

		FOR BHF USE					

LL1

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>0041855</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Lexington of Orland Park</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>14601 S John Humphry</u> <u>Orland Park</u> <u>60462</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>708-349-8300</u> Fax # <u>708-349-4093</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">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>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	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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Date of Initial License for Current Owners: <u>7/8/96</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☒</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other</td><td></td><td>_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☒	Corporation	☐	Other _____			☐	"Sub-S" Corp.		_____			☐	Limited Liability Co.		_____			☐	Trust		_____			☐	Other		_____
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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 Orland Park

#

0041855

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	275	Skilled (SNF)	275	100,650	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	275	TOTALS	275	100,650	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			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF			10,835	10,835
9	SNF/PED				
10	ICF	25,165	6,645	3,537	35,347
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	25,165	6,645	14,372	46,182

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

45.88%

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 07/08/96

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 259 and days of care provided 7,901

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ 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 Orland Park # 0041855 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		28,519	1,099,076	1,127,595		1,127,595		1,127,595			1
2	Food Purchase		(2,036)		(2,036)		(2,036)	900	(1,136)			2
3	Housekeeping		2,748	678,234	680,982		680,982		680,982			3
4	Laundry											4
5	Heat and Other Utilities			279,825	279,825		279,825	34,015	313,840			5
6	Maintenance	17,994	777	185,647	204,418		204,418	148,664	353,082			6
7	Other (specify):*							15,697	15,697			7
8	TOTAL General Services	17,994	30,008	2,242,782	2,290,784		2,290,784	199,276	2,490,060			8
	B. Health Care and Programs											
9	Medical Director			57,500	57,500		57,500		57,500			9
10	Nursing and Medical Records	5,155,995	620,993	858,444	6,635,432		6,635,432	36,789	6,672,221			10
10a	Therapy											10a
11	Activities	172,475	20,523	257	193,255		193,255		193,255			11
12	Social Services	191,893			191,893		191,893		191,893			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,501	4,501			15
16	TOTAL Health Care and Programs	5,520,363	641,516	916,201	7,078,080		7,078,080	41,290	7,119,370			16
	C. General Administration											
17	Administrative	173,253		2,375,160	2,548,413		2,548,413	(915,312)	1,633,101			17
18	Directors Fees											18
19	Professional Services			329,957	329,957		329,957	227,859	557,816			19
20	Dues, Fees, Subscriptions & Promotions			36,115	36,115		36,115	21,727	57,842			20
21	Clerical & General Office Expenses	249,251	29,713	66,378	345,342		345,342	1,617,598	1,962,940			21
22	Employee Benefits & Payroll Taxes			1,126,866	1,126,866		1,126,866		1,126,866			22
23	Inservice Training & Education							1,344	1,344			23
24	Travel and Seminar							131	131			24
25	Other Admin. Staff Transportation			727	727		727	25,749	26,476			25
26	Insurance-Prop.Liab.Malpractice			1,142,001	1,142,001		1,142,001	8,355	1,150,356			26
27	Other (specify):*							192,525	192,525			27
28	TOTAL General Administration	422,504	29,713	5,077,204	5,529,421		5,529,421	1,179,976	6,709,397			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,960,861	701,237	8,236,187	14,898,285		14,898,285	1,420,542	16,318,827			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			99,806	99,806		99,806	416,411	516,217			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			166,443	166,443		166,443	667,646	834,089			32
33	Real Estate Taxes			49,772	49,772		49,772	668,868	718,640			33
34	Rent-Facility & Grounds			1,583,587	1,583,587		1,583,587	(1,583,429)	158			34
35	Rent-Equipment & Vehicles			57,042	57,042		57,042	7,405	64,447			35
36	Other (specify):*											36
37	TOTAL Ownership			1,956,650	1,956,650		1,956,650	176,901	2,133,551			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		275,152	2,154,752	2,429,904		2,429,904		2,429,904			39
40	Barber and Beauty Shops			1,871	1,871		1,871	(1,871)				40
41	Coffee and Gift Shops			909	909		909		909			41
42	Provider Participation Fee			378,445	378,445		378,445		378,445			42
43	Other (specify):* pg 5a			1,218,185	1,218,185		1,218,185	(1,218,110)	75			43
44	TOTAL Special Cost Centers		275,152	3,754,162	4,029,314		4,029,314	(1,219,981)	2,809,333			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,960,861	976,389	13,946,999	20,884,249		20,884,249	377,462	21,261,711			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				4
5	Telephone, TV & Radio in Resident Rooms	(20,909)	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	36,783	30		9
10	Interest and Other Investment Income	(25,868)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15,188)	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	(4,290)	43		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	(1,055,758)	43		24
25	Fund Raising, Advertising and Promotional	(23,296)	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	(286,248)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,394,774)		\$	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)	1,772,236		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,772,236		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 377,462		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		\$		1
2	personal item replacement	(3,097)	43	2
3	lab - part A	(54,405)	43	3
4	xray - part A	(41,242)	43	4
5	gift shop income		41	5
6	collections	(21,443)	19	6
7	barber and beauty	(1,871)	40	7
8	lobbying portion of dues	(1,253)	20	8
9	Salesforce Computer Consulting	(6,510)	19	9
10				10
11				11
12	offset shareholder interest	(156,427)	32	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(286,248)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Orland Park# 0041855

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	900	0	0	0	0	0	0	0	900	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	34,015	0	0	0	0	0	0	0	0	34,015	5
6	Maintenance	0	0	148,664	0	0	0	0	0	0	0	0	148,664	6
7	Other (specify):*	0	0	15,697	0	0	0	0	0	0	0	0	15,697	7
8	TOTAL General Services	0	0	198,376	900	0	0	0	0	0	0	0	199,276	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	36,789	0	0	0	0	0	0	0	0	36,789	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	4,501	0	0	0	0	0	0	0	0	4,501	15
16	TOTAL Health Care and Programs	0	0	41,290	0	0	0	0	0	0	0	0	41,290	16
	C. General Administration													
17	Administrative	0	0	0	(915,312)	0	0	0	0	0	0	0	(915,312)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(27,953)	50	255,762	0	0	0	0	0	0	0	0	227,859	19
20	Fees, Subscriptions & Promotions	(1,253)	0	22,980	0	0	0	0	0	0	0	0	21,727	20
21	Clerical & General Office Expenses	0	300	1,617,298	0	0	0	0	0	0	0	0	1,617,598	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	1,344	0	0	0	0	0	0	0	1,344	23
24	Travel and Seminar	0	0	0	131	0	0	0	0	0	0	0	131	24
25	Other Admin. Staff Transportation	0	0	0	25,749	0	0	0	0	0	0	0	25,749	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	8,355	0	0	0	0	0	0	0	8,355	26
27	Other (specify):*	0	0	0	192,525	0	0	0	0	0	0	0	192,525	27
28	TOTAL General Administration	(29,206)	350	1,896,040	(687,208)	0	0	0	0	0	0	0	1,179,976	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,206)	350	2,135,706	(686,308)	0	0	0	0	0	0	0	1,420,542	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.

1OWNERS		2RELATED NURSING HOMES		3OTHER 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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	\$	Lexington Health Care Systems of Orland Park Ltd Ptsp.	**	\$ 50	\$ 50	1
2	V	30	Depreciation Expense		Lexington Health Care Systems of Orland Park Ltd Ptsp.	**	312,756	312,756	2
3	V	32	Amortization of Mortgage Cost		Lexington Health Care Systems of Orland Park Ltd Ptsp.	**	131,846	131,846	3
4	V	32	Interest		Lexington Health Care Systems of Orland Park Ltd Ptsp.	**	637,935	637,935	4
5	V	33	Property Tax		Lexington Health Care Systems of Orland Park Ltd Ptsp.	**	630,622	630,622	5
6	V	34	Rent	1,583,429	Lexington Health Care Systems of Orland Park Ltd Ptsp.	**		(1,583,429)	6
7	V	43	Unrealized loss on FMV of Swap		Lexington Health Care Systems of Orland Park Ltd Ptsp.	**			7
8	V	43	(Gain)/Loss - disposal - mortgage costs		Lexington Health Care Systems of Orland Park Ltd Ptsp.	**			8
9	V	21	Miscellaneous Expense		Lexington Health Care Systems of Orland Park Ltd Ptsp.	**	300	300	9
10	V	43	Trust fees		Lexington Health Care Systems of Orland Park Ltd Ptsp.	**	75	75	10
11	V								11
12	V				** The owners of Lexington Health Care Center of Orland Park Inc. own				12
13	V				100% of Lexington Health Care Systems of Orland Park Ltd Ptsp				13
14	Total			\$ 1,583,429			\$ 1,713,584	\$ * 130,155	14

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

Facility Name & ID Number Lexington of Orland Park# 0041855Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 Housekeeping Supplies	\$	Royal Management Corp.	**	\$	\$	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	33,058	33,058	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	957	957	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**			18
19	V	6 Management Allocation - salaries		Royal Management Corp.	**	128,262	128,262	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	20,402	20,402	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**			21
22	V	7 Management Allocation - employee benefits		Royal Management Corp.	**	15,697	15,697	22
23	V	10 Medical consultant		Royal Management Corp.	**			23
24	V	10 Management Allocation - salaries		Royal Management Corp.	**	36,789	36,789	24
25	V	15 Management Allocation - employee benefits		Royal Management Corp.	**	4,501	4,501	25
26	V	17 Management Allocation - salaries		Royal Management Corp.	**			26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	70,087	70,087	27
28	V	19 Professional fees		Royal Management Corp.	**	185,675	185,675	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,964	1,964	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	21,016	21,016	30
31	V	21 Management Allocation - salaries		Royal Management Corp.	**	1,573,130	1,573,130	31
32	V	21 Bank charges		Royal Management Corp.	**	8,565	8,565	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	5,146	5,146	33
34	V	21 Postage		Royal Management Corp.	**	7,091	7,091	34
35	V	21 Telephone		Royal Management Corp.	**	23,366	23,366	35
36	V							36
37	V							37
38	V	** The owners of Lexington Health Care Center of Orland Park Inc. own 100% of Royal Management Corp						38
39	Total		\$			\$ 2,135,706	\$ * 2,135,706	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	**	\$ 1,344	\$ 1,344	15
16	V	24 Travel & seminar		Royal Management Corp	**	131	131	16
17	V	25 Auto expense		Royal Management Corp	**	25,749	25,749	17
18	V	26 Insurance general		Royal Management Corp	**	8,355	8,355	18
19	V	27 Management Allocation - employee benefits		Royal Management Corp	**	192,525	192,525	19
20	V	30 Depreciation		Royal Management Corp	**	66,872	66,872	20
21	V	32 Interest		Royal Management Corp	**	80,160	80,160	21
22	V	2 Amortization of mortgage costs		Royal Management Corp	**	900	900	22
23	V	33 Property taxes		Royal Management Corp	**	38,246	38,246	23
24	V	34 Rent expense		Royal Management Corp	**			24
25	V	35 Equipment rental		Royal Management Corp	**	7,405	7,405	25
26	V	17 Management fees	915,312	Royal Management Corp	**		(915,312)	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 Orland Park Inc. own 100% of Royal Management Corp.						38
39	Total		\$ 915,312			\$ 421,687	\$ * (493,625)	39

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

Facility Name & ID Number

Lexington of Orland Park

0041855

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	30	Lexington HC Ctr. of Bloomingdale Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	30	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	30	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Lexington Square	Lombard	Independent and	3
4	Dean V. Sweitzer Family Trust	10	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Life Care of		Assisted Living	4
5			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lombard, LLC		Facility	5
6			Lexington HC Ctr. of Lombard, Inc.	Lombard	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Life Care of		Living Facility	7
8					Elmhurst, LLC			8
9					Vesta Mgmt	Lombard	Mgmt. Company	9
10					Group, LLC			10
11					Lexington Health	Orland Park	Real Estate	11
12					Care Systems of		Property	12
13					Orland Park Ltd. Ptsp			13
14					Royal Management	Lombard	Mgmt. Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance Company	16
17					Services, LLC			17
18					Heron Point Mgmt.	Lombard	Mgmt. Company	18
19					Corporation			19
20					Samvest of	Lombard	Lessor	20
21					Lombard II, LLC			21
22					Lexington Home	Lombard	Finance Company	22
23					Health Care, Inc.			23
24					Lexington Hospice	Lombard	Home Health	24
25					Services, LLC			25
26					Lexington Private	Lombard	Hospice	26
27					Home Care			27
28					Merit Sleep	Lombard	Mgmt. Com+Z12:Z3	28
29					Management, LLC			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					Sambell of	Bloomingtondale	Real Estate	1
2					Bloomingtondale Ltd. Pts		Property	2
3					Sambell of Chicago	Chicago Ridge	Real Estate	3
4					Ridge Ltd. Ptsp.		Property	4
5					Sambell of	Elmhurst	Real Estate	5
6					Elmhurst II Ltd. Ptsp.		Property	6
7					Sambell of	LaGrange	Real Estate	7
8					LaGrange Ltd. Ptsp.		Property	8
9					Lexington Health	Lake Zurich	Real Estate	9
10					Care Systems of		Property	10
11					Lake Zurich Ltd. Ptsp			11
12					Lexington Health	Lombard	Real Estate	12
13					Care Systems of		Property	13
14					Lombard Ltd. Ptsp.			14
15					Sambell of	Schaumburg	Real Estate	15
16					Schaumburg Ltd. Ptsp		Property	16
17					Samvest of	Algonquin	Real Estate	17
18					Algonquin Ltd. Ptsp.		Property	18
19					Curatess, LLC	Lombard	Telemedicine	19
20					Republic Construction	Lombard	Construction Comp	20
21								21
22								22
23								23
24								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 Orland Park# 0041855 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Royal Management Corp

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard IL 60148

Phone Number

(630-458-4700

Fax Number

630-458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping Supplies	Bed days available	565,750	8	\$	\$	100,375	\$ 0	1
2	5	Utilities - gas & electric	Bed days available	565,750	8	186,333		100,375	33,059	2
3	5	Utilities - water & sewer	Bed days available	565,750	8	5,398		100,375	958	3
4	5	Utilities - maintenance office	Bed days available	565,750	8			100,375	0	4
5	6	Management Allocation - salaries	Bed days available	565,750	8	722,929	722,929	100,375	128,262	5
6	6	Repairs & maintenance	Bed days available	565,750	8	114,986		100,375	20,401	6
7	6	Scavenger & exterminating	Bed days available	565,750	8			100,375	0	7
8	7	Management Allocation - employee ben	Bed days available	565,750	8	88,474		100,375	15,697	8
9	10	Medical consultant	Bed days available	565,750	8			100,375	0	9
10	10	Management Allocation - salaries	Bed days available	565,750	8			100,375	0	10
11	15	Management Allocation - employee ben	Bed days available	565,750	8	25,377		100,375	4,502	11
12	17	Management Allocation - salaries	Bed days available	565,750	8	207,358	207,358	100,375	36,789	12
13	19	Computer consultant & supplies	Bed days available	565,750	8	395,029		100,375	70,086	13
14	19	Professional fees	Bed days available	565,750	8	1,046,538		100,375	185,676	14
15	20	Dues & subscriptions	Bed days available	565,750	8	11,082		100,375	1,966	15
16	20	Advertising - help wanted	Bed days available	565,750	8	118,456		100,375	21,016	16
17	21	Management Allocation - salaries	Bed days available	565,750	8	8,866,730	8,866,730	100,375	1,573,130	17
18	21	Bank charges	Bed days available	565,750	8	48,277		100,375	8,565	18
19	21	Office supplies & printing	Bed days available	565,750	8	29,001		100,375	5,145	19
20	21	Postage	Bed days available	565,750	8	39,969		100,375	7,091	20
21	21	Telephone	Bed days available	565,750	8	131,703		100,375	23,367	21
22										22
23										23
24										24
25	TOTALS					\$ 12,037,640	\$ 9,797,017		\$ 2,135,710	25

Facility Name & ID Number Lexington of Orland Park# 0041855 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ 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	\$	100,375	\$ 1,344	1
2	24	Travel & seminar	Bed days available	565,750	8	735		100,375	130	2
3	25	Auto expense	Bed days available	565,750	8	145,140		100,375	25,751	3
4	26	Insurance general	Bed days available	565,750	8	47,093		100,375	8,355	4
5	27	Management Allocation - employee be	Bed days available	565,750	8	1,085,139		100,375	192,525	5
6	30	Depreciation	Bed days available	565,750	8	376,924		100,375	66,874	6
7	32	Interest	Bed days available	565,750	8	451,812		100,375	80,160	7
8	2	Amortization of mortgage costs	Bed days available	565,750	8	5,077		100,375	901	8
9	33	Property taxes	Bed days available	565,750	8	215,565		100,375	38,245	9
10	34	Rent expense	Bed days available	565,750	8			100,375		10
11	35	Equipment rental	Bed days available	565,750	8	41,748		100,375	7,407	11
12	17	Management fees	Bed days available	565,750	8			100,375		12
13	35	Auto lease	Bed days available	565,750	8			100,375		13
14	6	Security	Bed days available	565,750	8			100,375		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	\$		\$ 421,692	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	5/29/18	\$ 5,058,006	\$ 8,913,728	5/21/21	libor + 5.24	\$ 637,938	1
2												2
3												3
4								Offset Miscellaneous interest			(124)	4
5								Miscellaneous interest			124	5
	Working Capital											
6	Shareholder loan	x		working capital	varies	5/3/12	1,200,000	1,448,548	demand	0.0800	96,263	6
7	Shareholder loan	x		working capital	varies	9/30/13	750,000	905,342	demand	0.0800	60,164	7
8	West Suburban Bank		x	PPP loan	none		1,501,927	1,501,927	5/6/22	0.0100	10,013	8
9	TOTAL Facility Related						\$ 8,509,933	\$ 12,769,545			\$ 804,378	9
	B. Non-Facility Related*											
10								interest income offset			(25,868)	10
11								amortization			131,846	11
12								allocated from mgmt co			80,160	12
13								offset shareholder interest			(156,427)	13
14	TOTAL Non-Facility Related						\$	\$			\$ 29,711	14
15	TOTALS (line 9+line14)						\$ 8,509,933	\$ 12,769,545			\$ 834,089	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.		\$	827,952	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.)		\$	708,206	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(119,746)	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	840,000	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.)		\$	49,772	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 \$ 89,632 For 2017 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(89,632)	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	718,640	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	678,633	8	
		2016	685,216	9	
		2017	804,513	10	
		2018	709,199	11	
		2019	708,206	12	
				13	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 Orland Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

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: 104,332

B. General Construction Type: Exterior brickFrame block & 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).

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:

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	152,460	1995	\$ 776,408	1
2	management company allocation			32,707	2
3	TOTALS	152,460		\$ 809,115	3

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	250		1996	1996	\$ 8,569,286	\$	40	\$ 214,232	\$ 214,232	\$ 5,246,112	4
5	10		1998	1998	63,790	1,595	40	1,595		35,087	5
6	18		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Electrical wiring		1996		2,304	58	40	58		1,397	9
10	Paving		1997		11,589		40			11,589	10
11	Wiring		1998		3,932		40			3,932	11
12	Additional building costs - 10 bed addition		1999		1,808	45	10	45		992	12
13	Seal/restrip parking lot		1999		3,450		40			3,450	13
14	Wiring		1999		1,798	45	15	45		967	14
15	Roof repairs		2000		23,201		40			23,201	15
16	Electrical wiring		2000		5,732	164	15	164		3,360	16
17	Ceiling mount curtain rod hardware		2000		6,952	199	35	199		4,077	17
18	Automatic door closer/sensors		2000		3,624		35			3,624	18
19	Seal and restripe parking lot		2001		2,277		15			2,277	19
20	HVAC control		2001		2,548		10			2,548	20
21	Infrared curtains for elevator doors		2001		4,500		10			4,500	21
22	Fire alarm panel		2002		5,120		10			5,120	22
23	Parking lot lights		2002		9,975		10			9,975	23
24	Chiller room compressor		2002		8,879		10			8,879	24
25	Carpeting		2002		7,038		5			7,038	25
26	Pave and seal parking lot		2005		4,180	209	20	209		3,205	26
27	HVAC		2005		6,143	307	20	307		4,631	27
28	Electrical wiring		2005		3,637	182	20	182		2,760	28
29	Kitchen rehab		2005		6,360	318	20	318		5,008	29
30	Elevator rehab		2005		8,948	447	20	447		7,004	30
31	Lounge, lobby, and reception area rehab		2005		27,662	1,383	20	1,383		20,976	31
32	Landscaping enhancements		2006		5,795	386	20	386		5,533	32
33	HVAC		2006		9,300		15	465	465	6,549	33
34	LHI-therapy room rehab LL TCU/main therapy		2006		33,184	1,659	20	1,659		23,779	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 of Orland Park

0041855

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	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	Landscaping	2007	\$ 17,383	\$ 1,159	15	\$ 1,159	\$	\$ 15,550	37
38	Parking lot	2007	1,120	56	20	56		747	38
39	Plumbing-Fine Dining	2007	2,068	103	20	103		1,434	39
40	Laundry Room Rehab	2007	37,283	1,864	20	1,864		25,630	40
41	Employee lunch room	2007	2,865	143	20	143		1,966	41
42	Basement Renovation	2007	1,148	57	20	57		765	42
43	Patio Improvements	2007	7,000	350	20	350		4,638	43
44	1st floor remodel-carpentry, flooring, plumbing, electrical-	2007	1,481,886		40	37,426	37,426	502,133	44
45	fixtures, painting	2007							45
46									46
47	Basement Renovation	2007	20,191		20	1,010	1,010	13,126	47
48	Therapy Room Renovation	2007	978		20	49	49	637	48
49	Landscaping	2008	4,300	287	15	287		3,468	49
50	Spot Coolers	2008	3,790	189	20	189		2,268	50
51	Emergency A/C	2008	32,295	807	40	807		10,020	51
52	Plumbing & Sprinkler-Showers	2008	5,047	126	40	126		1,512	52
53	Parking lot repairs	2008	5,285	264	20	264		3,322	53
54	Phone closet	2008	5,954	149	40	149		1,875	54
55	Landscaping	2009	4,190	279	15	279		3,092	55
56	1st floor admin room-heating, fire protection	2009	16,422	821	20	821		9,578	56
57	Quick connectors	2009	7,091	355	20	355		4,023	57
58	Electrical Room	2009	4,692	235	20	235		2,585	58
59	Glass and Mirrors Med Room	2009	4,954	142	35	142		1,633	59
60	Key pad common areas	2009	3,757	107	35	107		1,258	60
61	2nd Floor remodel-Doors and Locks	2009	32,130	803	40	803		9,435	61
62	Patio Pergola	2009	7,930	529	15	529		5,951	62
63	Patio Fence	2009	11,293	712	15	712		7,891	63
64	2nd floor remodel-carpentry, flooring, electrical, painting	2009	1,014,056		27	36,875	36,875	442,500	64
65	2nd floor remodel-carpentry	2009	17,258		27	628	628	7,483	65
66	Office carpentry, flooring, electrical, painting, plumbing	2010	70,270	2,666	27	2,666		32,357	66
67	Landscaping	2010	11,399	760	15	760		7,790	67
68	Physican office carpentry	2010	2,926	106	27	106		1,060	68
69	Repave/Seal Cracks in parking lot	2010	21,817	1,091	20	1,091		11,273	69
70	TOTAL (lines 4 thru 69)		\$ 11,701,790	\$ 21,157		\$ 311,842	\$ 290,685	\$ 6,594,570	70

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

Facility Name & ID Number Lexington of Orland Park

0041855

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		\$ 11,701,790	\$ 21,157		\$ 311,842	\$ 290,685	\$ 6,594,570	1
2	Roof	2010	74,000	2,691	27	2,691		28,480	2
3	HVAC-Exhaust Modification	2010	4,202	153	27	153		1,555	3
4	Nurse pull cord station	2010	3,933	143	27	143		1,430	4
5	Paint lights over bed	2010	7,738	281	27	281		2,834	5
6	Trench/Awning	2010	11,666	424	27	424		4,330	6
7	Remodel Library/Lounge-art, flooring, carpentry	2010	4,120	150	27	150		1,500	7
8	3rd floor remodel-carpentry, electrical, plumbing	2010	868,783		27	67,183	67,183	699,823	8
9									9
10	Office-carpentry, flooring, electrical, painting, plumbing and signs	2011	6,710	244	27	244		2,318	10
11	Office Remodel- Doors and Locks	2011	31,324	1,139	27	1,139		12,244	11
12	Office Remodel- Doors and Locks	2011	5,282	192	27	192		1,888	12
13	Additional parking spaces	2011	196,376	7,141	27	7,141		66,054	13
14	Roof Repairs	2011	58,800	2,138	27	2,138		20,311	14
15	Fire Dampers	2011	5,586	203	27	203		1,844	15
16	Pantry Remodel - Millwork and Flooring	2011	3,730	136	27	136		1,247	16
17	Laundry Room Remodel - Flooring, Painting and Electrical	2011	9,172	334	27	334		3,089	17
18	2nd Floor Remodel - Doors	2011	12,612	459	27	459		4,284	18
19									19
20	Parking lot	2012	12,906	469	27	469		3,791	20
21	Chiller replacement kitchen	2012	108,732	3,954	27	3,954		33,279	21
22									22
23	Fire Pump- Basement	2013	5,000	125	40	125		990	23
24	EMR Wiring- Entire Facility	2013	19,542	711	27	711		5,036	24
25	New Countertop, wall, tile- Kitchen	2013	3,026	110	27	110		779	25
26	Stairway Access Control- Entire Facility (1st-3rd floor stairs)	2013	6,463	235	27	235		1,665	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,161,493	\$ 42,589		\$ 400,457	\$ 357,868	\$ 7,493,341	34

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

Facility Name & ID Number Lexington of Orland Park

0041855

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 13,161,493	\$ 42,589		\$ 400,457	\$ 357,868	\$ 7,493,341	1
2	Parking lot paving	2014	119,164	4,333	27	4,333		25,998	2
3	Kitchen Chiller Replacement	2014	126,990	4,618	27	4,618		30,402	3
4	Kitchen sink, drywall, tile	2014	15,968	581	27	581		3,824	4
5	Create Workspace in 1st floor library	2014	16,429	597	27	597		3,931	5
6									6
7	R/M Repair Concrete Walk (Front Entrance)	2014	3,393		15	223	223	1,463	7
8	R/M Replace Radiator/Thermostat	2014	7,190		10	719	719	4,674	8
9									9
10	EMR Building Wiring - Entire Facility	2015	5,038	183	27	183		1,022	10
11	Room Remodel - First Floor Semi-private room								11
12	converted to Private room	2015	5,375	195	27	195		992	12
13									13
14	R/M Parking Lot - Remove and replace asphalt	2015	5,200		20	260	260	1,430	14
15									15
16	Asphalt Removal/Replacement and Trench/Drain Installation in	2016	12,750	638	20	638		2,924	16
17	Parking Lot								17
18	Floor Tiling in First Floor Front Offices	2016	4,888	489	10	489		2,282	18
19	Chair Rail Installation in First Floor Rooms	2016	14,378	533	27	533		2,219	19
20									20
21	R/M: Frame/Drywall Installation in Boiler Room Exit Vestibule	2016	3,630		27	134	134	603	21
22									22
23	R/M: Striping Parking Lot	2017	2,600		27	96	96	336	23
24	R/M: Replace Canopy Roof and Block - Front Entrance	2017	2,900		15	193	193	676	24
25	R/M: Remove and replace underground pipe - Kitchen	2017	7,000		20	350	350	1,225	25
26	R/M: Millwork needed to install TV per drawing - common area	2017	2,750		15	183	183	641	26
27									27
28	Pavement replacement - exterior	2019	26,200	1,048	25	1,048		1,659	28
29									29
30	Reno. 1st floor - millwork, carpentry finish/trim, replace flooring,								30
31	elctrecal upgrades, window treatments, wallpaper, painting	2020	442,687						31
32				703			(703)		32
33	reconcile to book			703			(703)		33
34	TOTAL (lines 1 thru 33)		\$ 13,986,023	\$ 57,210		\$ 415,830	\$ 358,620	\$ 7,579,642	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		\$ 13,986,023	\$ 57,210		\$ 415,830	\$ 358,620	\$ 7,579,642	1
2	Building - management company	2002	452,606		40	16,300	16,300	211,521	2
3	HVAC, electrical, security system - management company	2003	3,975		30	197	197	3,169	3
4	Key card system - management company	2004	625		20	51	51	458	4
5	VAV TX controls - management company	2005	190		20	15	15	134	5
6	Interior Signs - management company	2006	139		20	15	15	118	6
7	Building improvements - management company	2008	19,594		20	729	729	8,623	7
8	Building improvements - management company	2009	3,638		20	321	321	2,086	8
9	Building improvements - management company	2010	3,586		20	251	251	1,859	9
10	Building improvements - management company	2011	2,816		20	214	214	1,156	10
11	Building improvements - management company	2012	8,288		20	499	499	2,475	11
12	Building improvements - management company	2013	7,353		20	338	338	2,803	12
13	Building improvements - management company	2014	3,979		20	647	647	2,498	13
14	Building improvements - management company	2015	699		20	139	139	464	14
15	Building improvements - management company	2016	11,546		20	1,394	1,394	3,846	15
16	Building improvements - management company	2017	7,283		20	514	514	1,161	16
17	Building improvements - management company	2018	1,308		20	77	77	142	17
18	Building improvements - management company	2019	23,587		20	639	639	1,179	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)		\$ 14,537,235	\$ 57,210		\$ 438,170	\$ 380,960	\$ 7,823,334	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	\$274,213	\$39,757	\$39,757	\$	5-10	\$163,033	71
72	Current Year Purchases	66,357	3,542	3,542		5	3,542	72
73	Fully Depreciated Assets	1,177,999					1,177,999	73
74	allocated from mgmt co	876,409		29,259	29,259		677,143	74
75	TOTALS	\$2,394,978	\$43,299	\$72,558	\$29,259		\$2,021,717	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			82,549		5,489	5,489		63,332	79
80	TOTALS			\$82,549	\$	\$5,489	\$5,489		\$63,332	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)	\$17,823,877
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$100,509
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$516,217
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$415,708
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$9,908,383

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	Parking space lease							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: \$9,185
- Description: see schedule 14a
- (Attach a schedule detailing the breakdown of movable equipment)
- ☒ YES☐ NO

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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	\$

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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	\$	20,601	\$ 805,801	\$	20,601	\$ 805,801	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		5,785	308,558		5,785	308,558	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2 &3)	hrs		20,692	911,022		20,692	911,022	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				244,548		244,548	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>ambulance</u>	39(3)				11,713			11,713	12
13	Other (specify): <u>see sch 16a</u>	39(2)					30,604		30,604	13
14	TOTAL			\$	47,078	\$ 2,037,094	\$ 275,152	47,078	\$ 2,312,246	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	\$ 475,791	\$ 712,461	1
2	Cash-Patient Deposits	69,810	69,810	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,151,482)	4,696,034	4,696,034	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(53,852)	(53,852)	6
7	Other Prepaid Expenses	68,857	68,857	7
8	Accounts Receivable (owners or related parties)	(482,117)	(324,781)	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,774,523	\$ 5,168,529	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,408	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	1,506,526	4,903,673	15
16	Equipment, at Historical Cost	775,188	1,473,661	16
17	Accumulated Depreciation (book methods)	(1,264,419)	(8,626,815)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Ins Recov, CIP	1,740,136	1,740,136	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,757,431	\$ 8,836,349	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,531,954	\$ 14,004,878	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 999,831	\$ 999,831	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	101,071	101,072	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	392,236	392,236	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,155	16,155	31
32	Accrued Real Estate Taxes(Sch.IX-B)		840,000	32
33	Accrued Interest Payable	10,013	63,743	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	see schedule 17a	17,182,869	9,235,607	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 18,702,175	\$ 11,648,644	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,854,817	3,854,817	39
40	Mortgage Payable		8,913,728	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)	\$ 3,854,817	\$ 12,768,545	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 22,556,992	\$ 24,417,189	46
47	TOTAL EQUITY (page 18, line 24)	\$ (15,025,038)	\$ (10,412,311)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,531,954	\$ 14,004,878	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (11,181,888)	1
2	Restatements (describe):		2
3	post closing adjustments	(249,821)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (11,431,709)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,593,329)	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)	\$ (3,593,329)	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)	\$ (15,025,038)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Orland Park

0041855

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	\$ 19,232,277	1
2	Discounts and Allowances for all Levels	(10,672,861)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,559,416	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,146,448	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,146,448	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,153	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	219,220	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	233,330	19
20	Radiology and X-Ray	(428)	20
21	Other Medical Services	130,295	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 585,570	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,868	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,868	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	miscellaneous	69	28
28a	provider relief funds	1,973,549	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,973,618	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,290,920	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,290,784	31
32	Health Care	7,078,080	32
33	General Administration	5,529,421	33
	B. Capital Expense		
34	Ownership	1,956,650	34
	C. Ancillary Expense		
35	Special Cost Centers	3,650,869	35
36	Provider Participation Fee	378,445	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,884,249	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,593,329)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,593,329)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,963,785	44
45	Private Pay - Net Inpatient Revenue	583,604	45
46	Medicare - Net Inpatient Revenue	813,695	46
47	Other-(specify) managed care/other	1,198,332	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,559,416	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	1,131	14,389	\$ 84,950	\$ 5.90	1
2	Assistant Director of Nursing	1,824	2,266	131,406	57.99	2
3	Registered Nurses	27,815	35,202	1,364,675	38.77	3
4	Licensed Practical Nurses	35,813	46,060	1,445,930	31.39	4
5	CNAs & Orderlies	73,232	92,464	1,642,300	17.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,549	1,910	34,306	17.96	9
10	Activity Assistants	8,137	9,808	138,169	14.09	10
11	Social Service Workers	6,586	7,732	191,893	24.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	651	734	17,994	24.51	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,443	1,850	173,253	93.65	20
21	Assistant Administrator					21
22	Other Administrative	3,803	4,745	119,860	25.26	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,463	5,836	101,814	17.45	31
32	Other Health Care(specify)					32
33	Other(specify) <u>see sch 20a</u>	12,555	15,991	514,311	32.16	33
34	TOTAL (lines 1 - 33)	179,002	238,987	\$ 5,960,861 *	\$ 24.94	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	\$ 77,719	1-3	35
36	Medical Director	monthly	57,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	25,201	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	4,388	19-3	44
45	Social Service Consultant	monthly	1,889	19-3	45
46	Other(specify) <u>marketing</u>	monthly	1,050	43-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 167,747		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,751	\$ 107,929	10-3	50
51	Licensed Practical Nurses	2,882	143,478	10-3	51
52	Certified Nurse Assistants/Aides	21,016	581,301	10-3	52
53	TOTAL (lines 50 - 52)	25,649	\$ 832,708		53

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

** See instructions.

STATE OF ILLINOIS

0041855

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

Facility Name & ID Number

Lexington of Orland Park

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nikki Dinsmore	Administrator	0	\$ 173,253
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 173,253

B. Administrative - Other

Description	Amount
shared services	\$ 1,459,848
management fees - royal ops	915,312
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 2,375,160

C. Professional Services

Vendor/Payee	Type	Amount
Cassiday	legal	\$ 102
Markoff	legal	6,290
Duane Morris	legal	20,937
Much Shelist	legal	5,889
Midcap	legal	4,347
Serpico	legal	360
Markoff/Much Shelist	collections	21,443
RSM/Wipfli	accounting	47,650
Midcap	DDS Exam fee	24,000
Personnel planners	u/c consulting	1,289
see schedule 21c		197,650
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 329,957

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 311,915
Unemployment Compensation Insurance	44,028
FICA Taxes	446,285
Employee Health Insurance	250,195
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k contribution	(16,549)
uniform	4,364
other fringes	86,628
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,126,866

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	15,843
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	5,792
IHCA	7,485
miscellaneous dues and subscriptions	4,146
miscellaneous licenses and permits	2,849
non-allowable lobbying portion of dues allocated from management co	(1,253) 22,980
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 57,842

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
allocated from management co	131
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 131

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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 7485

(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. \$ 54,704 Line 10(2)

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

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. n/a

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 378,445
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? no Indicate the amount. \$ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: _____

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

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