

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

0041855 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	<u>275</u>	Skilled (SNF)	<u>275</u>	<u>100,375</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>275</u>	TOTALS	<u>275</u>	<u>100,375</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			<u>11,589</u>	<u>11,589</u>	8
9	SNF/PED					9
10	ICF	<u>30,686</u>	<u>12,242</u>	<u>4,015</u>	<u>46,943</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,686</u>	<u>12,242</u>	<u>15,604</u>	<u>58,532</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.31%

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 7/8/96

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

YES Date New Construction NO

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

YES NO If YES, enter number of beds certified 259 and days of care provided 8,343

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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 Orland Park # 0041855 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
	A. General Services										
1	Dietary	475,666	38,570	2,787	517,023		517,023	-	517,023		1
2	Food Purchase		398,803		398,803		398,803	(370)	398,433		2
3	Housekeeping	430,876	39,916	-	470,792		470,792	377	471,169		3
4	Laundry	-	20,986	-	20,986		20,986	-	20,986		4
5	Heat and Other Utilities			266,240	266,240		266,240	10,686	276,926		5
6	Maintenance	44,441	-	201,540	245,981		245,981	174,288	420,269		6
7	Other (specify):* <u>Alloc. From Mgmt. C</u>	-	-	-				17,501	17,501		7
8	TOTAL General Services	950,983	498,275	470,567	1,919,825		1,919,825	202,482	2,122,307		8
	B. Health Care and Programs										
9	Medical Director	-	-	31,250	31,250		31,250	-	31,250		9
10	Nursing and Medical Records	5,318,866	311,816	111,788	5,742,470		5,742,470	31,976	5,774,446		10
10a	Therapy	-	-	-				-			10a
11	Activities	161,277	20,809	10,718	192,804		192,804	-	192,804		11
12	Social Services	198,768	-	4,626	203,394		203,394	-	203,394		12
13	CNA Training	-	-	-				-			13
14	Program Transportation	-	-	-				-			14
15	Other (specify):* <u>Alloc. From Mgmt. C</u>	-	-	-				3,348	3,348		15
16	TOTAL Health Care and Programs	5,678,911	332,625	158,382	6,169,918		6,169,918	35,324	6,205,242		16
	C. General Administration										
17	Administrative	158,481	-	1,728,408	1,886,889		1,886,889	(2,338,755)	(451,866)		17
18	Directors Fees			-				-			18
19	Professional Services			247,649	247,649		247,649	105,338	352,987		19
20	Dues, Fees, Subscriptions & Promotions			26,197	26,197		26,197	19,619	45,816		20
21	Clerical & General Office Expenses	116,147	36,853	57,659	210,659		210,659	1,258,811	1,469,470		21
22	Employee Benefits & Payroll Taxes			940,002	940,002		940,002	-	940,002		22
23	Inservice Training & Education			8,314	8,314		8,314	731	9,045		23
24	Travel and Seminar			-				948	948		24
25	Other Admin. Staff Transportation		-	3,123	3,123		3,123	21,049	24,172		25
26	Insurance-Prop.Liab.Malpractice			672,906	672,906		672,906	3,811	676,717		26
27	Other (specify):* <u>Alloc. From Mgmt. C</u>	-	-	-				133,609	133,609		27
28	TOTAL General Administration	274,628	36,853	3,684,258	3,995,739		3,995,739	(794,839)	3,200,900		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,904,522	867,753	4,313,207	12,085,482		12,085,482	(557,033)	11,528,449		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 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	
	D. Ownership											
30	Depreciation			88,770	88,770		88,770	390,347	479,117			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			159,139	159,139		159,139	587,840	746,979			32
33	Real Estate Taxes			-				683,416	683,416			33
34	Rent-Facility & Grounds			1,907,613	1,907,613		1,907,613	(1,895,392)	12,221			34
35	Rent-Equipment & Vehicles			43,338	43,338		43,338	2,472	45,810			35
36	Other (specify):*			-				-				36
37	TOTAL Ownership			2,198,860	2,198,860		2,198,860	(231,317)	1,967,543			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	337,258	1,804,607	2,141,865		2,141,865	-	2,141,865			39
40	Barber and Beauty Shops	-	-	12,091	12,091		12,091	(12,091)				40
41	Coffee and Gift Shops	-	-	2,912	2,912		2,912	(638)	2,274			41
42	Provider Participation Fee			458,449	458,449		458,449	-	458,449			42
43	Other (specify):* Non-Allowable Cos	4,787	-	1,073,084	1,077,871		1,077,871	(1,077,871)				43
44	TOTAL Special Cost Centers	4,787	337,258	3,351,143	3,693,188		3,693,188	(1,090,600)	2,602,588			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,909,309	1,205,011	9,863,210	17,977,530		17,977,530	(1,878,950)	16,098,580			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 Orland Park, Inc.

0041855

Report Period Beginning:

1/1/18

Ending:

12/31/18

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(370)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,635)	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	46,420	30		9
10	Interest and Other Investment Income	(30,307)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,574)	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	(14,630)	43		18
19	Entertainment				19
20	Contributions	(1,075)	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	(958,467)	43		24
25	Fund Raising, Advertising and Promotional	(21,734)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(400)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See PG5A</u>	(191,920)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,199,692)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(678,831)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (678,831)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,878,523)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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	TOTAL (C): (sum of lines 38-46)			\$		47

Lexington Health Care Center of Orland Park, Inc.

ID# 0041855

Report Period Beginning: 1/1/18

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (2,545)	43	1
2	Labs - Part A	(19,521)	43	2
3	X-Rays - Part A	(27,503)	43	3
4	Marketing Salary	(4,787)	43	4
5	Gift Shop Income	(638)	41	5
6	Unrealized loss on FMV swap	126,356	43	6
7	Trust Fees	(160)	43	7
8	Shareholder Interest	(156,000)	32	8
9	Collections	(29,137)	19	9
10	Out of Period Legal	(2,067)	19	10
11	Non-Allowable Dues & Subscription	(1,701)	20	11
12	Non-Allowable Finance Charge	(3,140)	32	12
13	Offset barber & beauty	(12,091)	40	13
14	Loss on disposal of asset	(57,871)	43	14
15	Misc. Income	(1,115)	21	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	(191,920)		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	\$	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	\$ 202	\$ 202	1
2	V	30 Depreciation Expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	312,756	312,756	2
3	V	32 Amortization of Mortgage Cost		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	78,521	78,521	3
4	V	32 Interest		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	676,269	676,269	4
5	V	33 Property Tax		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	675,009	675,009	5
6	V	34 Rent	1,901,113	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(1,901,113)	6
7	V	43 Unrealized loss on FMV of Swap	126,356	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(126,356)	7
8	V	43 (Gain)/Loss - disposal - mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	57,871	57,871	8
9	V	21 Miscellaneous Expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	1	1	9
10	V	43 Trust fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	160	160	10
11	V							11
12	V			** The owners of Lexington Health Care Center of Orland Park, Inc. own 100%				12
13	V			of Lexington Health Care Systems of Orland Park Ltd. Ptsp.				13
14	Total		\$ 2,027,469			\$ 1,800,789	\$ * (226,680)	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.	**	\$ 377	\$ 377	15	
16	V	5		Royal Management Corp.	**	9,730	9,730	16	
17	V	5		Royal Management Corp.	**	257	257	17	
18	V	5		Royal Management Corp.	**	699	699	18	
19	V	6		Royal Management Corp.	**	163,734	163,734	19	
20	V	6		Royal Management Corp.	**	10,129	10,129	20	
21	V	6		Royal Management Corp.	**	425	425	21	
22	V	7		Royal Management Corp.	**	17,501	17,501	22	
23	V	10		Royal Management Corp.	**	647	647	23	
24	V	10		Royal Management Corp.	**	31,329	31,329	24	
25	V	15		Royal Management Corp.	**	3,348	3,348	25	
26	V	17		Royal Management Corp.	**	26,635	26,635	26	
27	V	19		Royal Management Corp.	**	26,948	26,948	27	
28	V	19		Royal Management Corp.	**	109,392	109,392	28	
29	V	20		Royal Management Corp.	**	2,033	2,033	29	
30	V	20		Royal Management Corp.	**	19,287	19,287	30	
31	V	21		Royal Management Corp.	**	1,223,354	1,223,354	31	
32	V	21		Royal Management Corp.	**	3,321	3,321	32	
33	V	21		Royal Management Corp.	**	11,299	11,299	33	
34	V	21		Royal Management Corp.	**	5,595	5,595	34	
35	V	21		Royal Management Corp.	**	16,356	16,356	35	
36	V							36	
37	V							37	
38	V	** The owners of Lexington Health Care Center of Orland Park, Inc.							38
39	Total		\$			\$ 1,682,395	\$ *	1,682,395 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.	**	\$ 731	\$ 731	15
16	V	24 Travel & seminar		Royal Management Corp.	**	948	948	16
17	V	25 Auto expense		Royal Management Corp.	**	21,049	21,049	17
18	V	26 Insurance general		Royal Management Corp.	**	3,811	3,811	18
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	133,609	133,609	19
20	V	30 Depreciation		Royal Management Corp.	**	31,598	31,598	20
21	V	32 Interest		Royal Management Corp.	**	19,566	19,566	21
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	2,931	2,931	22
23	V	33 Property taxes		Royal Management Corp.	**	8,407	8,407	23
24	V	34 Rent expense		Royal Management Corp.	**	5,721	5,721	24
25	V	35 Equipment rental		Royal Management Corp.	**	2,196	2,196	25
26	V	17 Management fees	2,365,390	Royal Management Corp.	**		(2,365,390)	26
27	V	35 Auto Lease		Royal Management Corp.	**	276	276	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							36
37	V							37
38	V	** The owners of Lexington Health Care Center of Orland Park, Inc.						38
39	Total		\$ 2,365,390			\$ 230,844	\$ * (2,134,546)	39

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

Facility Name & ID Number

Lexington Health Care Center of Orland Park, Inc.

0041855

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

Facility Name & ID Number

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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					Sambell of	Bloomingtondale	Real Estate	1
2					Bloomingtondale Ltd. Pts		Property	2
3					Sambell of Chicago	Chicago Ridge	Real Estate	3
4					Ridge Ltd. Ptsp.		Property	4
5					Sambell of	Elmhurst	Real Estate	5
6					Elmhurst II Ltd. Ptsp.		Property	6
7					Sambell of	LaGrange	Real Estate	7
8					LaGrange Ltd. Ptsp.		Property	8
9					Lexington Health	Lake Zurich	Real Estate	9
10					Care Systems of		Property	10
11					Lake Zurich Ltd. Ptsp			11
12					Lexington Health	Lombard	Real Estate	12
13					Care Systems of		Property	13
14					Lombard Ltd. Ptsp.			14
15					Sambell of	Schaumburg	Real Estate	15
16					Schaumburg Ltd. Ptsp		Property	16
17					Sambell of	Streamwood	Real Estate	17
18					Streamwood Ltd. Ptsp		Property	18
19					Lexington Health	Wheeling	Real Estate	19
20					Care Systems of		Property	20
21					Wheeling Ltd. Ptsp.			21
22					Samvest of	Algonquin	Real Estate	22
23					Algonquin Ltd. Ptsp.		Property	23
24					Curatess, LLC	Lombard	Telemedicine	24
25					Republic Construction	Lombard	Construction Comp	25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington Health Care Center of Orland Pa # 0041855 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	James Samatas	Owner/officer	Administrative	30	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 6,841	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,131	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	30	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,841	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative		See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,131	L17, C7	4
5	Phil Thiem	Executive Committee	Administrative		See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,082	L17, C7	5
6	Jeremy Samatas	Executive Committee	Administrative		See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,609	L17, C7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,635		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 Orland Park, Inc. # 0041855 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	\$ 100,375	\$ 377	1	
2	5	Utilities - gas & electric	Bed Days Available	722,335	10	70,024	100,375	9,730	2	
3	5	Utilities - water & sewer	Bed Days Available	722,335	10	1,855	100,375	257	3	
4	5	Utilities - maintenance office	Bed Days Available	722,335	10	5,025	100,375	699	4	
5	6	Management allocation - salaries	Bed Days Available	722,335	10	1,178,292	1,178,292	100,375	163,734	5
6	6	Repairs & maintenance	Bed Days Available	722,335	10	72,883	100,375	10,129	6	
7	6	Scavenger & exterminating	Bed Days Available	722,335	10	3,054	100,375	425	7	
8	7	Management allocation - employees	Bed Days Available	722,335	10	125,945	100,375	17,501	8	
9	10	Medical Consultant	Bed Days Available	722,335	10	4,651	100,375	647	9	
10	10	Management allocation - salaries	Bed Days Available	722,335	10	225,449	225,449	100,375	31,329	10
11	15	Management allocation - employees	Bed Days Available	722,335	10	24,098	100,375	3,348	11	
12	17	Management allocation - salaries	Bed Days Available	722,335	10	191,670	191,670	100,375	26,635	12
13	19	Computer consultant & supplies	Bed Days Available	722,335	10	193,924	100,375	26,948	13	
14	19	Professional fees	Bed Days Available	722,335	10	787,232	100,375	109,392	14	
15	20	Dues & subscriptions	Bed Days Available	722,335	10	14,624	100,375	2,033	15	
16	20	Advertising - help wanted	Bed Days Available	722,335	10	138,799	100,375	19,287	16	
17	21	Management allocation - salaries	Bed Days Available	722,335	10	8,803,710	8,803,710	100,375	1,223,354	17
18	21	Bank charges	Bed Days Available	722,335	10	23,902	100,375	3,321	18	
19	21	Office supplies & printing	Bed Days Available	722,335	10	81,306	100,375	11,299	19	
20	21	Postage	Bed Days Available	722,335	10	40,262	100,375	5,595	20	
21	21	Telephone	Bed Days Available	722,335	10	117,714	100,375	16,356	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 12,107,123	\$ 10,399,121	\$ 1,682,395	25	

Facility Name & ID Number Lexington Health Care Center of Orland Park, Inc. # 0041855 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	\$ 100,375	\$ 731	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	6,817	100,375	948	2
3	25	Auto expense	Bed Days Available	722,335	10	151,483	100,375	21,049	3
4	26	Insurance general	Bed Days Available	722,335	10	27,426	100,375	3,811	4
5	27	Management allocation - employees	Bed Days Available	722,335	10	961,496	100,375	133,609	5
6	30	Depreciation	Bed Days Available	722,335	10	227,415	100,375	31,598	6
7	32	Interest	Bed Days Available	722,335	10	140,807	100,375	19,566	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	21,094	100,375	2,931	8
9	33	Property taxes	Bed Days Available	722,335	10	60,494	100,375	8,407	9
10	34	Rent expense	Bed Days Available	722,335	10	41,178	100,375	5,721	10
11	35	Equipment rental	Bed Days Available	722,335	10	15,819	100,375	2,196	11
12	35	Auto Lease	Bed Days Available	722,335	10	1,993	100,375	276	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	\$	\$ 230,844	25

Facility Name & ID Number Lexington Health Care Center of Orland Parl # 0041855 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
					Original	Balance				
Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
A. Directly Facility Related										
Long-Term										
1						\$	\$		\$	1
2	X	Mortgage	Varies	05/22/08	6,375,000			01/01/33	Variable	273,660
3	X	Mortgage	Varies	05/29/18	5,058,006	9,008,529		05/29/21	Libor + 5.25%	402,608
4										4
5		Finance Charge - Insurance Policy								3,140
Working Capital										
6	X	Working Capital	Varies	5/3/12	1,200,000	1,255,285		Demand	0.080	96,000
7	X	Working Capital	Varies	9/30/13	750,000	785,178		Demand	0.080	60,000
8										8
9	TOTAL Facility Related					\$ 13,383,006	\$ 11,048,992			\$ 835,408
B. Non-Facility Related*										
10								Amortization of Mortgage Cost		78,521
11								Allocated from Mgmt Co.		22,497
12								Interest Income Offset		(30,307)
13								See Sch. 9A		(159,140)
14	TOTAL Non-Facility Related					\$	\$			\$ (88,429)
15	TOTALS (line 9+line14)					\$ 13,383,006	\$ 11,048,992			\$ 746,979

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.)

Facility Name: Lexington Health Care Center of Orland Park, Inc.
IDPH License ID Number: 0041855
Fiscal Year End: 12/31/18

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	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							\$	\$			\$	1		
2												2		
3												3		
4												4		
5												5		
	Working Capital													
6												6		
7												7		
8												8		
9	TOTAL Facility Related				\$0.00		\$	0	\$	0		\$	0	9
	B. Non-Facility Related*													
10							Non-Allowable Finance Charge				(3,140)	10		
11							Shareholder Interest				(156,000)	11		
12												12		
13												13		
14	TOTAL Non-Facility Related				\$0.00		\$	0	\$	0		(159,140)	14	

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>860,300</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>781,083</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>(79,217)</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>804,516</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	<u>20,270</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. TOTAL REFUND \$ <u>70,560</u> For <u>###</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Alloc Fr. Mgmt Co.		<u>8,407</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>683,416</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2013	<u>623,620</u>	8		
	2014	<u>668,583</u>	9		
	2015	<u>678,633</u>	10		
	2016	<u>685,216</u>	11		
	2017	<u>804,516</u>	12		
See attached real estate accrual sheet					
FOR BHF USE ONLY					
	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 Orland Park, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

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>27-10-100-099-0000</u>	<u>Land & Building</u>	\$ <u>781,083.14</u>	\$ <u>781,083.14</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>253,394.82</u>	\$ <u>8,407.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>1,034,477.96</u>	\$ <u>789,490.14</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 Orland Park, Inc.

0041855 Report Period Beginning:

1/1/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 104332 B. General Construction Type: Exterior Brick Frame Block & Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>152,460</u>	<u>1995</u>	<u>\$ 776,408</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>24,846</u>	<u>2</u>
3	TOTALS	152,460		\$ 801,254	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	250		1996	1996	\$ 8,569,286	\$ -	40	\$ 214,232	\$ 214,232	\$ 4,817,648	4
5	10		1998	1998	63790	1,595	40	1,595		31,897	5
6	18		2001	2001		-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9		Electrical wiring	1996		2,304	58	40	58		1,281	9
10		Paving	1997		11,589	-	40	-		11,589	10
11		Wiring	1998		3,932	-	40	-		3,932	11
12		Additional building costs - 10 bed addition	1999		1,808	45	10	45		902	12
13		Seal/restrip parking lot	1999		3,450	-	40	-		3,450	13
14		Wiring	1999		1,798	45	15	45		877	14
15		Roof repairs	2000		23,201	-	40	-		23,201	15
16		Electrical wiring	2000		5,732	164	15	164		3,032	16
17		Ceiling mount curtain rod hardware	2000		6,952	199	35	199		3,679	17
18		Automatic door closer/sensors	2000		3,624	-	35	-		3,624	18
19		Seal and restripe parking lot	2001		2,277	-	15	-		2,277	19
20		HVAC control	2001		2,548	-	10	-		2,548	20
21		Infrared curtains for elevator doors	2001		4,500	-	10	-		4,500	21
22		Fire alarm panel	2002		5,120	-	10	-		5,120	22
23		Parking lot lights	2002		9,975	-	10	-		9,975	23
24		Chiller room compressor	2002		8,879	-	10	-		8,879	24
25		Carpeting	2002		7,038	-	5	-		7,038	25
26		Pave and seal parking lot	2005		4,180	209	20	209		2,787	26
27		HVAC	2005		6,143	307	20	307		4,017	27
28		Electrical wiring	2005		3,637	182	20	182		2,396	28
29		Kitchen rehab	2005		6,360	318	20	318		4,372	29
30		Elevator rehab	2005		8,948	447	20	447		6,110	30
31		Lounge, lobby, and reception area rehab	2005		27,662	1,383	20	1,383		18,210	31
32		Landscaping enhancements	2006		5,795	386	20	386		4,761	32
33		HVAC	2006		9,300	-	15	465	465	5,619	33
34		LHI-therapy room rehab LL TCU/main therapy	2006		33,184	1,659	20	1,659		20,461	34
35											35
36						-		-			36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center of Orland Park, Inc.# 0041855

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	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Landscaping	2007	\$ 17,383	\$ 1,159	15	\$ 1,159	\$	\$ 13,232	37
38	Parking lot	2007	1,120	56	20	56		635	38
39	Plumbing-Fine Dining	2007	2,068	103	20	103		1,228	39
40	Laundry Room Rehab	2007	37,283	1,864	20	1,864		21,902	40
41	Employee lunch room	2007	2,865	143	20	143		1,680	41
42	Basement Renovation	2007	1,148	57	20	57		651	42
43	Patio Improvements	2007	7,000	350	20	350		3,938	43
44	1st floor remodel-carpentry, flooring, plumbing, electrical-	2007	1,481,886	-	40	37,426	37,426	427,281	44
45	fixtures, painting	2007		-		-			45
46				-		-			46
47	Basement Renovation	2007	20,191	-	20	1,010	1,010	11,106	47
48	Therapy Room Renovation	2007	978	-	20	49	49	539	48
49	Landscaping	2008	4,300	287	15	287		2,894	49
50	Spot Coolers	2008	3,790	189	20	189		1,890	50
51	Emergency A/C	2008	32,295	807	40	807		8,406	51
52	Plumbing & Sprinkler-Showers	2008	5,047	126	40	126		1,260	52
53	Parking lot repairs	2008	5,285	264	20	264		2,794	53
54	Phone closet	2008	5,954	149	40	149		1,577	54
55	Landscaping	2009	4,190	279	15	279		2,534	55
56	1st floor admin room-heating, fire protection	2009	16,422	821	20	821		7,936	56
57	Quick connectors	2009	7,091	355	20	355		3,313	57
58	Electrical Room	2009	4,692	235	20	235		2,115	58
59	Glass and Mirrors Med Room	2009	4,954	142	35	142		1,349	59
60	Key pad common areas	2009	3,757	107	35	107		1,044	60
61	2nd Floor remodel-Doors and Locks	2009	32,130	803	40	803		7,829	61
62	Patio Pergola	2009	7,930	529	15	529		4,893	62
63	Patio Fence	2009	11,293	712	15	712		6,467	63
64	2nd floor remodel-carpentry, flooring, electrical, painting	2009	1,014,056	-	27	36,875	36,875	368,750	64
65	2nd floor remodel-carpentry	2009	17,258	-	27	628	628	6,227	65
66	Office carpentry, flooring, electrical, painting, plumbing	2010	70,270	2,666	27	2,666		27,025	66
67	Landscaping	2010	11,399	760	15	760		6,270	67
68	Physican office carpentry	2010	2,926	106	27	106		848	68
69	Repave/Seal Cracks in parking lot	2010	21,817	1,091	20	1,091		9,091	69
70	TOTAL (lines 4 thru 69)		\$ 11,701,790	\$ 21,157		\$ 311,842	\$ 290,685	\$ 5,970,886	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 Orland Park, Inc.

0041855

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	Totals from Page 12A, Carried Forward		\$ 11,701,790	\$ 21,157		\$ 311,842	\$ 290,685	\$ 5,970,886	1
2	Roof	2010	74,000	2,691	27	2,691		23,098	2
3	HVAC-Exhaust Modification	2010	4,202	153	27	153		1,249	3
4	Nurse pull cord station	2010	3,933	143	27	143		1,144	4
5	Paint lights over bed	2010	7,738	281	27	281		2,272	5
6	Trench/Awning	2010	11,666	424	27	424		3,482	6
7	Remodel Library/Lounge-art, flooring, carpentry	2010	4,120	150	27	150		1,200	7
8	3rd floor remodel-carpentry, electrical, plumbing	2010	868,783	-	27	67,183	67,183	565,457	8
9				-		-			9
10	Office-carpentry, flooring, electrical, painting, plumbing and signs	2011	6,710	244	27	244		1,830	10
11	Office Remodel- Doors and Locks	2011	31,324	1,139	27	1,139		9,966	11
12	Office Remodel- Doors and Locks	2011	5,282	192	27	192		1,504	12
13	Additional parking spaces	2011	196,376	7,141	27	7,141		51,772	13
14	Roof Repairs	2011	58,800	2,138	27	2,138		16,035	14
15	Fire Dampers	2011	5,586	203	27	203		1,438	15
16	Pantry Remodel - Millwork and Flooring	2011	3,730	136	27	136		975	16
17	Laundry Room Remodel - Flooring, Painting and Electrical	2011	9,172	334	27	334		2,421	17
18	2nd Floor Remodel - Doors	2011	12,612	459	27	459		3,366	18
19				-		-			19
20	Parking lot	2012	12,906	469	27	469		2,853	20
21	Chiller replacement kitchen	2012	108,732	3,954	27	3,954		25,371	21
22				-		-			22
23	Fire Pump- Basement	2013	5,000	125	40	125		740	23
24	EMR Wiring- Entire Facility	2013	19,542	711	27	711		3,614	24
25	New Countertop, wall, tile- Kitchen	2013	3,026	110	27	110		559	25
26	Stairway Access Control- Entire Facility (1st-3rd floor stairs)	2013	6,463	235	27	235		1,195	26
27				-		-			27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		\$ 13,161,493	\$ 42,589		\$ 400,457	\$ 357,868	\$ 6,692,427	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 Orland Park, Inc.

0041855

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	Totals from Page 12B, Carried Forward		\$ 13,161,493	\$ 42,589		\$ 400,457	\$ 357,868	\$ 6,692,427	1
2				-		-			2
3	Parking lot paving	2014	119,164	4,333	27	4,333		17,332	3
4	Kitchen Chiller Replacement	2014	126,990	4,618	27	4,618		21,166	4
5	Kitchen sink, drywall, tile	2014	15,968	581	27	581		2,662	5
6	Create Workspace in 1st floor library	2014	16,429	597	27	597		2,737	6
7				-		-			7
8	R/M Repair Concrete Walk (Front Entrance)	2014	3,393	-	15	223	223	1,017	8
9	R/M Replace Radiator/Thermostat	2014	7,190	-	10	719	719	3,236	9
10				-		-			10
11	EMR Building Wiring - Entire Facility	2015	5,038	183	27	183		656	11
12	Room Remodel - First Floor Semi-private room			-		-			12
13	converted to Private room	2015	5,375	195	27	195		602	13
14				-		-			14
15	R/M Parking Lot - Remove and replace asphalt	2015	5,200	-	20	260	260	910	15
16				-		-			16
17	Asphalt Removal/Replacement and Trench/Drain Installation in	2016	12,750	638	20	638		1,648	17
18	Parking Lot			-		-			18
19	Floor Tiling in First Floor Front Offices	2016	4,888	489	10	489		1,304	19
20	Chair Rail Installation in First Floor Rooms	2016	14,378	533	27	533		1,153	20
21				-		-			21
22	R/M: Frame/Drywall Installation in Boiler Room Exit Vestibule	2016	3,630	-	27	134	134	335	22
23				-		-			23
24	R/M: Striping Parking Lot	2017	2,600	-	27	96	96	144	24
25	R/M: Replace Canopy Roof and Block - Front Entrance	2017	2,900	-	15	193	193	290	25
26	R/M: Remove and replace underground pipe - Kitchen	2017	7,000	-	20	350	350	525	26
27	R/M: Millwork needed to install TV per drawing - common area	2017	2,750	-	15	183	183	275	27
28				-		-			28
29	Reconcile to book depreciation			854		-	(854)		29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		\$ 13,517,135	\$ 55,609		\$ 414,782	\$ 359,173	\$ 6,748,419	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 Orland Park, Inc.

0041855

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	Totals from Page 12C, Carried Forward		\$ 13,517,135	\$ 55,609		\$ 414,782	\$ 359,173	\$ 6,748,419	1
2				-		-			2
3	Building - management company	2002	343,815	-	40	7,922	7,922	168,004	3
4	HVAC, electrical, security system - management company	2003	3,021	-	30	275	275	2,583	4
5	Key card system - management company	2004	473	-	20	25	25	342	5
6	VAV TX controls - management company	2005	145	-	20	8	8	99	6
7	Interior Signs - management company	2006	107	-	20	7	7	85	7
8	Building improvements - management company	2008	15,194	-	20	191	191	6,875	8
9	Building improvements - management company	2009	2,896	-	20	166	166	1,505	9
10	Building improvements - management company	2010	2,842	-	20	127	127	1,365	10
11	Building improvements - management company	2011	2,142	-	20	104	104	746	11
12	Building improvements - management company	2012	6,722	-	20	259	259	1,650	12
13	Building improvements - management company	2013	5,585	-	20	337	337	2,059	13
14	Building improvements - management company	2014	3,021	-	20	314	314	1,363	14
15	Building improvements - management company	2015	532	-	20	68	68	225	15
16	Building improvements - management company	2016	8,771	-	20	677	677	1,552	16
17	Building improvements - management company	2017	5,607	-	20	252	252	347	17
18	Building improvements - management company	2018	1,063	-	20	23	23	22	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)		\$ 13,919,071	\$ 55,609		\$ 425,537	\$ 369,928	\$ 6,937,241	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	\$ 156,694	\$ 29,051	\$ 29,051	\$ -	5-10	\$ 92,638	71
72	Current Year Purchases	33,403	4,110	4,110	-	5	4,110	72
73	Fully Depreciated Assets	1,177,999			-	5-10	1,177,999	73
74	Allocated from Mgmt. Co.	660,154		18,448	18,448	5-7	604,803	74
75	TOTALS	\$ 2,028,250	\$ 33,161	\$ 51,609	\$ 18,448		\$ 1,879,550	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.			62,484	-	2,398	2,398	5	56,503	79
80	TOTALS			\$ 62,484	\$ -	\$ 2,398	\$ 2,398		\$ 56,503	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)	\$ 16,811,059	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,770	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 479,544	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 390,774	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,873,294	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	Parking space lease				6,500			5
6	Allocated from Management Compar				5,721			6
7	TOTAL				\$ 12,221			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: \$ 45,534 Description: See Sch 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20	Allocated from Management Company			276	20
21	TOTAL		\$ _____	\$ 276	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 Orland Park, Inc.
IDPH License ID Number: 0041855
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	10,336
Postage	323
Med Equip	14,089
Oxygen	18,590
Mgmt Alloc.	2,196
Total Rental Exp.	<u>45,534</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	12,809	\$ 744,396	\$	12,809	\$ 744,396	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		6,887	218,004		6,887	218,004	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		14,134	836,976	6,930	14,134	843,906	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				318,023		318,023	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Sch16A	39(3)				5,231			5,231	12
13	Other (specify): See Sch16A	39(2)					12,305		12,305	13
14	TOTAL			\$	33,830	\$ 1,804,607	\$ 337,258	33,830	\$ 2,141,865	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 Orland Park, Inc.
IDPH License ID Number: 0041855
Fiscal Year End: 12/31/18

Schedule 16A

XIV. Special Services (Direct Cost)

Line 12 Other (specify)

Description	Schedule V line and column reference	Amount
Dentist	39(3)	401
Ambulance	39(3)	4,830
Total - Line 12		5,231

Line 13 Other (specify)

Description	Schedule V line and column reference	Amount
DME	39(2)	136
Oxygen	39(2)	12,169
Total - Line 13		12,305

Facility Name & ID Number Lexington Health Care Center of Orland Park, Inc. # 0041855

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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 43,847	\$ 145,784	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>4,369,681</u>)	2,126,821	2,126,821	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	35,551	35,551	7
8	Accounts Receivable (owners or related parties)	119	119	8
9	Other(specify): <u>Accrued Insurance</u>	398,483	264,904	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,604,821	\$ 2,573,179	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1	1	12
13	Land		801,254	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	1,475,866	5,309,897	15
16	Equipment, at Historical Cost	669,624	2,090,734	16
17	Accumulated Depreciation (book methods)	(1,070,574)	(8,869,984)	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 (sp) <u>Rec. fr. Ins. Recovery</u>	1,552,546	1,552,546	22
23	Other(specify): <u>Mortgage cost net</u>		318,628	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,627,463	\$ 9,772,362	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,232,284	\$ 12,345,541	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 965,116	\$ 965,116	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	536,306	536,306	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,184	28,184	31
32	Accrued Real Estate Taxes(Sch.IX-B)		804,516	32
33	Accrued Interest Payable		58,950	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	12,991,629	5,090,818	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 14,521,235	\$ 7,483,890	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,040,463	2,040,463	39
40	Mortgage Payable		9,008,529	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)	\$ 2,040,463	\$ 11,048,992	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,561,698	\$ 18,532,882	46
47	TOTAL EQUITY(page 18, line 24)	\$ (11,329,414)	\$ (6,187,341)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,232,284	\$ 12,345,541	48

*(See instructions.)

Facility Name: Lexington Health Care Center of Orland Park, Inc.
 IDPH License ID Number: 0041855
 Fiscal Year End: 12/31/18

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Cash Patient Trust	(28,840)	(28,840)
Pa Audit Settlement	6	6
Rent Receivable	-	(7,900,811)
Due To Lex Fin Svcs I	-	-
Due To / From Rehab Care Therapy	(54)	(54)
Due From -/Royal	-	-
Prepaid Insurance	53,092	53,092
Cobra	(1,569)	(1,569)
Withholding - Dental Insurance	(6,201)	(6,201)
Withholding - Ep/Ci/WI	(3,562)	(3,562)
Withholding - Short Term Disab	-	-
Life Insurance Withholding	-	-
Vision Withholding	(774)	(774)
401K Withholding	299	299
Accrued Expenses	61,885	61,885
Accrued Resident Tax	-	-
Accrued Vesta 3% Management Fees	3,025,390	3,025,390
Accrued Royal Management Fees	(83,528)	(83,528)
Accrued Rent	7,900,811	7,900,811
Accrued Insurance	167,835	167,835
Due To Patient Trust Fund	29,803	29,803
Advance - Biweekly Part A Paym	25,348	25,348
Uncollectible Part A Co Pvts	-	-
Due To - Royal Operations	22,394	22,394
Due To Republic	2,550	2,550
Due To Lhcc Elmhurst	(14,633)	(14,633)
Due To Lagrange	-	-
Due From Ins Carrier	(15,238)	(15,238)
Professional Liabilities Claims	1,856,615	1,856,615
Total - Line 36	12,991,629	5,090,818

- -

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (9,568,810)	1
2	Restatements (describe):		2
3	Changes in Equity and Post Closing Adjustment	(415,652)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,984,462)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,344,952)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,344,952)	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)	\$ (11,329,414)	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 20,280,249	1
2	Discounts and Allowances for all Levels	(10,487,385)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,792,864	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,859,961	6
7	Oxygen	171	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,860,132	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	638	12
13	Barber and Beauty Care	13,420	13
14	Non-Patient Meals	370	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	441,246	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	245,148	19
20	Radiology and X-Ray	34,532	20
21	Other Medical Services	212,806	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 948,160	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	30,307	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30,307	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,115	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,115	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,632,578	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,919,825	31
32	Health Care	6,169,918	32
33	General Administration	3,995,739	33
B. Capital Expense			
34	Ownership	2,198,860	34
C. Ancillary Expense			
35	Special Cost Centers	3,234,739	35
36	Provider Participation Fee	458,449	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,977,530	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,344,952)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,344,952)	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,457,089	44
45	Private Pay - Net Inpatient Revenue	2,115,766	45
46	Medicare - Net Inpatient Revenue	766,778	46
47	Other-(specify) <u>Managed Care</u>	3,453,231	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,792,864	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 Orland Park, Inc.

0041855

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	1,761	2,185	\$ 145,845	\$ 66.75	1
2	Assistant Director of Nursing	1,789	2,050	101,980	49.73	2
3	Registered Nurses	35,285	43,788	1,456,852	33.27	3
4	Licensed Practical Nurses	31,242	39,277	1,054,165	26.84	4
5	CNAs & Orderlies	101,385	123,483	1,777,089	14.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,163	1,360	29,775	21.89	9
10	Activity Assistants	8,713	10,545	131,502	12.47	10
11	Social Service Workers	7,588	9,348	198,768	21.26	11
12	Dietician	3,479	3,950	90,607	22.94	12
13	Food Service Supervisor	1,692	2,206	46,601	21.12	13
14	Head Cook	1,780	2,100	43,236	20.59	14
15	Cook Helpers/Assistants	22,247	25,366	295,222	11.64	15
16	Dishwashers					16
17	Maintenance Workers	1,835	2,156	44,441	20.62	17
18	Housekeepers	30,087	35,106	430,876	12.27	18
19	Laundry					19
20	Administrator	1,767	2,182	158,481	72.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,246	5,416	116,147	21.44	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	1,667	2,019	40,743	20.18	31
32	Other Health C: See Sch 20A	21,171	26,555	742,192	27.95	32
33	Other(specify) <u>Marketing/Barber</u>			4,787		33
34	TOTAL (lines 1 - 33)	278,899	339,094	\$ 6,909,309 *	\$ 20.38	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	\$ 2,787	1(3) 35
36	Medical Director	Monthly	31,250	9(3) 36
37	Medical Records Consultant	Monthly	861	10(3) 37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly	17,490	10(3) 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly	4,879	11(3) 44
45	Social Service Consultant	Monthly	4,626	12(3) 45
46	Other(specify) <u>Pulmonary Consultant</u>	Monthly	80,303	10(3) 46
47	<u>Medical Consultant</u>	Monthly	647	10(7) 47
48	<u>See Sch 20B</u>	Monthly	13,134	10(3) 48
49	TOTAL (lines 35 - 48)		\$ 155,977	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name: Lexington Health Care Center of Orland Park, Inc.
IDPH License ID Number: 0041855
Fiscal Year End: 12/31/18

Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Accounts Coordinator	1,811	2,143	31,108	15
Admissions	1,712	2,033	76,672	38
Clinical Coordinator	3,129	3,976	141,583	36
MDS	2,494	3,189	125,135	39
Staffing Coordinator	1,841	2,268	44,334	20
Unit Secretary	5,365	6,863	142,489	21
Wound Care Coordinator	4,819	6,082	180,870	30
Total - Line 32 Other Health Care (specify):	21,171	26,555	742,192	

Facility Name:
IDPH License ID Number:
Fiscal Year End:

Schedule 20B

B. CONSULTANT SERVICES

Description	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
Post Acute Consultant	Monthly	4,009	10(3)
Telemedicine Consultant	Monthly	9,125	10(3)
Total - Line 48		13,134	

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	
Nikki Dinsmore	Administrator	0	\$ 158,481	Workers' Compensation Insurance	\$ 131,049	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	67,478	Advertising: Employee Recruitment	6,185	
				FICA Taxes	515,582	Health Care Worker Background Check (Indicate # of checks performed _____)	1,997	
				Employee Health Insurance	192,836	Patient Background Checks	6,322	
				Employee Meals		Miscellaneous Licenses & Fees	3,857	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	509	
				401K	6,395	IHCA	5,337	
				Tuition	234	Management Company Allocation	21,320	
				Other Employee Benefits	30,408	Less: Non-Allowable Dues	(1,701)	
				Uniform Allowance	(4,117)	Less: Public Relations Expense	()	
				CNA Testing	137	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 158,481	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL			\$ 158,481	TOTAL		\$ 45,816		
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
Royal-Shared Services			\$ 762,769	N/A		\$	Out-of-State Travel	\$
Management fees- Royal Operating			965,639				In-State Travel	
							Seminar Expense	
							Allocated from Home Office	948
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,728,408	TOTAL		\$	Entertainment Expense	()
TOTAL			\$ 1,728,408	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL			\$ 1,728,408	TOTAL		\$	TOTAL	
C. Professional Services			Amount					
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Much Shelist - Legal	Legal		\$ 5,752					
Serpico, Petrosino	Legal		14,100					
Midcap Financial	Legal		3,928					
Gneration Law	Legal		4,028					
General fee	Legal		100					
Hinshaw & Culbertson	Legal		234					
Huges Socol Piers	Legal		942					
Meguire Woods	Legal		5,341					
Bert Spilker Associates	Legal		76					
Duane Morris	Legal		1,954					
Various	Collections		29,137					
See Sch 21C	See Sch 21C		182,057					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 247,649	TOTAL		\$	TOTAL	
TOTAL			\$ 247,649	TOTAL		\$	TOTAL	

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Lexington Health Care Center of Orland Park, Inc.
 IDPH License ID Number: 0041855
 Fiscal Year End: 12/31/18

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	38,720
Personnel Planners Inc	U/C Consulting	2,340
Pension Administrators	401K Administrators	905
Midcap Financial	Financial	5,655
Lexington Financial Services	401K Audit	6,365
Telemedicine	Computer Services	5,792
Curatess	Computer Services	5,792
Royal Management/Operat	Computer Services	44,389
MHC	Computer Services	29
Onshift	Computer Services	9,578
Relias	Computer Services	9,569
Icims	Computer Services	6,078
Salesforce	Computer Services	8,705
Info Controls	Computer Services	3,491
National Datacare Corp.	Computer Services	3,022
Sophos	Computer Services	2,273
Comp Supply	Computer Services	1,436
Softchoice	Computer Services	3,241
Ms Licensung	Computer Services	11,541
Microsoft	Computer Services	3,024
Netsmart	Computer Services	3,507
The Joint Commission	Consultancy	6,606

Total (agree to Schedule V, line 19, column 3) 247,649

Allocated from Real Estate Entity	Professional Services	202
Less: Non-Allowable Legal Fees		(31,204)

Total (agree to Schedule V, line 19, column 8) 216,647

Allocated from Management Company

Much Shelist	Legal	2,050
Duane Morris	Legal	1,312
Partridge Partners	Legal	99
RSM	Accounting	2,252
Friedman & Huey	Accounting	678
IL Secretary of State	Filing Fees	7
West Suburban Bank	Banking	8
Personnel Planners	U/C Consultant	14
LaSalle Network	Recruiting / Finance	11,893
Pension Administrators, Inc.	401K Administration	309
Gene Whitehorn	Public Aid Pending Consultant	2,050
Steeley Group LLC	Financial Consulting	3,343
M Werner Consulting	Public Aid Consultant	92
Early Stage Solutions	Financial Consulting	22,672
Objective Arts	Public Aid Pending Consultants	415
Adam Lefton	Financial Consulting	9,615
Brilliant Staffing LLC	Financial Consulting	3,196
Mark J Eenigenburg	Budgeting Consultant	2,991
Deloitte Consulting LLP	Compensation Consulting	1,402
John Mattone Partners	Workplace Consultant	7,731
Mark Rodeghier	Survey Preparation Consultant	414
JGC Advisors LLC	Contracting Consultant	194
Michel Desjardins	Contracting Consultant	104
Pathway Health Services	Operational & Financial Consulting	(221)
Brandlin & Associates	Banking Consultants	29,822
Steven Wood	Strategy/Operations Consulting	1,176
Susan Parker	Social Service Consultant	19
Focus Pointe Global	Strategic Planning	325
Andrzej Stankiewicz	General Business Consulting	272
DLC	Financial Planning & Analysis	4,369
Fieldwork	Recruitment Consultant	584
Computer Services	Computer Consulting	26,948
		<u>136,137</u>

Allocated from SV of Lombard II

Friedman & Huey	Accounting	169
Duane Morris	Legal	31
Illinois Secretary of State	Filing Fees	3
		203

352,987

Facility Name & ID Number Lexington Health Care Center of Orland Park, Inc.# 0041855

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 - \$5337
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,587 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. \$ 458,449
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 370
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.