

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0042739</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																							
Facility Name: <u>Lexington of Chicago Ridge</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																							
Address: <u>10300 Southwest Hwy</u> <u>Chicago Ridge</u> <u>60415</u> Number City Zip Code																																									
County: <u>Cook</u>																																									
Telephone Number: <u>708-425-1100</u> Fax # <u>708-425-0779</u>																																									
HFS ID Number: _____																																									
Date of Initial License for Current Owners: <u>05/27/91</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Type or Print Name) _____</td></tr><tr><td colspan="2">(Title) _____</td></tr><tr><td colspan="2">(Signed) _____</td></tr><tr><td colspan="2">(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		(Title) _____		(Signed) _____		(Date) _____																												
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(Date) _____																																									
Type of Ownership:		<table><tr><td rowspan="5">Paid Preparer</td><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><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</td></tr><tr><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Paid Preparer	(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>	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																															
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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: _____																																									

Facility Name & ID Number Lexington of Chicago Ridge

0042739 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,298</u>	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	<u>203</u>	TOTALS	<u>203</u>	<u>74,298</u>	7

B. Census-For the entire report period.					
1	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF			<u>15,332</u>	<u>15,332</u>
9	SNF/PED				
10	ICF	<u>30,541</u>	<u>3,191</u>	<u>2,339</u>	<u>36,071</u>
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	<u>30,541</u>	<u>3,191</u>	<u>17,671</u>	<u>51,403</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.18%

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 6/4/91

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 203 and days of care provided 7,483

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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		20,198	1,101,551	1,121,749		1,121,749	(734)	1,121,015			1
2	Food Purchase		(1,166)		(1,166)		(1,166)	665	(501)			2
3	Housekeeping		2,700	600,135	602,835		602,835		602,835			3
4	Laundry											4
5	Heat and Other Utilities			250,023	250,023		250,023	25,111	275,134			5
6	Maintenance	42,275	518	200,764	243,557		243,557	109,739	353,296			6
7	Other (specify):*							11,587	11,587			7
8	TOTAL General Services	42,275	22,250	2,152,473	2,216,998		2,216,998	146,368	2,363,366			8
	B. Health Care and Programs											
9	Medical Director			83,300	83,300		83,300		83,300			9
10	Nursing and Medical Records	5,314,817	825,807	1,098,921	7,239,545		7,239,545	27,157	7,266,702			10
10a	Therapy											10a
11	Activities	134,333	10,480	656	145,469		145,469		145,469			11
12	Social Services	168,879			168,879		168,879		168,879			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,324	3,324			15
16	TOTAL Health Care and Programs	5,618,029	836,287	1,182,877	7,637,193		7,637,193	30,481	7,667,674			16
	C. General Administration											
17	Administrative	176,460		2,295,324	2,471,784		2,471,784	(884,544)	1,587,240			17
18	Directors Fees											18
19	Professional Services			344,224	309,622		309,622	128,021	437,643			19
20	Dues, Fees, Subscriptions & Promotions			34,310	34,310		34,310	16,040	50,350			20
21	Clerical & General Office Expenses	258,748	39,113	91,221	389,082		389,082	1,193,936	1,583,018			21
22	Employee Benefits & Payroll Taxes			1,200,984	1,200,984		1,200,984		1,200,984			22
23	Inservice Training & Education							992	992			23
24	Travel and Seminar			200	200		200	96	296			24
25	Other Admin. Staff Transportation			281	281		281	19,009	19,290			25
26	Insurance-Prop.Liab.Malpractice			1,059,577	1,059,577		1,059,577	6,168	1,065,745			26
27	Other (specify):*							142,118	142,118			27
28	TOTAL General Administration	435,208	39,113	5,026,121	5,465,840		5,465,840	621,836	6,087,676			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,095,512	897,650	8,361,471	15,320,031		15,320,031	798,685	16,118,716			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			77,796	77,796		77,796	259,848	337,644			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,908	6,908		6,908	285,513	292,421			32
33	Real Estate Taxes			34,602	34,602		34,602	1,134,412	1,169,014			33
34	Rent-Facility & Grounds			1,492,725	1,492,725		1,492,725	(1,492,566)	159			34
35	Rent-Equipment & Vehicles			143,480	143,480		143,480	5,468	148,948			35
36	Other (specify):*											36
37	TOTAL Ownership			1,755,511	1,755,511		1,755,511	192,675	1,948,186			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		500,049	2,035,343	2,535,392		2,535,392		2,535,392			39
40	Barber and Beauty Shops			822	822		822	(822)				40
41	Coffee and Gift Shops			2,415	2,415		2,415	(2,415)				41
42	Provider Participation Fee			375,204	375,204		375,204		375,204			42
43	Other (specify):*			761,207	761,207		761,207	(761,207)				43
44	TOTAL Special Cost Centers		500,049	3,174,991	3,675,040		3,675,040	(764,444)	2,910,596			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,095,512	1,397,699	13,291,973	20,750,582		20,750,582	226,916	20,977,498			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(734)	1		4
5	Telephone, TV & Radio in Resident Rooms	(17,637)	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	(3,675)	30		9
10	Interest and Other Investment Income	(6,908)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17,354)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(558,664)	43		24
25	Fund Raising, Advertising and Promotional	(31,623)	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	(184,837)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (821,432)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,048,348		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,048,348		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 226,916		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	GIFT SHOP INCOME	\$ (2,415)	41	1
2	RADIOLOGY	(52,562)	43	2
3	LABORATORY	(81,185)	43	3
4	SALESFORCE CONSULTING	(6,510)	19	4
5	PERSONAL ITEM REPLACEMENT	(2,182)	43	5
6	COLLECTIONS	(38,235)	19	6
7	BARBER/BEAUTY INCOME	(822)	40	7
8	LOBBYING DUES	(926)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(184,837)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(734)	0	0	0	0	0	0	0	0	0	0	(734)	1
2	Food Purchase	0	0	0	665	0	0	0	0	0	0	0	665	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	25,111	0	0	0	0	0	0	0	0	25,111	5
6	Maintenance	0	0	109,739	0	0	0	0	0	0	0	0	109,739	6
7	Other (specify):*	0	0	11,587	0	0	0	0	0	0	0	0	11,587	7
8	TOTAL General Services	(734)	0	146,437	665	0	0	0	0	0	0	0	146,368	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	27,157	0	0	0	0	0	0	0	0	27,157	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	3,324	0	0	0	0	0	0	0	0	3,324	15
16	TOTAL Health Care and Programs	0	0	30,481	0	0	0	0	0	0	0	0	30,481	16
	C. General Administration													
17	Administrative	0	0	0	(884,544)	0	0	0	0	0	0	0	(884,544)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(44,745)	(16,033)	188,799	0	0	0	0	0	0	0	0	128,021	19
20	Fees, Subscriptions & Promotions	(926)	0	16,966	0	0	0	0	0	0	0	0	16,040	20
21	Clerical & General Office Expenses	0	75	1,193,861	0	0	0	0	0	0	0	0	1,193,936	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	992	0	0	0	0	0	0	0	992	23
24	Travel and Seminar	0	0	0	96	0	0	0	0	0	0	0	96	24
25	Other Admin. Staff Transportation	0	0	0	19,009	0	0	0	0	0	0	0	19,009	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	6,168	0	0	0	0	0	0	0	6,168	26
27	Other (specify):*	0	0	0	142,118	0	0	0	0	0	0	0	142,118	27
28	TOTAL General Administration	(45,671)	(15,958)	1,399,626	(716,161)	0	0	0	0	0	0	0	621,836	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,405)	(15,958)	1,576,544	(715,496)	0	0	0	0	0	0	0	798,685	29

Summary B

12/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - supplement		See Page 6 - supplement		See Page 6 - supplement		

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 Chicago Ridge Limited Partnership	**	\$ (16,033)	\$ (16,033)	1
2	V	21	miscellaneous expense		Sambell of Chicago Ridge Limited Partnership	**	75	75	2
3	V	30	depreciation		Sambell of Chicago Ridge Limited Partnership	**	214,158	214,158	3
4	V	32	interest expense		Sambell of Chicago Ridge Limited Partnership	**	233,248	233,248	4
5	V	32	amortization on mortgage costs		Sambell of Chicago Ridge Limited Partnership	**			5
6	V	33	property tax		Sambell of Chicago Ridge Limited Partnership	**	1,106,180	1,106,180	6
7	V	34	rental expense	1,492,566	Sambell of Chicago Ridge Limited Partnership	**		(1,492,566)	7
8	V	43	trust fees		Sambell of Chicago Ridge Limited Partnership	**			8
9	V								9
10	V								10
11	V								11
12	V				** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own				12
13	V				100% of Sambell of Chicago Ridge Limited Partnership				13
14	Total			\$ 1,492,566			\$ 1,537,628	\$ * 45,062	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 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	3 Housekeeping Supplies	\$	Royal Management Corp.	**	\$	\$	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	24,404	24,404	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	707	707	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**			18
19	V	6 Management Allocation - salaries		Royal Management Corp.	**	94,680	94,680	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	15,059	15,059	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**			21
22	V	7 Management Allocation - employee benefits		Royal Management Corp.	**	11,587	11,587	22
23	V	10 Medical consultant		Royal Management Corp.	**			23
24	V	10 Management Allocation - salaries		Royal Management Corp.	**	27,157	27,157	24
25	V	15 Management Allocation - employee benefits		Royal Management Corp.	**	3,324	3,324	25
26	V	17 Management Allocation - salaries		Royal Management Corp.	**			26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	51,736	51,736	27
28	V	19 Professional fees		Royal Management Corp.	**	137,063	137,063	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,452	1,452	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	15,514	15,514	30
31	V	21 Management Allocation - salaries		Royal Management Corp.	**	1,161,256	1,161,256	31
32	V	21 Bank charges		Royal Management Corp.	**	6,323	6,323	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	3,798	3,798	33
34	V	21 Postage		Royal Management Corp.	**	5,235	5,235	34
35	V	21 Telephone		Royal Management Corp.	**	17,249	17,249	35
36	V							36
37	V							37
38	V	** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp						38
39	Total		\$			\$ 1,576,544	\$ * 1,576,544	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	**	\$ 992	\$ 992	15
16	V	24 Travel & seminar		Royal Management Corp	**	96	96	16
17	V	25 Auto expense		Royal Management Corp	**	19,009	19,009	17
18	V	26 Insurance general		Royal Management Corp	**	6,168	6,168	18
19	V	27 Management Allocation - employee benefits		Royal Management Corp	**	142,118	142,118	19
20	V	30 Depreciation		Royal Management Corp	**	49,365	49,365	20
21	V	32 Interest		Royal Management Corp	**	59,173	59,173	21
22	V	2 Amortization of mortgage costs		Royal Management Corp	**	665	665	22
23	V	33 Property taxes		Royal Management Corp	**	28,232	28,232	23
24	V	34 Rent expense		Royal Management Corp	**			24
25	V	35 Equipment rental		Royal Management Corp	**	5,468	5,468	25
26	V	17 Management fees	884,544	Royal Management Corp	**		(884,544)	26
27	V	35 Auto lease		Royal Management Corp	**			27
28	V	6 Security		Royal Management Corp	**			28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V	** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.						38
39	Total		\$ 884,544			\$ 311,286	\$ * (573,258)	39

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

Facility Name & ID Number

Lexington of Chicago Ridge

0042739

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	33.33	Lexington HC Ctr of Bloomingdale Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr of Elmhurst Inc.	Elmhurst	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr of LaGrange Inc.	LaGrange	Lexington Square	Lombard	Independent and	3
4			Lexington HC Ctr of Lake Zurich Inc.	Lake Zurich	Life Care		Assisted Living	4
5			Lexington HC Ctr of Lombard Inc.	Lombard	of Lombard LLC		Facility	5
6			Lexington HC Ctr of Orland Park Inc.	Orland Park	Lexington Square	Elmhurst	Independent and	6
7			Lexington HC Ctr of Schaumburg Inc.	Schaumburg	Life Care		Living Facility	7
8					of Elmhurst, LLC			8
9					Vesta Management	Lombard	Mgmt Company	9
10					Group LLC			10
11					Sambell of	Chicago Ridge	Real Estate	11
12					Chicago Ridge Ltd.		Company	12
13					Ptsp.			13
14					Royal Management	Lombard	Mgmt Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance Company	16
17					Services II LLC			17
18					Heron Point	Lombard	Mgmt Company	18
19					Management Corp			19
20					Samvest of Lombard	Lombard	Lessor	20
21					II, LLC			21
22					North Heron	Lombard	Finance Company	22
23					Investments, LLC			23
24					Curatess, LLC	Lombard	Telemedicine	24
25					Republic		Construction	25
26					Construction of	Lombard	Company	26
27					Illinois, Inc.			27
28					Lexington Home	Lombard	Home Health	28
29					Health Care, Inc.			29
30								30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Lexington Hospice	Lombard	Hospice	1
2					Services, LLC			2
3					Lexington Private	Lombard	Healthcare	3
4					Home Care			4
5					Merit Sleep	Lombard	Mgmt Company	5
6					Management LLC			6
7					Sambell of		Real Estate	7
8					Bloomington Ltd Ptsp		Property	8
9					Sambell of Elmhurst	Elmhurst	Real Estate	9
10					II Ltd Ptsp		Property	10
11					Sambell of	LaGrange	Real Estate	11
12					LaGrange Ltd Ptsp		Property	12
13					Lexington HC Sys	Lake Zurich	Real Estate	13
14					of Lake Zurich Ltd		Property	14
15					Ptsp			15
16					Lexington HC Sys	Lombard	Real Estate	16
17					of Lombard Ltd Ptsp		Property	17
18					Lexington HC Sys			18
19					of Orland Park Ltd	Orland Park	Real Estate	19
20					Ptsp		Property	20
21					Sambell of	Schaumburg	Real Estate	21
22					Schaumburg Ltd Ptsp		Property	22
23					Samvest of Algonquin	Algonquin	Real Estate	23
24					Ltd Ptsp		Property	24
25								25
26								26
27								27
28								28
29								29
30								30

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 salary in 2020								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping Supplies	Bed days available	565,750	8	\$	\$	74,095	\$ 0	1
2	5	Utilities - gas & electric	Bed days available	565,750	8	186,333		74,095	24,404	2
3	5	Utilities - water & sewer	Bed days available	565,750	8	5,398		74,095	707	3
4	5	Utilities - maintenance office	Bed days available	565,750	8			74,095	0	4
5	6	Management Allocation - salaries	Bed days available	565,750	8	722,929	722,929	74,095	94,680	5
6	6	Repairs & maintenance	Bed days available	565,750	8	114,986		74,095	15,059	6
7	6	Scavenger & exterminating	Bed days available	565,750	8			74,095	0	7
8	7	Management Allocation - employee ben	Bed days available	565,750	8	88,474		74,095	11,587	8
9	10	Medical consultant	Bed days available	565,750	8			74,095	0	9
10	10	Management Allocation - salaries	Bed days available	565,750	8			74,095	0	10
11	15	Management Allocation - employee ben	Bed days available	565,750	8	25,377		74,095	3,324	11
12	17	Management Allocation - salaries	Bed days available	565,750	8	207,358	207,358	74,095	27,157	12
13	19	Computer consultant & supplies	Bed days available	565,750	8	395,029		74,095	51,736	13
14	19	Professional fees	Bed days available	565,750	8	1,046,538		74,095	137,063	14
15	20	Dues & subscriptions	Bed days available	565,750	8	11,082		74,095	1,451	15
16	20	Advertising - help wanted	Bed days available	565,750	8	118,456		74,095	15,514	16
17	21	Management Allocation - salaries	Bed days available	565,750	8	8,866,730	8,866,730	74,095	1,161,256	17
18	21	Bank charges	Bed days available	565,750	8	48,277		74,095	6,323	18
19	21	Office supplies & printing	Bed days available	565,750	8	29,001		74,095	3,798	19
20	21	Postage	Bed days available	565,750	8	39,969		74,095	5,235	20
21	21	Telephone	Bed days available	565,750	8	131,703		74,095	17,249	21
22										22
23										23
24										24
25	TOTALS					\$ 12,037,640	\$ 9,797,017		\$ 1,576,543	25

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Royal Management Corp

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard IL 60148

Phone Number

(630-458-4700

Fax Number

(630-458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	23	Inservice training	Bed days available	565,750	8	\$ 7,573	\$	74,095	\$ 992	1
2	24	Travel & seminar	Bed days available	565,750	8	735		74,095	96	2
3	25	Auto expense	Bed days available	565,750	8	145,140		74,095	19,009	3
4	26	Insurance general	Bed days available	565,750	8	47,093		74,095	6,168	4
5	27	Management Allocation - employee be	Bed days available	565,750	8	1,085,139		74,095	142,118	5
6	30	Depreciation	Bed days available	565,750	8	376,924		74,095	49,365	6
7	32	Interest	Bed days available	565,750	8	451,812		74,095	59,173	7
8	2	Amortization of mortgage costs	Bed days available	565,750	8	5,077		74,095	665	8
9	33	Property taxes	Bed days available	565,750	8	215,565		74,095	28,232	9
10	34	Rent expense	Bed days available	565,750	8			74,095		10
11	35	Equipment rental	Bed days available	565,750	8	41,748		74,095	5,468	11
12	17	Management fees	Bed days available	565,750	8			74,095		12
13	35	Auto lease	Bed days available	565,750	8			74,095		13
14	6	Security	Bed days available	565,750	8			74,095		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,376,806	\$		\$ 311,286	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	MB Financial		x	Mortgage	Varies	9/15/2017	\$ 5,112,015	\$ 4,498,573	9/15/2019	Libor + 3.5	\$ 227,622	1
2	Sambell of Elmhurst II LP	x		Mortgage	Varies	9/15/2017	418,014	381,063	9/15/2019	Libor + 3.5%	5,631	2
3												3
4												4
5												5
	Working Capital											
6	West Suburban Bank		x	PPP loan	none	5/7/20	1,489,241	1,489,241	5/7/22	0.0100	9,887	6
7												7
8												8
9	TOTAL Facility Related						\$ 7,019,270	\$ 6,368,877			\$ 243,140	9
	B. Non-Facility Related*											
10								interest income offset			(7,620)	10
11								allocated from mgmt co			59,173	11
12								Misc interest			(2,272)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 49,281	14
15	TOTALS (line 9+line14)						\$ 7,019,270	\$ 6,368,877			\$ 292,421	15

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

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

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

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 2019 report.		\$	823,584	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.)		\$	816,223	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,361)	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	1,113,540	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.)		\$	34,602	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	1,169,014	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	773,127	8	
		2016	788,061	9	
		2017	777,907	10	
		2018	776,301	11	
		2019	816,223	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019 \$	13	
		14	PLUS APPEAL COST FROM LINE 5 \$	14	
		15	LESS REFUND FROM LINE 6 \$	15	
		16	AMOUNT TO USE FOR RATE CALCULATION \$	16	

- NOTES:
- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
 - 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Lexington of Chicago Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042739

CONTACT PERSON REGARDING THIS REPORT Christine Thompson

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

B. Real Estate Tax Cost Allocations

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.)

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551

B. General Construction Type: Exterior concrete blockFrame steelNumber 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	resident care	31,000	1989	\$ 505,000	1
2	management company allocation			24,153	2
3	TOTALS	31,000		\$ 529,153	3

Facility Name & ID Number Lexington of Chicago Ridge

#

0042739

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	203		1991	1991	\$ 5,143,342	\$	35	\$ 146,951	\$ 146,951	\$ 4,347,337	4
5			1995	1959	97,352	2,781	35	2,781		70,922	5
6											6
7											7
8											8
	Improvement Type**										
9	leasehold improvements			1993	2,694	77	35	77		2,118	9
10	leasehold improvements			1994	6,581	188	35	188		4,983	10
11	Dishwasher hood			1996	2,480		10			2,480	11
12	Lobby repairs			1996	8,698		10			8,698	12
13	basement rehab			1997	24,477		10			24,477	13
14	wiring			1998	3,429		10			3,429	14
15	handrails			1998	895		15			895	15
16	resurface & restripe parking lot			1998	4,450		10			4,450	16
17	fire wall			1998	2,169	62	35	62		1,395	17
18	foyer floor tile			1999	32,379		10			32,379	18
19	wallpaper/painting/decorating			1999	8,833		10			8,833	19
20	rebuild garage area			1999	1,762	50	35	50		1,061	20
21	roof repairs			2000	6,240		10			6,240	21
22	electrical wiring			2000	3,986	114	35	114		2,336	22
23	electrical wiring			2000	2,536	72	35	72		1,480	23
24	kitchen rehab			2000	6,623	221	35	221		4,529	24
25	automatic doors			2000	1,300		10			1,300	25
26	elevator eye sensors			2000	4,500		15			4,500	26
27	resurface and restripe parking lot			2001	3,319		10			3,319	27
28	door releases			2001	5,200		10			5,200	28
29	carpeting			2001	10,022		10			10,022	29
30	roof repairs			2002	25,600	1,280	20	1,280		24,367	30
31	elevator upgrade			2002	9,865		10			9,865	31
32	painting/decorating/carpet/wallpaper			2003	38,165	1,908	20	1,908		34,345	32
33	rehab/new office			2003	26,733	1,337	20	1,337		24,064	33
34	facility rehab-construction costs, apinting and decorating			2003	257,174	12,859	20	12,859		225,029	34
35	facility rehab - electrical			2003	12,840	642	20	642		11,235	35
36	facility rehab - carpeting			2003	7,800		10			7,800	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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

1	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 facility rehab - floor tile	2003	\$ 3,548	\$ 177	20	\$ 177	\$	\$ 3,099	37
38								38
39 kickplates/door protectors	2004	4,095		10			4,095	39
40 kitchen fire protection upgrade	2004	1,427		10			1,427	40
41 parking lot - paving and sealcoating	2005	4,375	219	20	219		3,357	41
42 kitchen rehab	2005	19,228	961	20	961		14,576	42
43 lobby/lounge reception area	2005	36,503	1,825	20	1,825		28,440	43
44 sidewalk - raise and support	2005	1,330	67	20	67		1,021	44
45 lower level therapy rehab	2005	52,525	2,626	20	2,626		40,266	45
46 transitional unit	2005	1,020	51	20	51		769	46
47 basement renovation	2005	3,754	188	20	188		2,851	47
48 landscping enhancement	2006	6,463	431	15	431		6,142	48
49 LHI-hvac	2006	4,333	217	20	217		3,056	49
50 rehab common areas	2006	7,661	383	20	383		5,554	50
51 modular units attached to wall	2006	10,316	516	20	516		7,396	51
52 cubical curtains	2006	1,578		5			1,578	52
53 landscaping	2007	5,000	333	15	333		4,468	53
54 parking lot - paving and sealcoating	2007	35,969		20	1,819	1,819	23,647	54
55 HVAC	2007	4,580	229	20	229		3,130	55
56 emergency A/C	2007	30,293	1,515	20	1,515		20,200	56
57 portable A/C	2007	3,768	188	20	188		2,523	57
58 employee lunch rom	2007	3,671	184	20	184		2,423	58
59 painting	2007	16,150	808	20	808		10,773	59
60 1st floor remodel carpentry, flooring, plumbing, electrical fixt	2007	641,616		40	16,225	16,225	210,925	60
61 painting								61
62 create first floor therapy	2007	185	9	20	9		126	62
63 landscaping	2008	19,600	1,307	15	1,307		16,228	63
64 parking lot paving, sealcoating and repairs	2008	44,050	2,203	20	2,203		26,987	64
65 HVAC sport coolers	2008	3,790	95	40	95		1,140	65
66 plumbing & sprinkler shower room	2008	9,668	483	20	483		5,796	66
67 common areas doors and locks	2008	3,162	158	20	158		2,028	67
68 basement renovation	2008	7,569	189	40	189		2,426	68
69 2nd floor remodel carpentry, flooring, electrical, painting	2008	578,270		27	21,028	21,028	254,088	69
70 TOTAL (lines 4 thru 69)		\$ 7,326,941	\$ 36,953		\$ 222,976	\$ 186,023	\$ 5,599,623	70

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

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,326,941	\$ 36,953		\$ 222,976	\$ 186,023	\$ 5,599,623	1
2	land improvements	2009	15,180	1,012	15	1,012		11,385	2
3	landscaping	2009	3,693	246	15	246		2,809	3
4	chiller	2009	178,462	8,923	20	8,923		103,358	4
5	quick connectors/spot cooler	2009	10,244	512	20	512		5,965	5
6	plumbing & sprinkler	2009	6,172	154	40	154		1,733	6
7	chiller fence	2009	5,350	268	20	268		2,948	7
8	land improvements - patio pergola	2009	7,930	397	20	397		4,499	8
9	land improvements patio fence	2009	14,308	715	20	715		7,925	9
10	3rd floor remodel - carpentry, flooring, electrical	2009	670,689		27	24,389	24,389	270,311	10
11	painting, sprinkler system								11
12	landscaping enhancements	2010	4,560	304	15	304		3,091	12
13	office carpentry, flooring, electrical, painting, plumbing, sign	2010	82,988	2,997	27	2,997		67,160	13
14	tree removal	2010	12,094	806	15	806		8,329	14
15	seal crack filling and striping	2010	3,000	200	15	200		2,067	15
16	parking lot signage, posts and lamps	2010	30,501	1,113	27	1,113		11,706	16
17	HVAC quick connects	2010	4,043	147	27	147		1,483	17
18	pantries tile, shelves	2010	2,855	104	27	104		1,066	18
19	DON office painting	2010	8,090	295	27	295		2,950	19
20	1st floor rehab - cabinest, library, lounge, art, flooring	2010	4,725	172	27	172		1,761	20
21	2nd floor rehab painting, flooring	2010	61,521	2,244	27	2,244		22,440	21
22									22
23	payroll office remodel electrical	2011	5,439	198	27	198		1,914	23
24	payroll office remodel doors and millwork	2011	10,336	376	27	376		3,541	24
25	holding tank	2011	16,400	596	27	596		5,612	25
26	bulk pipe removal of vent lines	2011	4,380	159	27	159		1,458	26
27	remodel laundry room - electrical, painting, flooring	2011	7,222	263	27	263		2,433	27
28	2nd floor doors	2011	23,290	847	27	847		7,905	28
29	2nd floor remodeling - carpentry, drywall, finish/trim	2011	17,949		27	653	653	6,530	29
30	exterior painting	2011	3,000		27	109	109	1,017	30
31	fire dampers	2011	20,441		27	743	743	6,749	31
32	boiler	2011	9,800		27	356	356	3,442	32
33	parking lot - seal and stripe	2011	4,300			156	156	1,443	33
34	TOTAL (lines 1 thru 33)		\$ 8,575,903	\$ 60,001		\$ 272,430	\$ 212,429	\$ 6,174,653	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 12B, Carried Forward		\$ 8,575,903	\$ 60,001		\$ 272,430	\$ 212,429	\$ 6,174,653	1
2	Building Wiring - EMR	2012	13,566		27	493	493	4,109	2
3									3
4	Exterior Lighting	2013	7,418		27	270	270	1,980	4
5									5
6									6
7	R/M Reclass: condenser motor/fan HVAC mechanical room	2014	2,648		20	132	132	858	7
8	R/M Reclass: elevator door restrictor	2014	5,250		10	525	525	3,413	8
9									9
10	R/M Reclass: Stairwell doors 3rd floor south & 2nd floor north	2015	4,146		20	207	207	1,140	10
11	R/M reclass: Replace 5 water tubes and sealing O rings basement	2015	3,559		20	178	178	979	11
12	R/M Reclass: crack seaing and striping parking lot	2015	4,700		27	174	174	957	12
13									13
14	RE Entity: chari rail installations in 1st & 2nd floor rooms	2016	26,509		27	982	982	4,088	14
15	R/M Reclass: (RE: Concrete paving in parking lot	2016	8,800		15	587	587	2,641	15
16									16
17	Parking lot - asphalt and resurface	2018	30,500	2,033	15	2,033		4,574	17
18									18
19	Remove and replace asphalt, sewer rebuild	2019	3,700	247	15	247	0	432	19
20	Provide power to touchscreens	2019	2,308	59	39	59	(0)	89	20
21	R&M Reclass: Elevator repair	2019	2,768		20	138	138	196	21
22									22
23	reconcile to book			(1,577)			1,577		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)		\$ 8,691,775	\$ 60,763		\$ 278,455	\$ 217,693	\$ 6,200,109	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 12C, Carried Forward		\$ 8,691,775	\$ 60,763		\$ 278,455	\$ 217,693	\$ 6,200,109	1
2	Building - management company	2002	334,224		40	12,037	12,037	156,172	2
3	HVAC electrical, security system, mgmt company	2003	2,936		30	145	145	2,340	3
4	key card system, management company	2004	461		20	37	37	337	4
5	VAV TX controls management company	2005	140		20	11	11	99	5
6	interior signs - management company	2006	102		20	11	11	87	6
7	Building improvements - management company	2008	14,469		20	539	539	6,367	7
8	Building improvements - management company	2009	2,686		20	237	237	1,540	8
9	Building improvements - management company	2010	2,647		20	186	186	1,373	9
10	Building improvements - management company	2011	2,080		20	158	158	854	10
11	Building improvements - management company	2012	6,120		20	368	368	1,826	11
12	Building improvements - management company	2013	5,430		20	249	249	2,069	12
13	Building improvements - management company	2014	2,938		20	478	478	1,845	13
14	Building improvements - management company	2015	517		20	103	103	343	14
15	Building improvements - management company	2016	8,527		20	1,030	1,030	2,840	15
16	Building improvements - management company	2017	5,377		20	379	379	856	16
17	Building improvements - management company	2018	966		20	57	57	105	17
18	Building improvements - management company	2019	17,418		20	472	472	870	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,098,813	\$ 60,763		\$ 294,952	\$ 234,190	\$ 6,380,032	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	\$138,143	\$11,736	\$11,736	\$	5-10	\$102,855	71
72	Current Year Purchases	50,721	5,297	5,297		5	5,297	72
73	Fully Depreciated Assets	1,250,482					1,250,482	73
74	allocated from mgmt co	647,180		21,606	21,606		499,949	74
75	TOTALS	\$2,086,526	\$17,033	\$38,639	\$21,606		\$1,858,583	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			60,958		4,053	4,053		46,759	79
80	TOTALS			\$60,958	\$	\$4,053	\$4,053		\$46,759	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$11,775,450	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$77,796	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$337,644	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$259,849	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$8,285,374	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$10,791
- Description:
- See Sch 14a

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	allocated from management co				20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed			Contract	Total
1	Community College Tuition	\$	\$			\$	\$
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$			\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	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	\$	18,892	\$ 721,079	\$	18,892	\$ 721,079	1
2	Licensed Speech and Language Development Therapist	39, 3	hrs		2,672	129,951		2,672	129,951	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39, 2 & 3	hrs		23,698	996,331		23,698	996,331	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				459,627		459,627	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>AMBULANCE</u>	39, 3				3,579			3,579	12
13	Other (specify): <u>SEE 16A</u>	39, 2					40,422		40,422	13
14	TOTAL			\$	45,262	\$ 1,850,940	\$ 500,049	45,262	\$ 2,350,989	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.

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	\$ 4,634,260	\$ 4,646,907	1
2	Cash-Patient Deposits	81,184	81,184	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,729,596)	2,849,218	2,849,218	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(41,648)	(41,648)	6
7	Other Prepaid Expenses	54,062	54,061	7
8	Accounts Receivable (owners or related parties)	136,811	(193,521)	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,713,887	\$ 7,396,201	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,090		12
13	Land		505,000	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	1,501,823	3,539,141	15
16	Equipment, at Historical Cost	846,663	1,441,554	16
17	Accumulated Depreciation (book methods)	(1,826,974)	(7,554,426)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>insur recoveries</u>)	1,410,140	1,410,140	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,939,742	\$ 4,484,751	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,653,629	\$ 11,880,952	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,136,582	\$ 2,136,582	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	124,788	124,788	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	321,833	321,833	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,758	19,758	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,113,540	32
33	Accrued Interest Payable	9,887	77,355	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>see schedule 17a</u>	14,240,403	7,449,762	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 16,853,251	\$ 11,243,618	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,489,241	1,489,241	39
40	Mortgage Payable		4,498,573	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)	\$ 1,489,241	\$ 5,987,814	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 18,342,492	\$ 17,231,432	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,688,863)	\$ (5,350,480)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,653,629	\$ 11,880,952	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,413,033)	1
2	Restatements (describe):		2
3	post closing adjustments	(804,729)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,217,762)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,471,101)	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)	\$ (1,471,101)	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)	\$ (8,688,863)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 22,361,976	1
2	Discounts and Allowances for all Levels	(13,273,494)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,088,482	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,018,558	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,018,558	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	3,854	12
13	Barber and Beauty Care	1,025	13
14	Non-Patient Meals	234	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	539,655	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	451,845	19
20	Radiology and X-Ray	(496)	20
21	Other Medical Services	702,051	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,698,168	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,621	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,621	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other income	22,276	28
28a	provider relief funds	1,444,376	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,466,652	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,279,481	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,216,998	31
32	Health Care	7,637,193	32
33	General Administration	5,465,840	33
	B. Capital Expense		
34	Ownership	1,755,511	34
	C. Ancillary Expense		
35	Special Cost Centers	3,299,836	35
36	Provider Participation Fee	375,204	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,750,582	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,471,101)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,471,101)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,004,694	44
45	Private Pay - Net Inpatient Revenue	915,424	45
46	Medicare - Net Inpatient Revenue	1,293,686	46
47	Other-(specify) <u>managed care/other</u>	874,678	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,088,482	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.

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	1,190	1,599	\$ 106,578	\$ 66.65	1
2	Assistant Director of Nursing	1,172	1,554	79,345	51.06	2
3	Registered Nurses	27,988	38,320	1,480,915	38.65	3
4	Licensed Practical Nurses	26,778	36,447	1,144,108	31.39	4
5	CNAs & Orderlies	63,850	85,136	1,642,767	19.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,386	1,804	34,266	18.99	9
10	Activity Assistants	5,369	6,633	100,067	15.09	10
11	Social Service Workers	5,839	7,394	168,879	22.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,451	1,890	42,275	22.37	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,834	2,335	176,460	75.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,756	5,643	101,074	17.91	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	4,159	5,528	99,695	18.03	31
32	Other Health Care(specify)					32
33	Other(specify) see sch 20a	19,639	26,141	919,083	35.16	33
34	TOTAL (lines 1 - 33)	165,411	220,424	\$ 6,095,512 *	\$ 27.65	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 79,732	1-3	35
36	Medical Director	monthly	83,300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	31,941	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	monthly	1,763	19-3	44
45	Social Service Consultant	monthly	2,262	19-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 198,998		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,598	\$ 225,417	10-3	50
51	Licensed Practical Nurses	4,229	219,798	10-3	51
52	Certified Nurse Assistants/Aides	21,515	618,759	10-3	52
53	TOTAL (lines 50 - 52)	29,341	\$ 1,063,974		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

yes
IHCA 7568
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

yes
yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

no
n/a
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

yes
5
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 64,197 Line 10(2)
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

x
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 375,204
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

no

- (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?
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.

no
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
no
Indicate the amount. \$ 0
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

no

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

no
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?
Indicate the amount of income earned from providing such transportation during this reporting period.

no
n/a
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

no
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

yes
- (19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees.

yes