



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

# 0038083 Report Period Beginning: 1/1/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			19,073	19,073	8
9	SNF/PED					9
10	ICF	4,592	3,823	51	8,466	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,592	3,823	19,124	27,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.87%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO  Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 7/31/92

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 120 and days of care provided 12,976

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, IL # 0038083 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	402,058	21,048	1,840	424,946		424,946	-	424,946		1
2	Food Purchase		182,315		182,315		182,315	(1,859)	180,456		2
3	Housekeeping	364,342	26,314	-	390,656		390,656	164	390,820		3
4	Laundry	-	7,798	-	7,798		7,798	-	7,798		4
5	Heat and Other Utilities			203,945	203,945		203,945	4,663	208,608		5
6	Maintenance	43,542	-	137,022	180,564		180,564	76,052	256,616		6
7	Other (specify):* <u>Alloc. Mgmt Co. Bene</u>	-	-	-				7,637	7,637		7
8	<b>TOTAL General Services</b>	809,942	237,475	342,807	1,390,224		1,390,224	86,657	1,476,881		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	-	-	33,438	33,438		33,438	-	33,438		9
10	Nursing and Medical Records	3,815,662	315,592	140,114	4,271,368		4,271,368	13,952	4,285,320		10
10a	Therapy	-	-	-				-			10a
11	Activities	91,364	9,704	7,125	108,193		108,193	-	108,193		11
12	Social Services	94,466	-	3,171	97,637		97,637	-	97,637		12
13	CNA Training	-	-	-				-			13
14	Program Transportation	-	-	-				-			14
15	Other (specify):* <u>Alloc. Mgmt Co. Bene</u>	-	-	-				1,461	1,461		15
16	<b>TOTAL Health Care and Programs</b>	4,001,492	325,296	183,848	4,510,636		4,510,636	15,413	4,526,049		16
	<b>C. General Administration</b>										
17	Administrative	128,949	-	1,362,108	1,491,057		1,491,057	(1,350,486)	140,571		17
18	Directors Fees			-				-			18
19	Professional Services			149,561	149,561		149,561	36,126	185,687		19
20	Dues, Fees, Subscriptions & Promotions			27,335	27,335		27,335	7,831	35,166		20
21	Clerical & General Office Expenses	112,206	19,420	94,961	226,587		226,587	549,786	776,373		21
22	Employee Benefits & Payroll Taxes			730,700	730,700		730,700	-	730,700		22
23	Inservice Training & Education			9,834	9,834		9,834	319	10,153		23
24	Travel and Seminar			-				413	413		24
25	Other Admin. Staff Transportation		-	1,887	1,887		1,887	9,185	11,072		25
26	Insurance-Prop.Liab.Malpractice			267,206	267,206		267,206	1,663	268,869		26
27	Other (specify):* <u>Alloc. Mgmt Co. Bene</u>	-	-	-				58,302	58,302		27
28	<b>TOTAL General Administration</b>	241,155	19,420	2,643,592	2,904,167		2,904,167	(686,861)	2,217,306		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,052,589	582,191	3,170,247	8,805,027		8,805,027	(584,791)	8,220,236		29

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

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. #0038083 Report Period Beginning: 1/1/18 Ending: 12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			81,260	81,260		81,260	245,931	327,191			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			(15,387)	(15,387)		(15,387)	334,023	318,636			32
33	Real Estate Taxes			-				301,450	301,450			33
34	Rent-Facility & Grounds			1,077,782	1,077,782		1,077,782	(1,075,285)	2,497			34
35	Rent-Equipment & Vehicles			79,396	79,396		79,396	1,080	80,476			35
36	Other (specify):*			-				-				36
37	<b>TOTAL Ownership</b>			1,223,051	1,223,051		1,223,051	(192,801)	1,030,250			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	533,310	1,875,139	2,408,449		2,408,449	-	2,408,449			39
40	Barber and Beauty Shops	-	-	8,200	8,200		8,200	-	8,200			40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			150,758	150,758		150,758	-	150,758			42
43	Other (specify):* <b>Non-Allowable Cos</b>	788	-	874,211	874,999		874,999	(874,999)				43
44	<b>TOTAL Special Cost Centers</b>	788	533,310	2,908,308	3,442,406		3,442,406	(874,999)	2,567,407			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,053,377	1,115,501	7,301,606	13,470,484		13,470,484	(1,652,591)	11,817,893			45

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

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

# 0038083

Report Period Beginning:

1/1/18

Ending:

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**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,859)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,123)	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	1,959	30		9
10	Interest and Other Investment Income	(9,436)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,708)	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	(23,414)	43		18
19	Entertainment				19
20	Contributions	(1,700)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(742,565)	43		24
25	Fund Raising, Advertising and Promotional	(30,251)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(437)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See PG5A</u>	(85,118)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (909,652)		\$	30

<b>BHF USE ONLY</b>					
48		49		50	
				51	
					52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(742,939)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (742,939)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,652,591)		37

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

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

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

Lexington Health Care Center of LaGrange, Inc.

ID# 0038083

Report Period Beginning: 1/1/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Labs-Part A	\$ (29,281)	43	1
2	X-Rays-Part A	(26,032)	43	2
3	Diagnostics Managed Care	(3,700)	43	3
4	Trust Fees	(275)	43	4
5	Collections	(14,108)	19	5
6	Out of Period & Non-Allowable Legal	(757)	19	6
7	Marketing Salary	(788)	43	7
12	Salesforce Disallow	(8,705)	19	12
13	Disallowed Lobbying	(1,472)	20	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
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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	<b>Total</b>	(85,118)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Fees	\$	Sambell of LaGrange Limited Partnership	**	\$ 202	\$ 202	1
2	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	230,182	230,182	2
3	V	32 Interest Expense		Sambell of LaGrange Limited Partnership	**	268,969	268,969	3
4	V	32 Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	64,673	64,673	4
5	V	33 Property Taxes		Sambell of LaGrange Limited Partnership	**	297,782	297,782	5
6	V	34 Rental Income	1,077,782	Sambell of LaGrange Limited Partnership	**		(1,077,782)	6
7	V	43 Trust Fees		Sambell of LaGrange Limited Partnership	**	275	275	7
8	V	43 Unrealized loss on FMV swap		Sambell of LaGrange Limited Partnership	**			8
9	V	43 Gain/Loss on Sale on Disposal		Sambell of LaGrange Limited Partnership	**			9
10	V			Sambell of LaGrange Limited Partnership	**			10
11	V							11
12	V			** The owners of Lexington Health Care Center of LaGrange, Inc. own 100%				12
13	V			of Sambell of LaGrange Limited Partnership.				13
14	Total		\$ 1,077,782			\$ 862,083	\$ * (215,699)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3		Royal Management Corp.	**	\$ 164	\$ 164	15	
16	V	5		Royal Management Corp.	**	4,246	4,246	16	
17	V	5		Royal Management Corp.	**	112	112	17	
18	V	5		Royal Management Corp.	**	305	305	18	
19	V	6		Royal Management Corp.	**	71,448	71,448	19	
20	V	6		Royal Management Corp.	**	4,419	4,419	20	
21	V	6		Royal Management Corp.	**	185	185	21	
22	V	7		Royal Management Corp.	**	7,637	7,637	22	
23	V	10		Royal Management Corp.	**	282	282	23	
24	V	10		Royal Management Corp.	**	13,670	13,670	24	
25	V	15		Royal Management Corp.	**	1,461	1,461	25	
26	V	17		Royal Management Corp.	**	11,622	11,622	26	
27	V	19		Royal Management Corp.	**	11,759	11,759	27	
28	V	19		Royal Management Corp.	**	47,735	47,735	28	
29	V	20		Royal Management Corp.	**	887	887	29	
30	V	20		Royal Management Corp.	**	8,416	8,416	30	
31	V	21		Royal Management Corp.	**	533,828	533,828	31	
32	V	21		Royal Management Corp.	**	1,449	1,449	32	
33	V	21		Royal Management Corp.	**	4,930	4,930	33	
34	V	21		Royal Management Corp.	**	2,441	2,441	34	
35	V	21		Royal Management Corp.	**	7,138	7,138	35	
36	V							36	
37	V							37	
38	V	**The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 734,134	\$ *	734,134	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	23 Inservice Training	\$	Royal Management Corp.	**	\$ 319	\$ 319	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	413	413	16	
17	V	25 Auto expense		Royal Management Corp.	**	9,185	9,185	17	
18	V	26 Insurance general		Royal Management Corp.	**	1,663	1,663	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	58,302	58,302	19	
20	V	30 Depreciation		Royal Management Corp.	**	13,790	13,790	20	
21	V	32 Interest		Royal Management Corp.	**	8,538	8,538	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	1,279	1,279	22	
23	V	33 Property taxes		Royal Management Corp.	**	3,668	3,668	23	
24	V	34 Rent expense		Royal Management Corp.	**	2,497	2,497	24	
25	V	35 Equipment rental		Royal Management Corp.	**	959	959	25	
26	V	17 Management fees	1,362,108	Royal Management Corp.	**	0	(1,362,108)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	121	121	27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V	**The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.							36
37	V							37	
38	V							38	
39	Total		\$ 1,362,108			\$ 100,734	\$ * (1,261,374)	39	

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

Facility Name &amp; ID Number

Lexington Health Care Center of LaGrange, Inc.

# 0038083

Report Period Beginning:

1/1/18

Ending:

12/31/18

## VII. RELATED PARTIES

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

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

Facility Name &amp; ID Number

Lexington Health Care Center of LaGrange, Inc.

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## VII. RELATED PARTIES

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

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, # 0038083 Report Period Beginning: 1/1/18 Ending: 12/31/18

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Samatas	Owner/officer	Administrative	33.33	See Sch 7A	See Sch 7B	See Sch 7B	Salary	\$ 2,239	L17, C7	1
2	James Samatas	Owner/officer	Admin/Plant Ops	33.33	See Sch 7A	See Sch 7B	See Sch 7B	Salary	2,985	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Sch 7A	See Sch 7B	See Sch 7B	Salary	2,985	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0	See Sch 7A	See Sch 7B	See Sch 7B	Salary	2,239	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0	See Sch 7A	See Sch 7B	See Sch 7B	Salary	0	L17, C7	5
6	Phil Thiem	Executive Committee	Administrative	0	See Sch 7A	See Sch 7B	See Sch 7B	Salary	472	L17, C7	6
7	Jeremy Samatas	Executive Committee	Administrative	0	See Sch 7A	See Sch 7B	See Sch 7B	Salary	702	L17, C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,622		13

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

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Royal Management Corp.  
 Street Address 665 W. North Avenue, Suite 500  
 City / State / Zip Code Lombard, IL 60148  
 Phone Number (630) 458-4700  
 Fax Number (630) 458-4796

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping supplies	Bed Days Available	722,335	10	\$ 2,704	\$ 0	43,800	\$ 164	1
2	5	Utilities - gas & electric	Bed Days Available	722,335	10	70,024	0	43,800	4,246	2
3	5	Utilities - water & sewer	Bed Days Available	722,335	10	1,855	0	43,800	112	3
4	5	Utilities - maintenance office	Bed Days Available	722,335	10	5,025	0	43,800	305	4
5	6	Management allocation - salaries	Bed Days Available	722,335	10	1,178,292	1,178,292	43,800	71,448	5
6	6	Repairs & maintenance	Bed Days Available	722,335	10	72,883	0	43,800	4,419	6
7	6	Scavenger & exterminating	Bed Days Available	722,335	10	3,054	0	43,800	185	7
8	7	Management allocation - employees	Bed Days Available	722,335	10	125,945	0	43,800	7,637	8
9	10	Medical consultant	Bed Days Available	722,335	10	4,651	0	43,800	282	9
10	10	Management allocation - salaries	Bed Days Available	722,335	10	225,449	225,449	43,800	13,670	10
11	15	Management allocation - employees	Bed Days Available	722,335	10	24,098	0	43,800	1,461	11
12	17	Management allocation - salaries	Bed Days Available	722,335	10	191,670	191,670	43,800	11,622	12
13	19	Computer consultant & supplies	Bed Days Available	722,335	10	193,924	0	43,800	11,759	13
14	19	Professional fees	Bed Days Available	722,335	10	787,232	0	43,800	47,735	14
15	20	Dues & subscriptions	Bed Days Available	722,335	10	14,624	0	43,800	887	15
16	20	Advertising - help wanted	Bed Days Available	722,335	10	138,799	0	43,800	8,416	16
17	21	Management allocation - salaries	Bed Days Available	722,335	10	8,803,710	8,803,710	43,800	533,828	17
18	21	Bank charges	Bed Days Available	722,335	10	23,902	0	43,800	1,449	18
19	21	Office supplies & printing	Bed Days Available	722,335	10	81,306	0	43,800	4,930	19
20	21	Postage	Bed Days Available	722,335	10	40,262	0	43,800	2,441	20
21	21	Telephone	Bed Days Available	722,335	10	117,714	0	43,800	7,138	21
22										22
23										23
24										24
25	TOTALS					\$ 12,107,123	\$ 10,399,121		\$ 734,134	25

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Royal Management Corp.  
 Street Address 665 W. North Avenue, Suite 500  
 City / State / Zip Code Lombard, IL 60148  
 Phone Number (630) 458-4700  
 Fax Number (630) 458-4796

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	23	Inservice Training	Bed Days Available	722,335	10	\$ 5,261	\$ 43,800	\$ 319	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	6,817	43,800	413	2
3	25	Auto expense	Bed Days Available	722,335	10	151,483	43,800	9,185	3
4	26	Insurance general	Bed Days Available	722,335	10	27,426	43,800	1,663	4
5	27	Management allocation - employees	Bed Days Available	722,335	10	961,496	43,800	58,302	5
6	30	Depreciation	Bed Days Available	722,335	10	227,415	43,800	13,790	6
7	32	Interest	Bed Days Available	722,335	10	140,807	43,800	8,538	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	21,094	43,800	1,279	8
9	33	Property taxes	Bed Days Available	722,335	10	60,494	43,800	3,668	9
10	34	Rent expense	Bed Days Available	722,335	10	41,178	43,800	2,497	10
11	35	Equipment rental	Bed Days Available	722,335	10	15,819	43,800	959	11
12	35	Auto Lease	Bed Days Available	722,335	10	1,993	43,800	121	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,661,283	\$	\$ 100,734	25

Facility Name & ID Number Lexington Health Care Center of LaGrange, I # 0038083 Report Period Beginning: 1/1/18 Ending: 12/31/18

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2	MB Financial		X	Mortgage	Varies	9/15/2017	\$ 4,481,325	\$ 4,257,262	9/15/2019	Libor + 3.5%	235,171									
3																				
4	Sambell of Elmhurt II LP	X		Loan	Varies	9/15/2017	329,288	318,232	9/15/2019	Libor + 3.5%	18,411									
5				Finance Charge - Insurance Policy							1,864									
<b>Working Capital</b>																				
6	MB Financial		X	Line of Credit	Various	9/15/2017	2,000,000		9/15/2019	Libor + 2.5%										
7																				
8																				
9	<b>TOTAL Facility Related</b>						\$ 6,810,613	\$ 4,575,494			\$ 255,446									
<b>B. Non-Facility Related*</b>																				
10								Amortization of Loan Cost			64,673									
11								Interest Income offset			(9,436)									
12								Non-Allowable Finance Charge			(1,864)									
13								Allocated from Mgmt Co.			9,817									
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 63,190									
15	<b>TOTALS (line 9+line14)</b>						\$ 6,810,613	\$ 4,575,494			\$ 318,636									

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

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2017 report.			\$	<u>477,000</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017		\$	<u>400,968</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>(76,032)</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>412,998</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<u>24,805</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>63,989</u> For <u>2015</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		Alloc Fr. Mgmt Co.		<u>3,668</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>301,450</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2013	<u>355,813</u>	8		
	2014	<u>363,484</u>	9		
	2015	<u>369,109</u>	10		
	2016	<u>386,004</u>	11		
	2017	<u>400,968</u>	12		
<a href="#">See attached real estate accrual sheet</a>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2017	\$		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.**

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

FACILITY NAME Lexington Health Care Center of LaGrange, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-08-207-017-0000</u>	<u>Land &amp; Building</u>	\$ <u>229,003.55</u>	\$ <u>229,003.55</u>
2. <u>18-08-207-018-0000</u>	<u>Land &amp; Building</u>	\$ <u>171,964.05</u>	\$ <u>171,964.05</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
4. <u>05-01-202-021</u>	<u>Land &amp; Building</u>	\$ <u>253,934.00</u>	\$ <u>3,668.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>654,901.60</u>	\$ <u>404,635.60</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

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

# 0038083

Report Period Beginning:

1/1/18

Ending:

12/31/18

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 50,072 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>40,000</u>	<u>1991</u>	<u>\$ 500,000</u>	1
2	<u>Management Company Allocation</u>			<u>10,030</u>	2
3	<b>TOTALS</b>	<b>40,000</b>		<b>\$ 510,030</b>	<b>3</b>

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

# 0038083

Report Period Beginning:

1/1/18

Ending:

12/31/18

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		1992	1992	\$ 2,661,448	\$ -	35	\$ 76,041	\$ 76,041	\$ 2,015,092	4
5			1995	1995	79,363	-	10	-		79,363	5
6			2005	2005	2,321,014	-	21	110,524	110,524	1,492,076	6
7						-		-			7
8						-		-			8
	<b>Improvement Type**</b>										
9		Land Improvements	1992		1,152	-	20	-		1,152	9
10		Building Improvements	1992		2,714	-	31	-		2,714	10
11		Building Improvements	1993		2,901	-	35	83	83	2,156	11
12		Leasehold Improvements	1994		6,402	-	10	-		6,402	12
13		Leasehold Improvements - Corner Guards	1996		2,195	-	10	-		2,122	13
14		Wiring	1998		3,378	-	10	-		3,378	14
15		Resurface & Restripe Parking Lot	1998		3,753	-	10	-		3,753	15
16		Lobby Tile	1998		19,488	-	10	-		19,488	16
17		Resurface & Restripe Parking Lot	2000		1,997	-	10	-		1,997	17
18		Automatic Door	2000		1,300	-	10	-		1,300	18
19		Kitchen Rehab	2001		1,441	-	10	-		1,441	19
20		Infrared curtains for elevator	2001		3,000	-	10	-		3,000	20
21		Dining room, resident rooms, and corridors renovation	2002		150,083	7,505	20	7,505		120,701	21
22		Elevator upgrade	2002		5,398	-	10	-		5,398	22
23		Air conditioner compressor	2003		9,218	-	10	-		9,218	23
24		Sidewalk and fencing	2005		46,701	2,335	20	2,335		30,744	24
25		HVAC	2005		8,141	407	20	407		5,325	25
26		Wiring	2005		4,506	225	20	225		2,982	26
27		Lobby, lounge and reception renovations	2005		24,362	1,218	20	1,218		16,240	27
28		1st floor new dining room, floors, ceilings, wallcoverings, doors	2005		326,862	-	20	16,343	16,343	212,459	28
29		Wallcoverings	2005		10,822	-	5	-		10,822	29
30		Medical records room rehab	2006		19,739	987	20	987		11,844	30
31		Activity/PT Room Rehab	2006		1,158	58	20	58		696	31
32		Land scape enhancement	2006		8,726	582	15	582		7,178	32
33		Roof	2006		29,700	1,980	15	1,980		24,420	33
34		HVAC	2006		3,254	163	20	163		2,010	34
35		Plumbing and sprinkler system	2006		20,725	1,036	20	1,036		13,469	35
36		Laundry Combustion Air	2006		16,814	841	20	841		10,722	36

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

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

See Page 12A, Line 70 for total

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

# 0038083

Report Period Beginning:

1/1/18

Ending:

12/31/18

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Lobby/Lounge/Reception rehab	2006	\$ 14,033	\$ -	10	\$ -	\$ -	\$ 14,033	37
38	Cubicle curtains/drapery	2006	6,955	-	5	-		6,955	38
39	Cabinets/counters for 2nd FI library	2006	2,665	-	10	-		2,665	39
40	TCU rehab	2006	2,402	120	20	120		1,450	40
41	First floor remodel	2006	212,084	-	20	10,604	10,604	127,248	41
42	Kitchen rehab	2006	8,165	408	20	408		5,101	42
43	Bath fixtures-2nd floor	2006	2,076	-	10	-		2,076	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		2,113	44
45	Landscaping	2007	3,862	257	15	257		2,977	45
46	HVAC	2007	58,326	2,916	20	2,916		33,291	46
47	Common Areas Remodel	2007	2,059	-	10	-		2,059	47
48	First Floor Remodel	2007	6,517	-	20	326	326	3,829	48
49	Garage	2007	16,487	824	20	824		9,133	49
50	Land Improvements	2008	3,745	250	15	250		2,521	50
51	Parking lot-paving	2008	8,720	436	20	436		4,542	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		1,400	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153	-	27	16,260	16,260	176,150	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		34,771	55
56	Irrigation System	2009	16,740	1,116	15	1,116		10,323	56
57	Landscaping	2009	10,321	688	15	688		6,364	57
58	Parking lot repairs	2009	3,500	175	20	175		1,677	58
59	HVAC Chiller	2009	2,594	130	20	130		1,224	59
60	Patio Pergola	2009	6,760	338	20	338		3,324	60
61	Stamped Concrete	2009	16,658	833	20	833		7,775	61
62	Fence	2009	4,084	204	20	204		1,853	62
63	Patio Wall	2009	8,212	411	20	411		3,802	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		2,562	64
65									65
66	Brick Panel Replacement	2010	16,578	603	27	603		5,226	66
67	Office carpentry, flooring, electrical, painting, signs, HVAC	2010	17,565	641	27	641		5,128	67
68	Landscaping Enhancements	2010	15,258	1,017	15	1,017		8,645	68
69	Drain tile, sewer concrete	2010	3,221	214	15	214		1,758	69
70	TOTAL (lines 4 thru 69)		\$ 6,882,020	\$ 33,327		\$ 263,508	\$ 230,181	\$ 4,611,637	70

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc.# 0038083

Report Period Beginning:

1/1/18

Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,882,020	\$ 33,327		\$ 263,508	\$ 230,181	\$ 4,611,637	1
2	Retaining wall	2010	15,736	1,049	15	1,049		8,392	2
3	Canopy Installation	2010	4,466	163	27	163		1,331	3
4	Dining Room HVAC	2010	4,169	152	27	152		1,292	4
5	Pantry carpentry, flooring, plumbing	2010	2,911	106	27	106		883	5
6	Director of Nursing office painting	2010	4,245	155	27	155		1,240	6
7	Remodel Library/Lounge-art, painting, flooring	2010	6,477	236	27	236		1,888	7
8	2nd floor doors	2010	3,046	111	27	111		971	8
9	Office changes-carpentry, painting, flooring	2011	2,487	90	27	90		683	9
10	Fence	2011	2,750	183	15	183		1,312	10
11	Mulch and stone	2011	2,662	177	15	177		1,269	11
12	Laundry Room-Tile, Painting	2011	7,311	266	27	266		1,951	12
13	Locker Room - Installation of 6 tier box lockers	2011	2,573	94	27	94		713	13
14	Place beds back into service - Carpentry, Flooring, Electrical,	2011	117,350	4,267	27	4,267		32,358	14
15	-Painting and Plumbing			-		-			15
16				-		-			16
17				-		-			17
18	Electrical wiring for EMR	2012	13,699	498	27	498		3,030	18
19				-		-			19
20	Landscaping (Planting roses and day lilies Main Entrance)	2014	10,648	177	15	177		885	20
21	Install Automatic Doors (Front Entrance)	2014	6,859	83	15	83		415	21
22	Install LED Lights throughout facility	2014	22,200	67	27	67		335	22
23	R/M Reclass: Elevator door restrictor (Front Entrance)	2014	3,500	-	10	350	350	1,575	23
24				-		-			24
25	Install LED Lights throughout facility	2015	22,799	829	27	829		2,556	25
26	Electrical wiring throughout facility	2015	5,832	212	27	212		760	26
27	R/M Reclass: asphalt and concrete work in parking lot	2015	15,650	-	20	783	783	2,740	27
28				-		-			28
29	Private Room Rehab - 1st floor install of chair rails	2016	17,444	634	27	634		1,374	29
30				-		-			30
31				-		-			31
32				-		-			32
33	Reconcile to book depreciation			1,508		-	(1,508)		33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,176,834	\$ 44,384		\$ 274,190	\$ 229,806	\$ 4,679,590	34

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

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

# 0038083

Report Period Beginning:

1/1/18

Ending:

12/31/18

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 7,176,834	\$ 44,384		\$ 274,190	\$ 229,806	\$ 4,679,590	1
2				-					2
3	Building - management company	2002	138,800	-	40	3,457	3,457	67,824	3
4	HVAC, electrical, security system - management company	2003	1,219	-	30	120	120	1,042	4
5	Key card system - management company	2004	192	-	20	11	11	138	5
6	VAV TX controls - management company	2005	58	-	20	3	3	40	6
7	Interior Signs-management company	2006	42	-	20	3	3	34	7
8	Building - management company	2008	6,136	-	20	83	83	2,777	8
9	Building - management company	2009	1,171	-	20	72	72	606	9
10	Building - management company	2010	1,148	-	20	55	55	551	10
11	Building - management company	2011	864	-	20	45	45	302	11
12	Building - management company	2012	2,714	-	20	113	113	665	12
13	Building - management company	2013	2,255	-	20	147	147	832	13
14	Building - management company	2014	1,220	-	20	137	137	550	14
15	Building - management company	2015	214	-	20	29	29	92	15
16	Building - management company	2016	3,541	-	20	296	296	628	16
17	Building - management company	2017	2,265	-	20	110	110	140	17
18	Building - management company	2018	430	-	20	10	10	9	18
19				-		-			19
20				-		-			20
21				-		-			21
22				-		-			22
23				-		-			23
24				-		-			24
25				-		-			25
26				-		-			26
27				-		-			27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,339,103	\$ 44,384		\$ 278,883	\$ 234,499	\$ 4,755,820	34

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	\$ 220,035	\$ 36,600	\$ 36,600	\$ -	5-10	\$ 187,502	71
72	Current Year Purchases	28,861	276	2,611	2,335	5	2,611	72
73	Fully Depreciated Assets	515,312			-		515,312	73
74	Allocated from Mgmt. Co.	266,507		8,050	8,050		244,161	74
75	TOTALS	\$ 1,030,715	\$ 36,876	\$ 47,261	\$ 10,385		\$ 949,586	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.			25,224	-	1,047	1,047		22,810	79
80	TOTALS			\$ 25,224	\$ -	\$ 1,047	\$ 1,047		\$ 22,810	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,905,072	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,260	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 327,191	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 245,931	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,728,216	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from Management Company</u>				<u>2,497</u>			6
7	TOTAL				\$ <u>2,497</u>			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

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

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 80,355 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocated from Management Company</u>			<u>121</u>	20
21	TOTAL		\$	\$ <u>121</u>	21

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

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

**Facility Name:** Lexington Health Care Center of LaGrange, Inc.  
**IDPH License ID Number:** 0038083  
**Fiscal Year End:** 12/31/18

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<u>Rental Description</u>	<u>Amount</u>
Copier	6,984
Postage Machine	404
Printer	2,935
Oxygen	35,858
Medical Equipment	33,215
Management Co.	959
<b>Total - Line 16</b>	<b><u><u>80,355</u></u></b>

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	18,316	\$ 747,876	\$	18,316	\$ 747,876	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		7,423	200,109		7,423	200,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		18,288	926,798		18,288	926,798	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				519,220		519,220	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Sch 16A</u>	39(2)					14,090		14,090	12
13	Other (specify): <u>Ambulance</u>	39(3)				356			356	13
14	TOTAL			\$	44,027	\$ 1,875,139	\$ 533,310	44,027	\$ 2,408,449	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

**Facility Name:** Lexington Health Care Center of LaGrange, Inc.  
**IDPH License ID Number:** 0038083  
**Fiscal Year End:** 12/31/18

**Schedule 16A**

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

**Line 12 Other (specify)**

<b>Description</b>	<b>Reference</b>	<b>Amount</b>
Oxygen	39(2)	13,279
DME	39(2)	811
<b>Total - Line 12</b>	<b>-</b>	<b>14,090</b>

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

# 0038083

Report Period Beginning: 1/1/18

Ending: 12/31/18

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of 12/31/18

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 984,570	\$ 995,951	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,507,945) )	1,471,552	1,471,552	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	157,331	157,331	6
7	Other Prepaid Expenses	29,077	29,077	7
8	Accounts Receivable (owners or related parties)	2,761	2,761	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,645,291	\$ 2,656,672	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		510,030	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	1,146,866	4,677,655	15
16	Equipment, at Historical Cost	454,185	1,055,939	16
17	Accumulated Depreciation (book methods)	(1,008,757)	(5,728,216)	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 (spec Insurance recoveries	459,919	459,919	22
23	Other(specify): Mortgage cost, net		45,810	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,059,265	\$ 3,689,637	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,704,556	\$ 6,346,309	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 697,716	\$ 697,716	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		4,575,494	29
30	Accrued Salaries Payable	341,955	341,955	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,504	11,504	31
32	Accrued Real Estate Taxes(Sch.IX-B)		412,998	32
33	Accrued Interest Payable		21,615	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Schedule 17A	1,308,198	381,034	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,359,373	\$ 6,442,316	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,359,373	\$ 6,442,316	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,345,183	\$ (96,007)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,704,556	\$ 6,346,309	48

\*(See instructions.)

**Facility Name:** Lexington Health Care Center of LaGrange, Inc.  
**IDPH License ID Number:** 0038083  
**Fiscal Year End:** 12/31/18

**Schedule 17A**

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

	<b>Description</b>	<b>Operating</b>	<b>After Consolidation</b>
00-10140-00	Cash Patient Trust	932	932
00-13040-00	Rent Receivable	-	692,164
00-13200-00	Due From -	(170,000)	(170,000)
00-13240-00	Due To Lex Fin Svcs I	314	314
00-14530-00	Prepaid Insurance	2,403	2,403
00-13705-00	Due From Lhcc Lagrange	-	65,000
00-13709-00	Due From /(To) Lhcc Lagrange	-	170,000
00-21030-00	Cobra	(2,121)	(2,121)
00-21040-00	Withholding - Dental Insurance	(1,032)	(1,032)
00-21050-00	Withholding - Ep/Ci/WI	(1,973)	(1,973)
00-21085-00	Vision Withholding	97	97
00-21100-00	401K Withholding	(4,621)	(4,621)
00-22030-00	Accrued Expenses	(26,076)	(26,076)
00-22040-00	Accrued Resident Tax	-	-
00-22060-00	Accrued Vesta 3% Management Fees	(947,417)	(947,417)
00-22065-00	Accrued Royal Management Fees	52,048	52,048
00-22120-00	Accrued Rent	(692,164)	(692,164)
00-22140-00	Accrued Insurance	(71,301)	(71,301)
00-22270-00	Due To Patient Trust Fund	(433)	(433)
00-22330-00	Advance - Biweekly Part A Paym	(29,538)	(29,538)
00-22360-00	Uncollectible Part A Co Pvts	1	1
00-23530-00	Due To - Royal Operations	(19,037)	(19,037)
00-24400-00	Professional Liabilities Claims	(653,476)	(653,476)
00-23850-00	Due/To From Sambell Of Lag	(65,037)	(65,037)
00-23820-00	Due From Wheeling	1,304,876	1,304,876
00-21260-00	Due From Ins Carrier	15,357	15,357
	<b>Total - Line 36</b>	<b>(1,308,198)</b>	<b>(381,034)</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,774,235</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior period adjustment</b>	<b>301,149</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,075,384</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(310,201)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(420,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(730,201)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,345,183</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1		2	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,529,029	1
2	Discounts and Allowances for all Levels	(8,134,950)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,394,079	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,224,207	6
7	Oxygen	32,662	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 7,256,869	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,099	13
14	Non-Patient Meals	1,859	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	826,104	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	309,849	19
20	Radiology and X-Ray	35,898	20
21	Other Medical Services	317,090	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,499,899	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	9,436	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,436	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,160,283	30

1		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,390,224	31
32	Health Care	4,510,636	32
33	General Administration	2,904,167	33
<b>B. Capital Expense</b>			
34	Ownership	1,223,051	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,291,648	35
36	Provider Participation Fee	150,758	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,470,484	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(310,201)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (310,201)	43
<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 878,568	44
45	Private Pay - Net Inpatient Revenue	992,163	45
46	Medicare - Net Inpatient Revenue	1,951,278	46
47	Other-(specify) <u>Managed Care</u>	572,070	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,394,079	49

\* This must agree with page 4, line 45, column 4.  
 \*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.  
 \*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.  
 \*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.  
 ^ Entity is a cash basis taxpayer

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

# 0038083

Report Period Beginning:

1/1/18

Ending:

12/31/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,704	2,211	\$ 130,813	\$ 59.17	1
2	Assistant Director of Nursing	1,778	2,194	99,238	45.24	2
3	Registered Nurses	30,537	37,023	1,217,758	32.89	3
4	Licensed Practical Nurses	19,507	22,668	629,794	27.78	4
5	CNAs & Orderlies	59,983	64,716	1,015,347	15.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,774	2,055	40,051	19.49	9
10	Activity Assistants	3,837	4,456	51,313	11.52	10
11	Social Service Workers	4,073	4,762	94,466	19.84	11
12	Dietician	1,903	2,190	61,858	28.24	12
13	Food Service Supervisor	3,853	4,497	89,988	20.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,730	21,378	250,211	11.70	15
16	Dishwashers					16
17	Maintenance Workers	1,765	2,168	43,542	20.08	17
18	Housekeepers	23,649	28,345	364,342	12.85	18
19	Laundry					19
20	Administrator	1,701	2,009	128,949	64.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,331	6,379	112,206	17.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,728	2,181	41,412	18.99	31
32	Other Health C: See Sch 20A	18,507	23,395	681,300	29.12	32
33	Other(specify) <u>Marketing</u>			788		33
34	TOTAL (lines 1 - 33)	199,360	232,626	\$ 5,053,377 *	\$ 21.72	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	\$ 0	1(3) 35
36	Medical Director	Monthly	33,438	9(3) 36
37	Medical Records Consultant	Monthly	813	10(3) 37
38	Nurse Consultant	Monthly	282	10(7) 38
39	Pharmacist Consultant	Monthly	12,280	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	7,125	11(3) 44
45	Social Service Consultant	Monthly	3,171	12(3) 45
46	Other(specify) <u>Pulmonary</u>	Monthly	92,114	10(3) 46
47	<u>Post Acute Consulting</u>	Monthly	4,134	10(3) 47
48	<u>Telemedicine Consulting</u>	Monthly	9,150	10(3) 48
49	TOTAL (lines 35 - 48)		\$ 162,507	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	51	\$ 3,018	10(3) 50
51	Licensed Practical Nurses	37	1,821	10(3) 51
52	Certified Nurse Assistants/Aides	646	16,784	10(3) 52
53	TOTAL (lines 50 - 52)	734	\$ 21,623	53

**Facility Name:** Lexington Health Care Center of LaGrange, Inc.  
**IDPH License ID Number:** 0038083  
**Fiscal Year End:** 12/31/18

**Schedule 20A**

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

<b>Description</b>	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Total Salaries</b>	<b>Average Hourly Wage</b>
Accounts Coordinator	1,553	2,020	38,851	\$ 19.23
Admissions	1,897	2,236	78,949	\$ 35.31
Clinical Coordinator	3,851	4,818	192,031	\$ 39.86
MDS	1,830	2,257	96,002	\$ 42.53
Staffing Coordinator	660	894	17,081	\$ 19.10
Unit Secretary	8,299	10,646	244,241	\$ 22.94
Wound Care Coordinator	418	524	14,146	\$ 27.00
<b>Total - Line 32 Other Health Care (specify):</b>	<b>18,507</b>	<b>23,395</b>	<b>681,300</b>	<b>\$ 29.12</b>

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Bonny Mundt</u>	<u>Administrator</u>	<u>0</u>	\$ <u>128,949</u>	<u>Workers' Compensation Insurance</u>	\$ <u>87,198</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>24,316</u>	<u>Advertising: Employee Recruitment</u>	<u>14,826</u>	
				<u>FICA Taxes</u>	<u>376,434</u>	<u>Health Care Worker Background Check</u>	<u>1,700</u>	
				<u>Employee Health Insurance</u>	<u>205,863</u>	(Indicate # of checks performed <u>142</u> )		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>473</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Fees</u>	<u>6,625</u>	
				<u>401K</u>	<u>11,606</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>320</u>	
				<u>Other Employee Benefits</u>	<u>17,687</u>	<u>IHCA Dues</u>	<u>4,620</u>	
				<u>Uniform Expense</u>	<u>(15)</u>	<u>Management Company Allocation</u>	<u>887</u>	
				<u>Tuition</u>	<u>7,611</u>	<u>Less: Non-Allowable Dues</u>	<u>(1,472)</u>	
						<u>Less: Public Relations Expense</u>	( )	
						<u>Non-allowable advertising</u>	( )	
						<u>Yellow page advertising</u>	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 128,949</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>		<b>\$ 35,166</b>		
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-Royal Operating</u>			\$ <u>760,992</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	\$
<u>Royal - Shared Services</u>			<u>601,116</u>				<u>In-State Travel</u>	
							<u>Seminar Expense</u>	
							<u>Allocated from Home Office</u>	<u>413</u>
							<u>Entertainment Expense</u>	( )
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 1,362,108</b>	<b>TOTAL</b>		<b>\$</b>	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	
<b>(Attach a copy of any management service agreement)</b>								<b>\$ 413</b>
C. Professional Services			Amount	TOTAL				
Vendor/Payee	Type			Amount				
<u>RSM US LLP</u>	<u>Accounting</u>			\$ <u>33,603</u>				
<u>Personnel Planners, Inc.</u>	<u>401K Administration</u>			<u>1,061</u>				
<u>Pension Administrators</u>	<u>U/C Consulting</u>			<u>576</u>				
<u>Much Shelist</u>	<u>Legal Services</u>			<u>6,144</u>				
<u>Duane Morris</u>	<u>Legal Services</u>			<u>95</u>				
<u>Hinshaw &amp; Culbert Son Llp</u>	<u>Legal Services</u>			<u>234</u>				
<u>Secretary Of State</u>	<u>Legal Services</u>			<u>100</u>				
<u>Hughes Socol Piers Resnick &amp; Dym L</u>	<u>Legal Services</u>			<u>942</u>				
<u>Bert Spilker &amp; Associates</u>	<u>Legal Services</u>			<u>76</u>				
<u>Collections</u>	<u>Legal Services</u>			<u>14,108</u>				
<u>See Sch 21C</u>	<u>Various</u>			<u>92,622</u>				
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 149,561</b>					
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name: Lexington Health Care Center of LaGrange, Inc.  
 IDPH License ID Number: 0038083  
 Fiscal Year End: 12/31/18

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**  
**C. Professional Services**

Vendor	Type	Amount
Other	Legal Services	220
Connected For Care	Computer Services	6,443
Royal Management/Operat	Computer Services	35,972
Relias	Computer Services	6,366
Icims	Computer Services	2,836
Salesforce	Computer Services	8,705
Info Controls	Computer Services	1,846
Onshift	Computer Services	1,165
National Datacare Corp.	Computer Services	1,356
On Shift	Computer Services	4,068
Softchoice	Computer Services	3,466
Microsoft	Computer Services	12,255
Helathmedx	Computer Services	1,814
Netsmart	Computer Services	6,110

**Total (agree to Schedule V, line 19, column 3)** 149,561

Allocated from Management CompanyLegal Fees		
Allocated from Management CompanyProfessional Services		
Less: Non-Allowable legal fees Collections and out of period	(14,865)	
Less: Non-Allowable computer servicesSalesforce	(8,705)	
Real estate AdjustmentOther	202	

Allocated from Mgmt. Co.	Type	Amount
Much Shelist	Legal	895
Duane Morris	Legal	573
Partridge Partners	Legal	43
RSM	Accounting	983
Friedman & Huey	Accounting	296
IL Secretary of State	Filing Fees	3
West Suburban Bank	Banking	3
Personnel Planners	U/C Consultant	6
LaSalle Network	Recruiting / Finance	5,190
Pension Administrators, Inc.	401K Administration	135
Gene Whitehorn	Public Aid Pending Consultant	894
Steele Group LLC	Financial Consulting	1,459
M Werner Consulting	Public Aid Consultant	40
Early Stage Solutions	Financial Consulting	9,893
Objective Arts	Public Aid Pending Consultants	181
Adam Leffon	Financial Consulting	4,195
Brilliant Staffing LLC	Financial Consulting	1,395
Mark J Eenigenburg	Budgeting Consultant	1,305
Deloitte Consulting LLP	Compensation Consulting	612
John Mattone Partners	Workplace Consultant	3,374
Mark Rodeghier	Survey Preparation Consultant	181
JGC Advisors LLC	Contracting Consultant	85
Michel Desjardins	Contracting Consultant	45
Pathway Health Services	Operational & Financial Consulting	(96)
Brandlin & Associates	Banking Consultants	13,013
Steven Wood	Strategy/Operations Consulting	513
Susan Parker	Social Service Consultant	8
Focus Pointe Global	Strategic Planning	142
Andrzej Stankiewicz	General Business Consulting	119
DLC	Financial Planning & Analysis	1,906
Fieldwork	Recruitment Consultant	255
Computer Services	Computer Consulting	11,759

Sambell of Lombard II		
Friedman & Huey	Accounting	74
Duane Morris	Legal	14
Illinois Secretary of State	Filing Fees	1

**Total (agree to Schedule V, line 19, column 8)** 185,687

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc.# 0038083

Report Period Beginning:

1/1/18

Ending:

12/31/18**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$4,620
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,635 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 150,758  
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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1859
- (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? N/A  
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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.