Service Workers	7,393	8,878	198,131	22.32	11
12	Dietician	840	1,136	35,247	31.03	12
13	Food Service Supervisor	352	385	10,749	27.92	13
14	Head Cook	2,661	3,372	50,448	14.96	14
15	Cook Helpers/Assistants	8,281	9,292	109,490	11.78	15
16	Dishwashers					16
17	Maintenance Workers	1,739	2,176	48,611	22.34	17
18	Housekeepers	11,027	14,494	177,700	12.26	18
19	Laundry					19
20	Administrator	1,647	2,118	142,608	67.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,199	7,170	125,431	17.49	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	1,588	1,957	37,077	18.95	31
32	Other Health Care <u>see sch 20a</u>	19,506	24,098	653,658	27.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	244,719	315,241	\$ 6,911,044 *	\$ 21.92	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	monthly 24,500	9-3	36
37	Medical Records Consultant	monthly 423	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	monthly 20,991	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 4,763	11-3	44
45	Social Service Consultant	monthly 2,880	12-3	45
46	Other(specify) <u>marketing</u>	monthly 6,110	43-3	46
47	<u>pulmoary</u>	monthly 53,555	10-3	47
48	<u>telemedecine</u>	monthly 8,350	10-3	48
49	TOTAL (lines 35 - 48)	\$ 121,572		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			52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jason Lee	Administrator	0	\$ 81,564	Workers' Compensation Insurance	\$ 216,730	IDPH License Fee	\$ 1,430	
Maivette Gleeson	Administrator	0	46,291	Unemployment Compensation Insurance	36,673	Advertising: Employee Recruitment	12,784	
Erika Streit	Administrator	0	14,752	FICA Taxes	514,663	Health Care Worker Background Check (Indicate # of checks performed 0)		
				Employee Health Insurance	350,654	Patient Background Checks	8,436	
				Employee Meals		Miscellaneous licenses and fees	3,748	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA	5,658	
				401k contibution	39,433	Miscellaneous dues	560	
				uniform	582	lobbying portion of IHCA dues	(1,608)	
				tuition	6,991	allocated from management company	6,249	
				other fringes	35,546	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 142,607	TOTAL (agree to Schedule V, line 22, col.8)		\$ 37,257		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
shared services			\$ 700,243				Out-of-State Travel	\$
management fees-royal ops			848,616					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,548,859				Seminar Expense	
C. Professional Services				TOTAL			Management Company allocation	
Vendor/Payee	Type		Amount	\$			Entertainment Expense ()	
RSM US LLP	Accounting		\$ 36,413				(agree to Sch. V, line 24, col. 8)	
Midcap Financial	Financial		13,585				TOTAL	
Pension Administrators	401k admin		1,730				\$ 90	
Personnel Planners	Unemp Consulting		840					
JSO Valuation Group	Valuation		3,500					
Much Shelist	Legal		8,065					
Markoff Law	Legal		491					
Midcap Financial	REnt		2,525					
Secretary of State	Annual Report		100					
Royal Management	Collections		5,286					
Markoff Law	Collections		1,115					
See Sch 21c	Various		109,843					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 183,493					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lexington Health Care Center of Schaumburg Inc.# 0036095Report Period Beginning: 01/01/2019Ending: 12/31/2019**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 - \$6008
- (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. \$ 52,088 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. \$ 412,478
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? 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