

		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: 0036095			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER		
Facility Name: Lexington of Schaumburg			I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.		
Address: 675 South Roselle Rd Schaumburg 60193 Number City Zip Code					
County: Cook					
Telephone Number: 847-351-5500 Fax #: 847-352-8592					
HFS ID Number:					
Date of Initial License for Current Owners: 3/3/90			Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____		
Type of Ownership:					
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____ ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____					

Facility Name & ID Number Lexington of Schaumburg

0036095 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>214</u>	Skilled (SNF)	<u>214</u>	<u>78,324</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>214</u>	TOTALS	<u>214</u>	<u>78,324</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>8,213</u>	<u>8,213</u>	8
9	SNF/PED					9
10	ICF	<u>39,526</u>	<u>3,673</u>	<u>2,808</u>	<u>46,007</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,526</u>	<u>3,673</u>	<u>11,021</u>	<u>54,220</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.23%

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

04/1/1990

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

YES

☒

Date

new construction

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

214

and days of care provided

5,314

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year:

12/31/20

Fiscal Year:

12/31/20

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

Facility Name & ID Number Lexington of Schaumburg # 0036095 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		13,687	1,109,786	1,123,473		1,123,473		1,123,473			1
2	Food Purchase		(1,659)		(1,659)		(1,659)	(88)	(1,747)			2
3	Housekeeping			635,861	635,861		635,861		635,861			3
4	Laundry											4
5	Heat and Other Utilities			238,339	238,339		238,339	26,472	264,811			5
6	Maintenance	36,675	488	217,579	254,742		254,742	115,686	370,428			6
7	Other (specify):*							12,215	12,215			7
8	TOTAL General Services	36,675	12,516	2,201,565	2,250,756		2,250,756	154,285	2,405,041			8
	B. Health Care and Programs											
9	Medical Director			50,250	50,250		50,250		50,250			9
10	Nursing and Medical Records	6,292,598	606,180	99,610	6,998,388		6,998,388	28,629	7,027,017			10
10a	Therapy											10a
11	Activities	218,007	19,525	2,247	239,779		239,779		239,779			11
12	Social Services	207,717			207,717		207,717		207,717			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,504	3,504			15
16	TOTAL Health Care and Programs	6,718,322	625,705	152,107	7,496,134		7,496,134	32,133	7,528,267			16
	C. General Administration											
17	Administrative	148,229		1,698,997	1,847,226		1,847,226	(654,744)	1,192,482			17
18	Directors Fees											18
19	Professional Services			274,682	274,682		274,682	181,431	456,113			19
20	Dues, Fees, Subscriptions & Promotions			39,012	39,012		39,012	17,045	56,057			20
21	Clerical & General Office Expenses	291,877	47,826	57,715	397,418		397,418	1,258,552	1,655,970			21
22	Employee Benefits & Payroll Taxes			1,367,858	1,367,858		1,367,858		1,367,858			22
23	Inservice Training & Education							1,046	1,046			23
24	Travel and Seminar							101	101			24
25	Other Admin. Staff Transportation			349	349		349	20,039	20,388			25
26	Insurance-Prop.Liab.Malpractice			1,000,401	1,000,401		1,000,401	6,502	1,006,903			26
27	Other (specify):*							149,819	149,819			27
28	TOTAL General Administration	440,106	47,826	4,439,014	4,926,946		4,926,946	979,791	5,906,737			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,195,103	686,047	6,792,686	14,673,836		14,673,836	1,166,209	15,840,045			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			149,779	149,779		149,779	296,569	446,348			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,076	89,076		89,076	429,783	518,859			32
33	Real Estate Taxes			48,462	48,462		48,462	448,627	497,089			33
34	Rent-Facility & Grounds			978,535	978,535		978,535	(978,377)	158			34
35	Rent-Equipment & Vehicles			61,803	61,803		61,803	5,764	67,567			35
36	Other (specify):*											36
37	TOTAL Ownership			1,327,655	1,327,655		1,327,655	202,366	1,530,021			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		349,441	943,856	1,293,297		1,293,297		1,293,297			39
40	Barber and Beauty Shops			2,719	2,719		2,719	(2,719)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			389,410	389,410		389,410		389,410			42
43	Other (specify):*			710,164	710,164		710,164	(709,939)	225			43
44	TOTAL Special Cost Centers		349,441	2,046,149	2,395,590		2,395,590	(712,658)	1,682,932			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,195,103	1,035,488	10,166,490	18,397,081		18,397,081	655,917	19,052,998			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	(88)	2		4
5	Telephone, TV & Radio in Resident Rooms	(19,141)	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	(1,561)	30		9
10	Interest and Other Investment Income	(16,189)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13,999)	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	(570,090)	43		24
25	Fund Raising, Advertising and Promotional	(30,948)	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	(167,174)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (819,190)		\$	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)	1,475,107		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,475,107		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 655,917		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	labs part a	(55,190)	43	2
3	xray part a	(19,792)	43	3
4	personal item replacement	(1,004)	43	4
5				5
6	collections	(11,088)	19	6
7	barber and beauty	(2,719)	40	7
8	lobbying portion of dues	(840)	20	8
9	Salesforce Computer Consulting	(6,510)	19	9
10				10
11				11
12				12
13	offset shareholder interest	(70,031)	32	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(167,174)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Schaumburg# 0036095

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	(88)	0	0	0	0	0	0	0	0	0	0	(88)	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	26,472	0	0	0	0	0	0	0	0	26,472	5
6	Maintenance	0	0	115,686	0	0	0	0	0	0	0	0	115,686	6
7	Other (specify):*	0	0	12,215	0	0	0	0	0	0	0	0	12,215	7
8	TOTAL General Services	(88)	0	154,373	0	0	0	0	0	0	0	0	154,285	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	28,629	0	0	0	0	0	0	0	0	28,629	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	3,504	0	0	0	0	0	0	0	0	3,504	15
16	TOTAL Health Care and Programs	0	0	32,133	0	0	0	0	0	0	0	0	32,133	16
	C. General Administration													
17	Administrative	0	0	0	(654,744)	0	0	0	0	0	0	0	(654,744)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,598)	0	199,029	0	0	0	0	0	0	0	0	181,431	19
20	Fees, Subscriptions & Promotions	(840)	0	17,885	0	0	0	0	0	0	0	0	17,045	20
21	Clerical & General Office Expenses	0	0	1,258,552	0	0	0	0	0	0	0	0	1,258,552	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	1,046	0	0	0	0	0	0	0	1,046	23
24	Travel and Seminar	0	0	0	101	0	0	0	0	0	0	0	101	24
25	Other Admin. Staff Transportation	0	0	0	20,039	0	0	0	0	0	0	0	20,039	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	6,502	0	0	0	0	0	0	0	6,502	26
27	Other (specify):*	0	0	0	149,819	0	0	0	0	0	0	0	149,819	27
28	TOTAL General Administration	(18,438)	0	1,475,466	(477,237)	0	0	0	0	0	0	0	979,791	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(18,526)	0	1,661,972	(477,237)	0	0	0	0	0	0	0	1,166,209	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-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	\$	Sambell of Schaumburg Limited Partnership	**	\$	\$	1
2	V	30	Depreciation Expense		Sambell of Schaumburg Limited Partnership	**	246,090	246,090	2
3	V	32	Amortization of Mortgage Cost		Sambell of Schaumburg Limited Partnership	**	93,137	93,137	3
4	V	32	Interest		Sambell of Schaumburg Limited Partnership	**	359,786	359,786	4
5	V	33	Property Tax		Sambell of Schaumburg Limited Partnership	**	418,865	418,865	5
6	V	34	Rent	978,377	Sambell of Schaumburg Limited Partnership	**		(978,377)	6
7	V	43	Trust fees		Sambell of Schaumburg Limited Partnership	**	225	225	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V				** The owners of Lexington Health Care Center of Schaumburg Inc. own				12
13	V				100% of Sambell of Schaumburg Limited Partnership				13
14	Total			\$ 978,377			\$ 1,118,103	\$ * 139,726	14

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

Facility Name & ID Number Lexington of Schaumburg# 0036095Report 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.	**	25,726	25,726	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	746	746	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**			18
19	V	6 Management Allocation - salaries		Royal Management Corp.	**	99,811	99,811	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	15,875	15,875	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**			21
22	V	7 Management Allocation - employee benefits		Royal Management Corp.	**	12,215	12,215	22
23	V	10 Medical consultant		Royal Management Corp.	**			23
24	V	10 Management Allocation - salaries		Royal Management Corp.	**	28,629	28,629	24
25	V	15 Management Allocation - employee benefits		Royal Management Corp.	**	3,504	3,504	25
26	V	17 Management Allocation - salaries		Royal Management Corp.	**			26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	54,539	54,539	27
28	V	19 Professional fees		Royal Management Corp.	**	144,490	144,490	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,530	1,530	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	16,355	16,355	30
31	V	21 Management Allocation - salaries		Royal Management Corp.	**	1,224,181	1,224,181	31
32	V	21 Bank charges		Royal Management Corp.	**	6,665	6,665	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	4,004	4,004	33
34	V	21 Postage		Royal Management Corp.	**	5,518	5,518	34
35	V	21 Telephone		Royal Management Corp.	**	18,184	18,184	35
36	V							36
37	V							37
38	V	** The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Royal Management Corp						38
39	Total		\$			\$ 1,661,972	\$ * 1,661,972	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.	**	\$ 1,046	\$ 1,046	15
16	V	24 Travel & seminar		Royal Management Corp.	**	101	101	16
17	V	25 Auto expense		Royal Management Corp.	**	20,039	20,039	17
18	V	26 Insurance general		Royal Management Corp.	**	6,502	6,502	18
19	V	27 Management Allocation - employee benefits		Royal Management Corp.	**	149,819	149,819	19
20	V	30 Depreciation		Royal Management Corp.	**	52,040	52,040	20
21	V	32 Interest		Royal Management Corp.	**	62,379	62,379	21
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	701	701	22
23	V	33 Property taxes		Royal Management Corp.	**	29,762	29,762	23
24	V	34 Rent expense		Royal Management Corp.	**			24
25	V	35 Equipment rental		Royal Management Corp.	**	5,764	5,764	25
26	V	17 Management fees	654,744	Royal Management Corp.	**		(654,744)	26
27	V	35 Auto lease		Royal Management Corp.	**			27
28	V	6 Security Service		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 Schaumburg own 100% of Royal Management Corp.						38
39	Total		\$ 654,744			\$ 328,153	\$ * (326,591)	39

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

Facility Name & ID Number

Lexington of Schaumburg

0036095

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 Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Lexington Square	Lombard	Independent	3
4			Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Life Care of		and Assisted	4
5			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Lombard, LLC		Living Facility	5
6			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Life Care of		Living Facility	7
8					Elmhurst, LLC			8
9					Vesta Management	Lombard	Mgmt. Company	9
10					Group, LLC			10
11					Sambell of	Schaumburg	Real Estate	11
12					Schaumburg		Property	12
13					Ltd. Ptsp.			13
14					Royal Management	Lombard	Mgmt. Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance	16
17					Services, LLC		Company	17
18					Heron Point	Lombard	Mgmt. Company	18
19					Management Corp.			19
20					Samvest of	Lombard	Lessor	20
21					Lombard II, LLC			21
22					North Heron	Lombard	Finance Company	22
23					Investments, LLC			23
24					Lexington Home	Lombard	Home Health	24
25					Health Care, Inc.			25
26					Lexington Hospice	Lombard	Hospice	26
27					Services, LLC			27
28					Lexington Private	Lombard	Healthcare	28
29					Home Care			29
30					Merit Sleep Mgmt, LL	Lombard	Mgmt. Company	30

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		Real Estate	11
12					Lexington Health	Lombard	Property	12
13					Care Systems of			13
14					Lombard Ltd. Ptsp.			14
15					Lexington Health	Orland Park	Real Estate	15
16					Care Systems of		Property	16
17					Orland Park Ltd. Ptsp			17
18					Samvest of	Algonquin	Real Estate	18
19					Algonquin Ltd. Ptsp.		Property	19
20					Curatess, LLC	Lombard	Telemedicine	20
21					Republic Construction	Lombard	Construction Comp	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	2	3	4	5	6		7		8	
					Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	owners took no salaries 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 Schaumburg# 0036095

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	3	Housekeeping Supplies	Bed days available	565,750	8	\$	\$	78,110	\$ 0	1
2	5	Utilities - gas & electric	Bed days available	565,750	8	186,333		78,110	25,726	2
3	5	Utilities - water & sewer	Bed days available	565,750	8	5,398		78,110	745	3
4	5	Utilities - maintenance office	Bed days available	565,750	8			78,110	0	4
5	6	Management Allocation - salaries	Bed days available	565,750	8	722,929	722,929	78,110	99,811	5
6	6	Repairs & maintenance	Bed days available	565,750	8	114,986		78,110	15,875	6
7	6	Scavenger & exterminating	Bed days available	565,750	8			78,110	0	7
8	7	Management Allocation - employee	Bed days available	565,750	8	88,474		78,110	12,215	8
9	10	Medical consultant	Bed days available	565,750	8			78,110	0	9
10	10	Management Allocation - salaries	Bed days available	565,750	8			78,110	0	10
11	15	Management Allocation - employee	Bed days available	565,750	8	25,377		78,110	3,504	11
12	17	Management Allocation - salaries	Bed days available	565,750	8	207,358	207,358	78,110	28,629	12
13	19	Computer consultant & supplies	Bed days available	565,750	8	395,029		78,110	54,539	13
14	19	Professional fees	Bed days available	565,750	8	1,046,538		78,110	144,490	14
15	20	Dues & subscriptions	Bed days available	565,750	8	11,082		78,110	1,530	15
16	20	Advertising - help wanted	Bed days available	565,750	8	118,456		78,110	16,355	16
17	21	Management Allocation - salaries	Bed days available	565,750	8	8,866,730	8,866,730	78,110	1,224,181	17
18	21	Bank charges	Bed days available	565,750	8	48,277		78,110	6,665	18
19	21	Office supplies & printing	Bed days available	565,750	8	29,001		78,110	4,004	19
20	21	Postage	Bed days available	565,750	8	39,969		78,110	5,518	20
21	21	Telephone	Bed days available	565,750	8	131,703		78,110	18,184	21
22										22
23										23
24										24
25	TOTALS					\$ 12,037,640	\$ 9,797,017		\$ 1,661,971	25

Facility Name & ID Number Lexington of Schaumburg# 0036095 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	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	23	Inservice training	Bed days available	8	\$ 7,573	\$	78,110	\$ 1,046	1
2	24	Travel & seminar	Bed days available	8	735		78,110	101	2
3	25	Auto expense	Bed days available	8	145,140		78,110	20,039	3
4	26	Insurance general	Bed days available	8	47,093		78,110	6,502	4
5	27	Management Allocation - employee	Bed days available	8	1,085,139		78,110	149,819	5
6	30	Depreciation	Bed days available	8	376,924		78,110	52,040	6
7	32	Interest	Bed days available	8	451,812		78,110	62,379	7
8	2	Amortization of mortgage costs	Bed days available	8	5,077		78,110	701	8
9	33	Property taxes	Bed days available	8	215,565		78,110	29,762	9
10	34	Rent expense	Bed days available	8			78,110		10
11	35	Equipment rental	Bed days available	8	41,748		78,110	5,764	11
12	17	Management fees	Bed days available	8			78,110		12
13	35	Auto lease	Bed days available	8			78,110		13
14	6	Security Service	Bed days available	8			78,110		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	\$		\$ 328,153	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Midcap Financial Trust		x	Mortgage	varies	5/29/2018	\$ 5,058,006	\$ 5,046,590	5/29/2021	libor+5.25%	\$ 359,788	1	
2												2	
3								Offset Miscellaneous Interest			(112)	3	
4								Miscellaneous Interest			112	4	
5								Health & Family Services interest			9,501	5	
	Working Capital												
6	LHCS of Lombard LP	x		working capital	none	2/20/18	300,000		2/19/20	libor+5.25%	42,716	6	
7	Shareholder	x		working capital	varies	5/11/12	452,000	527,853	demand	variable	27,316	7	
8	West Suburban Bank		x	PPP Loan	none	5/5/20	1,425,272	1,425,272	5/5/22	0.0100	9,541	8	
9	TOTAL Facility Related						\$ 7,235,278	\$ 6,999,715				\$ 448,862	9
	B. Non-Facility Related*												
10								Interest Income offset			(16,189)	10	
11								amortization			93,137	11	
12								allocated from mgmt co			63,080	12	
13								offset shareholder interest			(70,031)	13	
14	TOTAL Non-Facility Related						\$	\$				\$ 69,997	14
15	TOTALS (line 9+line14)						\$ 7,235,278	\$ 6,999,715				\$ 518,859	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.		\$	710,244	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.)		\$	584,571	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(125,673)	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	602,004	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	48,462	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 \$ 57,466 For 2017 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(57,466)	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	497,089	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	571,449	8	
		2016	578,572	9	
		2017	618,691	10	
		2018	628,604	11	
		2019	584,571	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 Schaumburg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036095

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.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 07-27-201-039-0000	nursing facility	\$ 584,571.00	\$ 584,571.00
2. Royol Management Corp (Samvest of Lombard II)		\$	\$
3. 05-01-202-021	Land & Building	\$ 215,565.00	\$ 29,762.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 800,136.00	\$ 614,333.00

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

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

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,541

B. General Construction Type: Exterior concrete Frame steel Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

n/a

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: n/a

2. Number of Years Over Which it is Being Amortized: n/a

3. Current Period Amortization: n/a

4. Dates Incurred: n/a

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	resident care	230,000	1988	\$ 211,532	1
2	Management Company allocation			25,462	2
3	TOTALS	230,000		\$ 236,994	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	214		1990	1990	\$ 6,091,126	\$	35	\$ 174,032	\$ 174,032	\$ 5,348,664	4
5			1995	1995	146,217	4,178	35	4,178		103,356	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements		1991		3,521		10			3,491	9
10	Building improvements		1992		860	25	35	25		706	10
11	Land improvements		1992		5,764		20			5,764	11
12	Land improvements		1992		5,000		20			5,000	12
13	Fan coil units in offices		1996		5,149	147	35	147		3,603	13
14	Basement rehab		1997		14,697		10			14,697	14
15	Brick		1997		1,500	43	35	43		1,005	15
16	Dining room rehab		1997		6,422		10			6,422	16
17	Parking lot repave and restripe		1998		2,777		10			2,777	17
18	Wiring		1998		3,667		10			3,667	18
19	Retile 2nd and 3rd floor corridors		1998		10,100		10			10,100	19
20	Plumbing for HVAC		1998		2,263		5			2,263	20
21	Lobby-floor tile		1999		7,478		10			7,478	21
22	Wallpaper-labor		1999		9,705		10			9,705	22
23	New patio		1999		19,039		15			19,039	23
24	New pay phone/wiring		1999		2,975		10			2,975	24
25	Roof repairs		2000		9,625		10			9,625	25
26	Water heater		2000		6,688		10			6,688	26
27	Automatic door		2000		1,300		10			1,300	27
28	Rehab project - paint resident rooms, carpet hallways, and tile		2000		52,760		10			52,760	28
29	Water heater and storage tanks		2001		12,102		10			12,102	29
30	Garbage area		2001		4,788		20			4,788	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Schaumburg

0036095

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 Roof	2002	\$ 25,600	\$	10	\$	\$	\$ 25,600	37
38 Facility rehab - paint resident rooms, carpet hallways, and tile	2002	327,253	16,363	20	16,363		317,268	38
39 Elevator electronic curtain	2002	4,500		10			4,500	39
40 Elevator upgrade	2002	5,471		10			5,471	40
41 Painting and decorating	2003	13,477		10			13,477	41
42 Electrical improvements	2003	844	42	20	42		718	42
43 Repave parking lot	2004	28,840	721	40	721		11,836	43
44 Dining room remodel - paint	2004	11,387	569	20	569		9,485	44
45 Landscaping	2005	593	30	20	30		462	45
46 HVAC upgrade	2005	17,734	887	20	887		13,378	46
47 Generator upgrade	2005	19,650	983	20	983		15,727	47
48 Window replacement	2005	3,899	195	20	195		2,990	48
49 Flooring replacement	2005	1,483	74	20	74		1,135	49
50 Lobby, lounge and reception rehab	2005	27,180	1,359	20	1,359		20,385	50
51 Therapy room rehab	2005	35,135	1,757	20	1,757		26,646	51
52 Create first floor therapy room	2005	32,045	1,602	20	1,602		25,366	52
53 Create transitional care unit	2005	29,170	1,458	20	1,458		21,993	53
54 Basement renovation	2005	5,996	300	20	300		4,500	54
55 Countertops	2005	845		5			845	55
56 Interior signs	2005	4,412		5			4,412	56
57 Window treatments	2005	912		5			912	57
58 Wall covering	2005	439		5			439	58
59 Panel Brick Replacement	2006	17,387	869	20	869		12,311	59
60 Landscaping Enhancement	2006	7,608	507	15	507		7,225	60
61 HVAC	2006	12,232	612	20	612		8,619	61
62 Sink	2006	2,331	117	20	117		1,715	62
63 TCU Units	2006	16,379	819	20	819		11,671	63
64 Employee lunch room rehab	2006	8,127	406	20	406		5,888	64
65 Dining room rehab	2006	2,357	118	20	118		1,711	65
66 Basement renovation	2006	9,465	473	20	473		6,780	66
67 Oxygen room rehab	2006	2,664	133	20	133		1,907	67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 7,100,938	\$ 34,787		\$ 208,819	\$ 174,032	\$ 6,223,347	70

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

Facility Name & ID Number Lexington of Schaumburg

0036095

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		\$ 7,100,938	\$ 34,787		\$ 208,819	\$ 174,032	\$ 6,223,347	1
2	Replace Sidewalk	2007	14,625	731	20	731		9,808	2
3	Landscaping	2007	15,700	785	20	785		10,401	3
4	Emergency A/C	2007	15,545	777	20	777		10,554	4
5	1st Floor Remodel - Carpentry, Flooring, Plumbing, Paint	2007	676,072		40	16,902	16,902	225,360	5
6	Bathroom Faucets	2007	12,358	618	20	618		8,085	6
7	Landscaping	2008	10,000	667	15	667		8,448	7
8	Roofing	2008	11,950	598	20	598		7,375	8
9	HVAC-Air tank	2008	2,671	67	40	67		832	9
10	HVAC-Spot Cooler	2008	3,790	95	40	95		1,140	10
11	Electrical-Fire panel upgrade	2008	71,077	1,777	40	1,777		22,509	11
12	Electrical-Replace Gasket	2008	6,125		10			6,125	12
13	2nd floor remodel-carpentry, painting, plumbing,electrical	2008	558,949		27	20,325	20,325	247,288	13
14	Panel Brick Replacement	2009	184,595	9,230	20	9,230		101,530	14
15	Land Improvements	2009	12,400	620	20	620		7,130	15
16	Parking Lot	2009	4,600	230	20	230		2,645	16
17	Front Entrance Improvements	2009	28,660	717	40	717		8,126	17
18	HVAC Quick Connectors	2009	5,591	140	40	140		1,598	18
19	HVAC Spot Cooler	2009	4,254	106	40	106		1,210	19
20	1st floor Admin-Tile,electical	2009	11,679	292	40	292		5,912	20
21	Kitchen Plumbing	2009	8,210		10			8,210	21
22	Fire Alarm Electrical	2009	31,710	793	40	793		8,987	22
23	Glass & Mirror Med Room	2009	2,836		10			2,836	23
24	2nd Floor Remodel -Carpentry	2009	14,592	730	20	730		8,648	24
25	Patio Pergola	2009	9,505	475	20	475		5,344	25
26	Patio Fence	2009	5,100	255	20	255		2,826	26
27	Landscaping	2009	17,332	1,155	15	1,155		13,283	27
28	3rd Floor Remodel-Carpentry, flooring,electrical,painting	2009	627,866		27	22,832	22,832	256,860	28
29	Landscaping Enhancement	2010	14,885	992	15	992		10,582	29
30	Physician Office carpentry	2010	4,849	177	27	177		1,785	30
31	Kitchen Pantries construction	2010	5,676	207	27	207		2,070	31
32	HVAC Admin Office	2010	7,357	268	27	268		2,714	32
33	Loading Ramp/Foundation Wall	2010	3,000	200	15	200		2,183	33
34	TOTAL (lines 1 thru 33)		\$ 9,504,497	\$ 57,489		\$ 291,580	\$ 234,091	\$ 7,235,751	34

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

Facility Name & ID Number Lexington of Schaumburg

0036095

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		\$ 9,504,497	\$ 57,489		\$ 291,580	\$ 234,091	\$ 7,235,751	1
2	Hallway doors	2010	14,916	1,364	10	1,364		14,916	2
3	Library/Lounge carpentry,electrical,painting,signs	2010	5,009	183	27	183		1,830	3
4	Basement carpentry	2010	3,945	144	27	144		1,560	4
5	Patio/Pergola	2010	12,005	996	10	996		12,005	5
6	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	50,935	2,091	27	2,091		30,416	6
7									7
8	Fire Dampers	2011	65,681		27	2,388	2,388	21,694	8
9	Parking Lot Remodel (Adjusted for Capital Audit)	2011	141,596		27	6,173	6,173	55,557	9
10	Kitchen Hood/duct work	2011	22,604	822	27	822		7,603	10
11	Payroll Office Remodel - Electrical and Wiring	2011	2,696	98	27	98		939	11
12	Metal edging & drain tile	2011	5,442	363	27	363		3,297	12
13	Repair doors on 1st floor	2011	39,986	1,454	27	1,454		13,086	13
14	Office Remodel - carpentry,flooring,electrical,painting,signs	2011	22,584	821	27	821		7,457	14
15	Exhaust Study HVAC	2011	5,736	209	27	209		2,037	15
16	Pipe and fitting	2011	4,375	159	27	159		1,471	16
17	Laundry Room Remodel - Flooring, Ceiling Tiles and Painting	2011	9,388	341	27	341		3,211	17
18	New Marker Boards	2011	9,887	360	27	360		3,570	18
19	Interior Doors	2011	6,183	225	27	225		2,081	19
20	2nd Floor Doors	2011	27,318	993	27	993		9,268	20
21									21
22	End Air Louvers	2012	3,744		27	136	136	1,190	22
23	Parking Lot (Adjusted for Capital Audit)	2012	-					-	23
24	Kitchen steel hood, floor, sink, drywall and tile	2012	7,307	266	27	266		2,321	24
25	Fire Pump basement	2012	3,461	126	27	126		1,102	25
26	Replace holding tank	2012	21,985	799	27	799		6,925	26
27	1st floor door opener	2012	8,646	314	27	314		2,643	27
28									28
29	EMR Wiring - Entire Facility	2013	20,058	729	27	729		5,225	29
30	Landscaping - Stump Removal/Trees	2013	42,118		15	2,808	2,808	20,186	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,062,102	\$ 70,346		\$ 315,942	\$ 245,596	\$ 7,467,341	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		\$ 10,062,102	\$ 70,346		\$ 315,942	\$ 245,596	\$ 7,467,341	1
2									2
3	Elevator Renovation - Centrally located	2014	183,936	6,689	27	6,689		41,248	3
4	R/M Reclass: Adding Double Egress Doors (Basement)	2014	3,279		27	121	121	787	4
5	R/M Reclass: Install container fence & garbage container	2014	5,674		15	378	378	2,457	5
6	R/M Reclass: Cast iron waste line for grease trap (kitchen)	2014	8,000		27	296	296	1,924	6
7	R/M Reclass: Patching and crack sealing (parking lot)	2014	9,700		20	485	485	3,153	7
8	Kitchen Sewer Line Addition	2014	7,075	193	27	193		1,351	8
9									9
10	EMR Wiring - Entire Facility	2015	5,896	214	6	214		1,195	10
11	R/M Reclass: Decorating & Tile for Service Ramp	2015	3,503		20	176	176	966	11
12	R/M Reclass: Striping & Sealing Parking Lot	2015	5,400		20	270	270	1,487	12
13	R/M Reclass: Landscaping to the Entire property	2015	13,693		15	913	913	5,021	13
14									14
15	Electrical Wiring - Entire Facility	2016	4,474	447	10	447		2,014	15
16	Chair Rail Installation in First Floor Rooms	2016	11,516	419	27.5	419		1,781	16
17	R/M Reclass: Underground sanitary pipe replacement in the lower	2016	10,500		15	700	700	3,150	17
18	level entrance to ramp area and back elevator hallway								18
19	R/M: Rusted end dome caps repair (cutting, grinding, welding)	2016	2,750		15	183	183	824	19
20	in the mechanical room								20
21									21
22	Window replacement's	2017	20,739	1,037	20	1,037		3,197	22
23	R/M Reclass : Furnish and install freeze door - kitchen	2017	2,845		27	105	105	368	23
24	R/M Reclass : Removal of Trees and Stumps	2017	5,225		15	348	348	1,218	24
25	R/M Reclass : Cooling Water Treatment, Water Biocide	2017	5,571		10	557	557	1,950	25
26	R/M Reclass : Furnish, Remove & Install 15 doors across the	2017	4,187		27	155	155	543	26
27	building (1st floor utility room 2nd floor staff restroom,								27
28	2nd floor tub/shower room 2nd floor lounge, Room 310,								28
29	Room 316, 3rd floor servery, 3rd floor linen room,								29
30	3rd floor tub/shower, 3rd floor staff restroom,								30
31	LL Equip room, 1st floor staff restroom)								31
32									32
33	Reconcile to book								33
34	TOTAL (lines 1 thru 33)		\$ 10,376,065	\$ 79,345		\$ 329,628	\$ 250,283	\$ 7,541,975	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,376,065	\$ 79,345		\$ 329,628	\$ 250,283	\$ 7,541,975	1
2									2
3	Mill and resurface pavement - building exterior	2019	50,150	2,006	25	2,006		3,009	3
4	HVAC - York Chiller #2 - Compressor & suction filter dryer	2019	23,387	3,341	7	3,341		4,176	4
5									5
6	R&M reclass - Removal of trees and branches	2019	2,800		15	187	187	249	6
7	R&M reclass - removal of trees and planting of new trees	2019	3,310		15	221	221	295	7
8	R&M reclass - replace and install new trees	2019	8,005		15	534	534	667	8
9	R&M reclass - replace sprinklers/sprinkler heads hallways	2019	2,687		25	107	107	152	9
10									10
11	Renovate 1st floor - carpentry (frame, finish, trim), millwork,	2020	477,162		20				11
12	doors, wallpaper, flooring, HVAC, electrical, window treat, painting								12
13									13
14	(2) York Water Cooled Chiller	2020	324,182	27,015	7	27,015		27,015	14
15									15
16	reconcile to book			(794)			794		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,267,748	\$ 110,913		\$ 363,039	\$ 252,126	\$ 7,577,538	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 12E, Carried Forward		\$ 11,267,748	\$ 110,913		\$ 363,039	\$ 252,126	\$ 7,577,538	1
2	Building - management company	2002	352,339		40	12,689	12,689	164,643	2
3	HVAC, electrical, security system - management company	2003	3,095		30	153	153	2,467	3
4	key card system - management company	2004	486		20	39	39	355	4
5	VAV TX controls - management company	2005	148		20	12	12	105	5
6	Interior signs - management company	2006	108		20	12	12	92	6
7	Building - management company	2008	15,254		20	568	568	6,713	7
8	Building - management company	2009	2,831		20	250	250	1,623	8
9	Building - management company	2010	2,791		20	196	196	1,447	9
10	Building - management company	2011	2,192		20	166	166	899	10
11	Building - management company	2012	6,452		20	389	389	1,926	11
12	Building - management company	2013	5,724		20	263	263	2,182	12
13	Building - management company	2014	3,097		20	504	504	1,945	13
14	Building - management company	2015	545		20	108	108	361	14
15	Building - management company	2016	8,989		20	1,085	1,085	2,994	15
16	Building - management company	2017	5,669		20	400	400	903	16
17	Building - management company	2018	1,018		20	60	60	111	17
18	Building - management company	2019	18,362		20	498	498	918	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)		\$ 11,696,848	\$ 110,913		\$ 380,431	\$ 269,518	\$ 7,767,222	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	\$285,786	\$16,257	\$16,257	\$	various	\$157,633	71
72	Current Year Purchases	77,711	22,609	22,609		5	22,609	72
73	Fully Depreciated Assets	852,301					852,301	73
74	allocated from mgmt co	682,255		22,778	22,778		527,072	74
75	TOTALS	\$1,898,053	\$38,866	\$61,644	\$22,778		\$1,559,615	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			64,262		4,273	4,273		49,296	79
80	TOTALS			\$ 64,262	\$	\$ 4,273	\$ 4,273		\$ 49,296	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)			\$13,896,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$149,779	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$446,348	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$296,569	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$9,376,133	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: \$ 10,862
- Description: see attachment 14a
- ☐ YES☐ NO

(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					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.

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	\$	7,404	\$ 336,557	\$	7,404	\$ 336,557	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,419	110,315		2,419	110,315	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2 & 3)	hrs		7,205	414,623		7,205	414,623	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				308,778		308,778	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>ambulance</u>	39(3)				7,053			7,053	12
13	Other (specify): <u>see sch 16a</u>	39(2)					40,663		40,663	13
14	TOTAL			\$	17,028	\$ 868,548	\$ 349,441	17,028	\$ 1,217,989	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	\$ 215,919	\$ 357,536	1
2	Cash-Patient Deposits	86,482	86,482	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,195,521)	3,363,651	3,363,651	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,554	6,554	6
7	Other Prepaid Expenses	53,769	53,769	7
8	Accounts Receivable (owners or related parties)	(2,521,530)	(2,199,892)	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,204,845	\$ 1,668,100	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		211,532	13
14	Buildings, at Historical Cost		6,091,126	14
15	Leasehold Improvements, at Historical Cost	2,424,621	4,593,139	15
16	Equipment, at Historical Cost	656,394	1,149,521	16
17	Accumulated Depreciation (book methods)	(1,858,420)	(8,539,957)	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	720,012	720,012	22
23	Other(specify): <u>deferred financing</u>		38,807	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,942,607	\$ 4,264,180	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,147,452	\$ 5,932,280	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,682,703	\$ 1,682,703	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	104,004	104,004	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	331,484	331,484	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,537	17,537	31
32	Accrued Real Estate Taxes(Sch.IX-B)		602,004	32
33	Accrued Interest Payable	9,539	39,957	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>see schedule 17a</u>	12,511,432	6,443,910	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 14,656,699	\$ 9,221,599	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,953,125	1,953,127	39
40	Mortgage Payable		5,046,590	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)	\$ 1,953,125	\$ 6,999,717	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,609,824	\$ 16,221,316	46
47	TOTAL EQUITY (page 18, line 24)	\$ (13,462,372)	\$ (10,289,036)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,147,452	\$ 5,932,280	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (10,908,032)	1
2	Restatements (describe):		2
3	post closing adjustments	(185,534)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (11,093,566)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,368,806)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,368,806)	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)	\$ (13,462,372)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Schaumburg# 0036095Report 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	\$ 20,420,358	1
2	Discounts and Allowances for all Levels	(10,170,243)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,250,115	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,908,154	6
7	Oxygen	63,720	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,971,874	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	12
13	Barber and Beauty Care	4,734	13
14	Non-Patient Meals	88	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,925	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	202,574	19
20	Radiology and X-Ray		20
21	Other Medical Services	899,175	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,371,499	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,189	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,189	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>miscellaneous</u>	35,369	28
28a	<u>provider relief funds</u>	1,383,229	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,418,598	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,028,275	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,250,756	31
32	Health Care	7,496,134	32
33	General Administration	4,975,408	33
	B. Capital Expense		
34	Ownership	1,279,193	34
	C. Ancillary Expense		
35	Special Cost Centers	2,006,180	35
36	Provider Participation Fee	389,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,397,081	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,368,806)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,368,806)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,905,208	44
45	Private Pay - Net Inpatient Revenue	1,350,886	45
46	Medicare - Net Inpatient Revenue	1,046,052	46
47	Other-(specify) <u>mgd care, hospice, insurance</u>	947,969	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,250,115	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	1,391	2,043	\$ 148,651	\$ 72.76	1
2	Assistant Director of Nursing	1,481	2,042	101,083	49.50	2
3	Registered Nurses	36,338	57,379	2,215,152	38.61	3
4	Licensed Practical Nurses	13,831	22,559	763,224	33.83	4
5	CNAs & Orderlies	87,276	131,829	2,602,144	19.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,585	2,032	54,532	26.84	9
10	Activity Assistants	8,492	11,583	163,475	14.11	10
11	Social Service Workers	6,143	7,858	207,717	26.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,296	1,653	36,675	22.19	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,570	2,019	148,229	73.42	20
21	Assistant Administrator					21
22	Other Administrative	4,889	6,811	135,531	19.90	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	3,640	5,526	96,180	17.40	31
32	Other Health Care(specify)					32
33	Other(specify) see sched 20a	12,955	18,576	522,510	28.13	33
34	TOTAL (lines 1 - 33)	180,887	271,910	\$ 7,195,103 *	\$ 26.46	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 80,403	1-3	35
36	Medical Director	monthly	50,250	9-3	36
37	Medical Records Consultant	monthly	390	10-3	37
38	Nurse Consultant	monthly	1,152	10-3	38
39	Pharmacist Consultant	monthly	24,902	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	1,679	19-3	44
45	Social Service Consultant	monthly	1,981	19-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 160,757		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	198	\$ 11,852	10-3	50
51	Licensed Practical Nurses	32	1,501	10-3	51
52	Certified Nurse Assistants/Aides	2,052	57,551	10-3	52
53	TOTAL (lines 50 - 52)	2,282	\$ 70,904		53

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. IHCA 6826 yes

(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?
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. \$ 36,874 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. \$ 389,410
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.