FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0038083

Facility Name: Lexington of LaGrange

Address: 4735 Willow Springs (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 352-6900 **Fax #** (708) 482-0239

HFS ID Number:

Date of Initial License for Current Owners: 7/31/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	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	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			19,812	19,812	8
9	SNF/PED					9
10	ICF	4,253	4,517	382	9,152	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,253	4,517	20,194	28,964	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.95%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold 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 [X] 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 [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 13,933

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	401,401	19,068	3,531	424,000		424,000		424,000			1
2	Food Purchase		202,884		202,884		202,884	(3,715)	199,169			2
3	Housekeeping	330,005	25,360		355,365		355,365	198	355,563			3
4	Laundry		8,489		8,489		8,489		8,489			4
5	Heat and Other Utilities			190,029	190,029		190,029	4,843	194,872			5
6	Maintenance	43,439		153,458	196,897		196,897	49,289	246,186			6
7	Other (specify):* Alloc. Mgmt Co. Bene							6,337	6,337			7
8	TOTAL General Services	774,845	255,801	347,018	1,377,664		1,377,664	56,952	1,434,616			8
	B. Health Care and Programs											
9	Medical Director			50,547	50,547		50,547		50,547			9
10	Nursing and Medical Records	3,663,619	311,606	108,329	4,083,554		4,083,554	21,994	4,105,548			10
10a	Therapy											10a
11	Activities	95,735	17,904	7,995	121,634		121,634		121,634			11
12	Social Services	176,859		3,427	180,286		180,286		180,286			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Mgmt Co. Bene							2,869	2,869			15
16	TOTAL Health Care and Programs	3,936,213	329,510	170,298	4,436,021		4,436,021	24,863	4,460,884			16
	C. General Administration											
17	Administrative	128,410		1,105,932	1,234,342		1,234,342	(1,072,034)	162,308			17
18	Directors Fees											18
19	Professional Services			206,090	206,090		206,090	8,270	214,360			19
20	Dues, Fees, Subscriptions & Promotions			34,035	34,035		34,035	7,622	41,657			20
21	Clerical & General Office Expenses	158,086	25,193	78,176	261,455		261,455	432,795	694,250			21
22	Employee Benefits & Payroll Taxes			965,848	965,848		965,848		965,848			22
23	Inservice Training & Education			7,744	7,744		7,744	220	7,964			23
24	Travel and Seminar			80	80		80	664	744			24
25	Other Admin. Staff Transportation			5,599	5,599		5,599	7,236	12,835			25
26	Insurance-Prop.Liab.Malpractice			192,181	192,181		192,181	1,792	193,973			26
27	Other (specify):* Alloc. Mgmt Co. Bene							63,560	63,560			27
28	TOTAL General Administration	286,496	25,193	2,595,685	2,907,374		2,907,374	(549,875)	2,357,499			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,997,554	610,504	3,113,001	8,721,059		8,721,059	(468,060)	8,252,999			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 of LaGrange #0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			102,695	102,695		102,695	289,091	391,786			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,146	2,146		2,146	328,333	330,479			32
33	Real Estate Taxes							339,894	339,894			33
34	Rent-Facility & Grounds			1,180,936	1,180,936		1,180,936	(1,178,027)	2,909			34
35	Rent-Equipment & Vehicles			72,393	72,393		72,393	1,379	73,772			35
36	Other (specify):*											36
37	TOTAL Ownership			1,358,170	1,358,170		1,358,170	(219,330)	1,138,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		580,892	1,918,705	2,499,597		2,499,597		2,499,597			39
40	Barber and Beauty Shops			8,942	8,942		8,942		8,942			40
41	Coffee and Gift Shops			109	109		109		109			41
42	Provider Participation Fee			152,668	152,668		152,668		152,668			42
43	Other (specify):* Non-Allowable Cos	93,175		240,693	333,868		333,868	(333,868)				43
44	TOTAL Special Cost Centers	93,175	580,892	2,321,117	2,995,184		2,995,184	(333,868)	2,661,316			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,090,729	1,191,396	6,792,288	13,074,413		13,074,413	(1,021,258)	12,053,155			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 of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,715)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,643)	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	(1,602)	30		9
10	Interest and Other Investment Income	(4,473)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,985)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,530)	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	(141,145)	43		24
25	Fund Raising, Advertising and Promotional	(30,484)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(393)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	57,604	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (139,366)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(881,892)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (881,892)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,021,258)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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 of LaGrange

ID# 0038083

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (30,451)	43	1
2	X-Rays-Part A	(19,201)	43	2
3	Diagnostics Managed Care	(3,861)	43	3
4	Trust Fees	(195)	43	4
5	Collections	(4,983)	19	5
6	Out of Period & Non-Allowable Legal	(722)	19	6
7	Marketing Salary	(93,175)	43	7
8	Unrealized Loss on FMV Swap	220,358	43	8
9	Disallow Marketing Software	(6,490)	19	9
10	Disallowed Lobbying	(1,564)	20	10
11	Non-Allowable Consulting	(2,112)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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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**	57,604		49

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Sambell of LaGrange Limited Partnership	**	$ 200	$ 200	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	**	320,464	320,464	3
4	V	32	Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	1,339	1,339	4
5	V	33	Property Taxes		Sambell of LaGrange Limited Partnership	**	335,936	335,936	5
6	V	34	Rental Income	1,180,936	Sambell of LaGrange Limited Partnership	**		(1,180,936)	6
7	V	43	Trust Fees		Sambell of LaGrange Limited Partnership	**	195	195	7
8	V	43	Unrealized loss on FMV swap	220,358	Sambell of LaGrange Limited Partnership	**		(220,358)	8
9	V				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			$ 1,401,294			$ 888,316	$ * (512,978)	14

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 198	$ 198	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	4,366	4,366	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	184	184	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	293	293	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	44,949	44,949	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	4,152	4,152	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	188	188	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	6,337	6,337	22
23	V	10	Medical consultant		Royal Management Corp.	**	1,640	1,640	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	20,354	20,354	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	2,869	2,869	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	33,898	33,898	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	9,074	9,074	27
28	V	19	Professional fees		Royal Management Corp.	**	13,303	13,303	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,352	1,352	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	7,834	7,834	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	416,955	416,955	31
32	V	21	Bank charges		Royal Management Corp.	**	1,669	1,669	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	5,638	5,638	33
34	V	21	Postage		Royal Management Corp.	**	2,098	2,098	34
35	V	21	Telephone		Royal Management Corp.	**	6,435	6,435	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			$			$ 583,786	$ * 583,786	39

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	23	Inservice Training	$	Royal Management Corp.	**	$ 220	$ 220	15
16	V	24	Travel & seminar		Royal Management Corp.	**	664	664	16
17	V	25	Auto expense		Royal Management Corp.	**	7,236	7,236	17
18	V	26	Insurance general		Royal Management Corp.	**	1,792	1,792	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	63,560	63,560	19
20	V	30	Depreciation		Royal Management Corp.	**	60,511	60,511	20
21	V	32	Interest		Royal Management Corp.	**	9,641	9,641	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,362	1,362	22
23	V	33	Property taxes		Royal Management Corp.	**	3,958	3,958	23
24	V	34	Rent expense		Royal Management Corp.	**	2,909	2,909	24
25	V	35	Equipment rental		Royal Management Corp.	**	846	846	25
26	V	17	Management fees	1,105,932	Royal Management Corp.	**		(1,105,932)	26
27	V	35	Auto Lease		Royal Management Corp.	**	533	533	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			$ 1,105,932			$ 153,232	$ * (952,700)	39

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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					Lexington Home	Lombard	Home Health	23
24					Health Care, Inc.			24
25					Lexington Hospice	Lombard	Hospice	25
26					Services, LLC			26
27					Lexington Private	Lombard	Healthcare	27
28					Home Care			28
29					Merit Sleep	Lombard	Mgmt. Company	29
30					Management, LLC			30

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Bloomingdale	Real Estate	1
2					Bloomingdale Ltd.		Property	2
3					Ptsp.			3
4					Sambell of Chicago	Chicago Ridge	Real Estate	4
5					Ridge Ltd. Ptsp.		Property	5
6					Sambell of Elmhurst	Elmhurst	Real Estate	6
7					II Ltd. Ptsp.		Property	7
8					Lexington HC Sys	Lake Zurich	Real Estate	8
9					of Lake Zurich Ltd.		Property	9
10					Ptsp.			10
11					Lexington HC Sys	Lombard	Real Estate	11
12					of Lombard Ltd. Ptsp.		Property	12
13					Lexington HC Sys	Orland Park	Real Estate	13
14					of Orland Park Ltd.		Property	14
15					Ptsp.			15
16					Sambell of	Schaumburg	Real Estate	16
17					Schaumburg Ltd. Ptsp		Property	17
18					Sambell of	Streamwood	Real Estate	18
19					Streamwood Ltd. Ptsp		Property	19
20					Lexington HC Sys	Wheeling	Real Estate	20
21					of Wheeling Ltd. Ptsp.		Property	21
22					Samvest of Algonquin	Algonquin	Real Estate	22
23					Ltd. Ptsp.		Property	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 5,653	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,932	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,243	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,852	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	11,218	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,898		13

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

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days Available	724,314	10	$ 3,263	$	43,920	$ 198	1
2	5	Utilities - gas & electric	Bed Days Available	724,314	10	72,000		43,920	4,366	2
3	5	Utilities - water & sewer	Bed Days Available	724,314	10	3,036		43,920	184	3
4	5	Utilities - maintenance office	Bed Days Available	724,314	10	4,835		43,920	293	4
5	6	Management allocation - salaries	Bed Days Available	724,314	10	741,281	741,281	43,920	44,949	5
6	6	Repairs & maintenance	Bed Days Available	724,314	10	68,481		43,920	4,152	6
7	6	Scavenger & exterminating	Bed Days Available	724,314	10	3,101		43,920	188	7
8	7	Management allocation - employee	Bed Days Available	724,314	10	104,504		43,920	6,337	8
9	10	Medical consultant	Bed Days Available	724,314	10	27,047		43,920	1,640	9
10	10	Management allocation - salaries	Bed Days Available	724,314	10	335,674	335,674	43,920	20,354	10
11	15	Management allocation - employee	Bed Days Available	724,314	10	47,322		43,920	2,869	11
12	17	Management allocation - salaries	Bed Days Available	724,314	10	559,036	559,036	43,920	33,898	12
13	19	Computer consultant & supplies	Bed Days Available	724,314	10	149,651		43,920	9,074	13
14	19	Professional fees	Bed Days Available	724,314	10	219,386		43,920	13,303	14
15	20	Dues & subscriptions	Bed Days Available	724,314	10	22,289		43,920	1,352	15
16	20	Advertising - help wanted	Bed Days Available	724,314	10	129,203		43,920	7,834	16
17	21	Management allocation - salaries	Bed Days Available	724,314	10	6,876,284	6,876,284	43,920	416,955	17
18	21	Bank charges	Bed Days Available	724,314	10	27,523		43,920	1,669	18
19	21	Office supplies & printing	Bed Days Available	724,314	10	92,982		43,920	5,638	19
20	21	Postage	Bed Days Available	724,314	10	34,606		43,920	2,098	20
21	21	Telephone	Bed Days Available	724,314	10	106,126		43,920	6,435	21
22										22
23										23
24										24
25	TOTALS					$ 9,627,630	$ 8,512,275		$ 583,786	25

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	23	Inservice Training	Bed Days Available	724,314	10	$ 3,621	$	43,920	$ 220	1
2	24	Travel and Seminar	Bed Days Available	724,314	10	10,947		43,920	664	2
3	25	Auto expense	Bed Days Available	724,314	10	119,337		43,920	7,236	3
4	26	Insurance general	Bed Days Available	724,314	10	29,556		43,920	1,792	4
5	27	Management allocation - employee	Bed Days Available	724,314	10	1,048,208		43,920	63,560	5
6	30	Depreciation	Bed Days Available	724,314	10	997,930		43,920	60,511	6
7	32	Interest	Bed Days Available	724,314	10	158,994		43,920	9,641	7
8	32	Amortization of mortgage costs	Bed Days Available	724,314	10	22,462		43,920	1,362	8
9	33	Property taxes	Bed Days Available	724,314	10	65,273		43,920	3,958	9
10	34	Rent expense	Bed Days Available	724,314	10	47,968		43,920	2,909	10
11	35	Equipment rental	Bed Days Available	724,314	10	13,953		43,920	846	11
12	35	Auto Lease	Bed Days Available	724,314	10	8,793		43,920	533	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					$ 2,527,042	$		$ 153,232	25

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Sevices II, LLC	X		Mortgage	Varies	4/30/07	5,991,000	4,758,651	5/1/17	0.0650	320,464	2
3												3
4				Finance Charge - Insurance Poli								4
5								Finance Charge - Insurance Policy			1,301	5
	Working Capital											
6	American Chartered Bank		X	Line of Credit	Various	6/29/13	5,600,000		6/24/2017	Libor +2.25%		6
7												7
8												8
9	TOTAL Facility Related						$ 11,591,000	$ 4,758,651			$ 321,765	9
	B. Non-Facility Related*											
10								Amortization of loan cost			1,339	10
11								Interest Income			(3,172)	11
12								Allocated from Mgmt Co.			11,003	12
13								See Sch 9A			(456)	13
14	TOTAL Non-Facility Related						$	$			$ 8,714	14
15	TOTALS (line 9+line14)						$ 11,591,000	$ 4,758,651			$ 330,479	15

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 of LaGrange
IDPH License ID Number: 0038083
Fiscal Year End: 12/31/2016

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related* YES	Related* NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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-Use fee line of credit			791	10
11								Microsoft			46	11
12								American Chartered Bank			8	12
13								Non -Allowable Finance Charge			(1,301)	13
14	TOTAL Non-Facility Related				$0.00		$ 0	$ 0			$ (456)	14

Facility Name & ID Number Lexington of LaGrange # 0038083 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 374,400	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.)	2015	$ 369,109	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,291)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 390,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 16,448	5
	Alloc. Fr. Mgmt Co.	3,958	
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** $ 65,222 **For** 04/13 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (65,222)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 339,894	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	331,522	8
	2012	345,195	9
	2013	355,813	10
	2014	363,484	11
	2015	369,109	12

See attached real estate accrual sheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-08-207-017-0000	Land & Building	$ 205,951.61	$ 205,951.61
2.	18-08-207-018-0000	Land & Building	$ 163,157.67	$ 163,157.67
3.	Royal Management Corp. (Samvest of Lombard II)		$	$
4.	05-01-202-021	Land & Building	$ 249,002.30	$ 3,958.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 618,111.58	$ 373,067.28

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	40,000	1991	$ 500,000	1
2	Management Company Allocation			10,802	2
3	TOTALS	40,000		$ 510,802	3

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1992	1992	$ 2,661,448	$	35	$ 76,041	$ 76,041	$ 1,863,010	4
5			1995	1995	79,363		10			79,363	5
6			2005	2005	2,321,014		21	110,524	110,524	1,271,028	6
7											7
8											8
	Improvement Type**										
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	1,990	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 renovations			2002	150,083	7,505	20	7,505		105,691	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		26,074	24
25	HVAC			2005	8,141	407	20	407		4,511	25
26	Wiring			2005	4,506	225	20	225		2,532	26
27	Lobby, lounge and reception renovations			2005	24,362	1,218	20	1,218		13,804	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors			2005	326,862		20	16,343	16,343	179,773	28
29	Wallcoverings			2005	10,822		5			10,822	29
30	Medical records room rehab			2006	19,739	987	20	987		9,870	30
31	Activity/PT Room Rehab			2006	1,158	58	20	58		580	31
32	Land scape enhancement			2006	8,726	582	15	582		6,014	32
33	Roof			2006	29,700	1,980	15	1,980		20,460	33
34	HVAC			2006	3,254	163	20	163		1,684	34
35	Plumbing and sprinkler system			2006	20,725	1,036	20	1,036		11,397	35
36	Laundry Combustion Air			2006	16,814	841	20	841		9,040	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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		1,210	40
41	First floor remodel	2006	212,084		20	10,604	10,604	106,040	41
42	Kitchen rehab	2006	8,165	408	20	408		4,285	42
43	Bath fixtures-2nd foor	2006	2,076		10			2,076	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		1,761	44
45	Landscaping	2007	3,862	257	15	257		2,463	45
46	HVAC	2007	58,326	2,916	20	2,916		27,459	46
47	Common Areas Remodel	2007	2,059		10			2,059	47
48	First Floor Remodel	2007	6,517	-	20	326	326	3,177	48
49	Garage	2007	16,487	824	20	824		7,485	49
50	Land Improvements	2008	3,745	250	15	250		2,021	50
51	Parking lot-paving	2008	8,720	436	20	436		3,670	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		1,120	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	16,260	16,260	143,630	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		27,115	55
56	Irrigation System	2009	16,740	1,116	15	1,116		8,091	56
57	Landscaping	2009	10,321	688	15	688		4,988	57
58	Parking lot repairs	2009	3,500	175	20	175		1,327	58
59	HVAC Chiller	2009	2,594	130	20	130		964	59
60	Patio Pergola	2009	6,760	338	20	338		2,648	60
61	Stamped Concrete	2009	16,658	833	20	833		6,109	61
62	Fence	2009	4,084	204	20	204		1,445	62
63	Patio Wall	2009	8,212	411	20	411		2,980	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		2,032	64
65									65
66	Brick Panel Replacement	2010	16,578	603	27	603		4,020	66
67	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	17,565	641	27	641		3,846	67
68	Landscaping Enhancements	2010	15,258	1,017	15	1,017		6,611	68
69	Drain tile,sewer concrete	2010	3,221	214	15	214		1,330	69
70	TOTAL (lines 4 thru 69)		$ 6,882,020	$ 33,327		$ 263,508	$ 230,181	$ 4,084,621	70

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,882,020	$ 33,327		$ 263,508	$ 230,181	$ 4,084,621	1
2	Retaining wall	2010	15,736	1,049	15	1,049		6,294	2
3	Canopy Installation	2010	4,466	163	27	163		1,005	3
4	Dining Room HVAC	2010	4,169	152	27	152		988	4
5	Pantry carpentry,flooring,plumbing	2010	2,911	106	27	106		671	5
6	Director of Nursing office painting	2010	4,245	155	27	155		930	6
7	Remodel Library/Lounge-art,painting,flooring	2010	6,477	236	27	236		1,416	7
8	2nd floor doors	2010	3,046	111	27	111		749	8
9	Office changes-carpentry, painting, flooring	2011	2,487	90	27	90		503	9
10	Fence	2011	2,750	183	15	183		946	10
11	Mulch and stone	2011	2,662	177	15	177		915	11
12	Laundry Room-Tile, Painting	2011	7,311	266	27	266		1,419	12
13	Locker Room - Installation of 6 tier box lockers	2011	2,573	94	27	94		525	13
14	Place beds back into service - Carpentry, Flooring, Electrical,	2011	117,350	4,267	27	4,267		23,824	14
15	-Painting and Plumbing								15
16									16
17									17
18	Electrical wiring for EMR	2012	13,699	498	27	498		2,034	18
19									19
20	Landscaping (Planting roses and day lilies Main Entrance)	2014	10,648	177	15	177		531	20
21	Install Automatic Doors (Front Entrance)	2014	6,859	83	15	83		249	21
22	Install LED Lights throughout facility	2014	22,200	67	27	67		201	22
23	R/M Reclass: Elevator door restrictor (Front Entrance)	2014	3,500		10	350	350	875	23
24									24
25	Install LED Lights throughout facility	2015	22,799	829	27	829		898	25
26	Electrical wiring throughout facility	2015	5,832	212	27	212		336	26
27	R/M Reclass: asphalt and concrete work in parking lot	2015	15,650		20	783	783	1,174	27
28									28
29	Private Room Rehab - 1st floor install of chair rails	2016	17,444	106	27	106		106	29
30									30
31									31
32									32
33	Reconcile to book depreciation			2,734			(2,734)		33
34	TOTAL (lines 1 thru 33)		$ 7,176,834	$ 45,082		$ 273,662	$ 228,580	$ 4,131,210	34

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,176,834	$ 45,082		$ 273,662	$ 228,580	$ 4,131,210	1
2									2
3	Building - management company	2002	149,472		40	4,999	4,999	66,322	3
4	HVAC, electrical, security system - management company	2003	1,313		30	355	355	1,043	4
5	Key card system - management company	2004	206		20	12	12	128	5
6	VAV TX controls - management company	2005	63		20	4	4	37	6
7	Interior Signs-management company	2006	46		20	3	3	31	7
8	Building - management company	2008	7,244		20	91	91	3,166	8
9	Building - management company	2009	1,353		20	28	28	548	9
10	Building - management company	2010	1,319		20	28	28	506	10
11	Building - management company	2011	930		20	49	49	238	11
12	Building - management company	2012	3,213		20	19	19	549	12
13	Building - management company	2013	2,428		20	199	199	578	13
14	Building - management company	2014	1,314		20	148	148	330	14
15	Building - management company	2015	231		20	32	32	42	15
16	Building - management company	2016	3,814		20	109	109	109	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,349,780	$ 45,082		$ 279,738	$ 234,656	$ 4,204,837	34

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 559,598	$ 51,487	$ 51,487	$ -	5-10	$ 287,502	71
72	Current Year Purchases	4,562	6,126	6,126	-	10	6,126	72
73	Fully Depreciated Assets	458,067			-	5-7	458,067	73
74	Allocated from Mgmt. Co.	310,016		52,861	52,861	5-7	255,803	74
75	TOTALS	$ 1,332,243	$ 57,613	$ 110,474	$ 52,861		$ 1,007,498	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.			27,948	-	1,574	1,574	5	24,816	79
80	TOTALS			$ 27,948	$ -	$ 1,574	$ 1,574		$ 24,816	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)	$ 9,220,773	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 102,695	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 391,786	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 289,091	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,237,151	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.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Allocated from Management Company				2,909			6
7	TOTAL				$ 2,909 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 73,239 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	Allocated from Management Company			533	20
21	TOTAL		$	$ 533	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 of LaGrange**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2016**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	7,582
Mailing System	323
Printer	2,826
Medical Equipment	32,142
Oxygen Equipment	29,520
Management Company	846
Total - Line 16	**73,239**

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	12,990	$ 613,352	$	12,990	$ 613,352	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,776	138,804		4,776	138,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		31,820	1,165,061		31,820	1,165,061	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 prescrpts				566,613		566,613	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				1,488			1,488	12
13	Other (specify): See Sch. 16A	39(2)					14,279		14,279	13
14	TOTAL			$	49,586	$ 1,918,705	$ 580,892	49,586	$ 2,499,597	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 Streamwood, Inc.
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/2015

Schedule 16A

STATE OF ILLINOIS — Page 16A

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 **Report Period Beginning:** 1/01/201 **Ending** 12/31/2015

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Uni (Column 2	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therap		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify Oxygen	39(2)					9,241		10,345	12
13	Other (specify DME	39(2)					5,038		18,496	13
14	TOTAL			$		$	$ 14,279		$ 28,841	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 & ID Number Lexington of LaGrange **#** 0038083 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,077,719	$ 2,242,746	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 610,328)	1,777,919	1,777,919	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,946	83,946	6
7	Other Prepaid Expenses	12,213	12,213	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,951,797	$ 4,116,824	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		510,802	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	1,148,024	4,688,332	15
16	Equipment, at Historical Cost	424,167	1,360,191	16
17	Accumulated Depreciation (book methods)	(841,289)	(5,237,151)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe			22
23	Other(specify): Mortgage cost, net		20,859	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 737,954	$ 4,011,533	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,689,751	$ 8,128,357	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 565,618	$ 565,618	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	341,377	341,377	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,073	17,073	31
32	Accrued Real Estate Taxes(Sch.IX-B)		390,000	32
33	Accrued Interest Payable		27,861	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,187,002	960,347	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,111,070	$ 2,302,276	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,758,651	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)**	$	$ 4,758,651	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,111,070	$ 7,060,927	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,578,681	$ 1,067,430	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,689,751	$ 8,128,357	48

***(See instructions.)**

Facility Name: **Lexington of LaGrange**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2016**

Schedule 17A

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
Total - Line 23	-	-

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Cash Patient Trust	2,570	2,570
Due from LLC II	-	(1,804)
Sambell Rent Receivable	-	(314,504)
Due From Lexington Fin Svcs	275	275
Prepaid Insurance	2,230	2,230
401K Withholding	3,138	3,138
Accrued Expenses	166,050	166,050
Accrued Resident Tax	15,309	15,309
Accrued Royal/Vesta Mgmt Fees	748,409	748,409
Accrued Rent	314,504	314,504
Accrued Insurance	14,769	14,769
Due To Patient Trust Fund	(3,123)	(3,123)
Advance - Biweekly Part A Paymt	(125,931)	(125,931)
Uncollectible Part A Co Pvts	(184,792)	(184,792)
Due To - Royal Operations	10,948	10,948
Due To Republic	2,363	2,363
Due To Lake Zurich	(1,154)	(1,154)
Due To Wheeling	385	385
Sambell Interest Rate Swap Liability	-	89,653
Professional Liabilities Claim	221,052	221,052
Total - Line 36	**1,187,002**	**960,347**

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,531,532	1
2	Restatements (describe):		2
3	**Post closing adjustment**	(295,003)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,236,529	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(249,848)	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	(408,000)	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)**	$ (657,848)	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)**	$ 2,578,681	24 *

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,516,897	1
2	Discounts and Allowances for all Levels	(7,984,082)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,532,815	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,738,836	6
7	Oxygen	38,697	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,777,533	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,922	13
14	Non-Patient Meals	3,715	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	966,669	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	261,176	19
20	Radiology and X-Ray	28,424	20
21	Other Medical Services	241,139	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,511,045	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,172	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,172	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,824,565	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,377,664	31
32	Health Care	4,436,021	32
33	General Administration	2,907,374	33
	B. Capital Expense		
34	Ownership	1,358,170	34
	C. Ancillary Expense		
35	Special Cost Centers	2,842,516	35
36	Provider Participation Fee	152,668	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,074,413	40
41	**Income before Income Taxes (line 30 minus line 40)****	(249,848)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (249,848)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 737,704	44
45	Private Pay - Net Inpatient Revenue	1,229,035	45
46	Medicare - Net Inpatient Revenue	2,114,163	46
47	Other-(specify) Managed Care	451,913	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,532,815	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 of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,673	1,938	$ 112,236	$ 57.91	1
2	Assistant Director of Nursing	2,228	2,513	106,156	42.24	2
3	Registered Nurses	27,226	33,832	1,098,601	32.47	3
4	Licensed Practical Nurses	16,756	19,921	541,410	27.18	4
5	CNAs & Orderlies	67,864	78,585	1,097,941	13.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,789	2,160	41,056	19.01	9
10	Activity Assistants	3,982	4,746	54,679	11.52	10
11	Social Service Workers	7,549	8,533	176,859	20.73	11
12	Dietician	3,592	3,890	94,711	24.35	12
13	Food Service Supervisor	1,762	1,973	41,356	20.96	13
14	Head Cook	1,820	2,086	36,570	17.53	14
15	Cook Helpers/Assistants	18,170	21,044	228,764	10.87	15
16	Dishwashers					16
17	Maintenance Workers	1,883	2,206	43,439	19.69	17
18	Housekeepers	24,872	29,241	330,005	11.29	18
19	Laundry					19
20	Administrator	1,242	1,758	128,410	73.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,151	9,510	158,086	16.62	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	1,535	1,865	31,748	17.02	31
32	Other Health C: See Sch 20A	22,595	26,835	675,527	25.17	32
33	Other(specify) Marketing	1,752	2,027	93,175	45.97	33
34	TOTAL (lines 1 - 33)	215,441	254,663	$ 5,090,729 *	$ 19.99	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	50,547	9(3)	36
37	Medical Records Consultant	Monthly	390	10(3)	37
38	Nurse Consultant	Monthly			38
39	Pharmacist Consultant	Monthly	7,940	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	7,995	11(3)	44
45	Social Service Consultant	Monthly	3,427	12(3)	45
46	Other(specify) Pulmonary	Monthly	88,643	10(3)	46
47	Medical Consultant	Monthly	1,640	10(7)	47
48	See Sch 20B	Monthly	11,356	10(3)	48
49	TOTAL (lines 35 - 48)		$ 171,938		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 of LaGrange**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2016**

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
Staffing Coordinator	999	1,317	16,220	$ 12.32
Unit Secretary	5,415	6,282	116,408	$ 18.53
Accounts Coordinator	1,598	1,984	38,635	$ 19.47
Admissions	3,352	3,877	82,464	$ 21.27
MDS	1,693	1,992	81,886	$ 41.11
Clinical Coordinator	4,420	5,354	186,229	$ 34.78
Concierge	1,396	1,613	27,460	$ 17.02
Wound Care Coordinator	1,862	2,260	58,851	$ 26.04
Transitional Care Nurse	1,860	2,156	67,373	$ 31.26
Total - Line 32 Other Health Care (specify):	**22,595**	**26,835**	**675,527**	**$ 25.17**

Facility Name: **Lexington Health Care Center of LaGrange, Inc.**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2016**

Schedule 20B

XVIII. SUPPORT SCHEDULES
B: Consultant Services

Description	# of Hrs. Paid and Accrued	Total Consultant Cost	Ref.
Post Acute Consulting	Monthly	2,206	10(3)
Telemedicine Consulting	Monthly	9,150	10(3)
Total - Line 48		**11,356**	

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Renee Mills	Administrator	0	$ 36,603
Rachel Mabe	Administrator	0	91,807
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 128,410

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 721,584
Management Fees-Vesta Mgmt.	384,348
Management Fees (Eliminated in Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,105,932
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cash Receipts	Collections	$ 3,488
Cassiday Schade	Legal	64,638
Duane Morris	Legal	2,276
RSM US LLP	Accounting	40,909
Personnel Planners	U/C Consulting	2,100
Much Shelist	Legal	2,862
Pension Administrators	401K Administration	740
American Chartered Bank	Financial	9,361
SB2, Inc.	Medicaid Consulting	2,484
Attadale Partners	Operations Consulting	9,990
Jefferies	Tax Consulting	2,112
See Schedule 21C		65,130
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 206,090

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 177,674
Unemployment Compensation Insurance	79,470
FICA Taxes	382,603
Employee Health Insurance	275,653
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	19,253
Other Employee Benefits	19,140
Uniform Expense	2,964
Tuition	9,091
TOTAL (agree to Schedule V, line 22, col.8)	$ 965,848

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,613
Health Care Worker Background Check	
(Indicate # of checks performed 254)	3,044
Patient Background Checks 846	10,155
Miscellaneous Licenses & Fees	3,661
Miscellaneous Dues & Subscriptions	8,420
IHCA Dues	4,152
Management Company Allocation	9,186
Less: Non-Allowable Dues	(1,564)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,657

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	80
Management Company Allocation	664
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 744

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Lexington of LaGrange**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Voya	Financial	4
Grabowski Law	Collections	1,495
Scott & Kraus	Legal	86
NTT	Computer Services	5,318
MHC	Computer Services	591
BSI	Computer Services	444
Ability Network	Computer Services	5,980
Avatier	Computer Services	121
Cinetec	Computer Services	851
Citrix	Computer Services	702
Corepoint	Computer Services	1,353
Docusign	Computer Services	462
E-Health Data Solutions	Computer Services	863
Information Controls	Computer Services	7,828
OnShift	Computer Services	5,720
Relias	Computer Services	7,172
Salesforce.Com	Computer Services	6,490
Softchoice	Computer Services	3,588
Symbria	Computer Services	2,200
Tableau	Computer Services	411
Availity	Computer Services	255
Provinet	Computer Services	112
National Datacare	Computer Services	1,467
HealthMedex	Computer Services	9,160
Microcenter	Computer Services	157
Topnotch	Computer Services	273
Microsoft	Computer Services	1,374
Genesis Tech	Computer Services	653
	Total (agree to Schedule V, line 19, column 3)	206,090

Real Estate Entity		200
Less: Non-Allowable Legal Fees		(5,705)
Less: Non-Allowable Computer Services		(6,490)
Less: Non-AllowableProfessional Fees		(2,112)
Allocated from Management Co.		
RSM US LLP	Accounting	2,013
Marcum LLP	Accounting	241
Gilson Labus & Silverman	Accounting	62
Illinois Secretary of State	Filing Fees	29
LaSalle Network	Recruiting/Finance	1,399
Callan Associates, Ltd.	Recruiting	7,494
Pension Administrators, Inc.	401K Administration	240
Voya Financial	401K Administration	10
Gene Whitehorn	Medicaid Reimb Specialist	1,080
M. Werner Consulting	Financial Consultant	575
M. Rodeghier Consulting	Process Improvement Consultant	43
Wordy.com	Proofreading	39
Computer Services	Computer Consulting	9,074
Allocated from SV of Lombard II		
Gilson Labus & Silverman	Accounting	74
Illinois Secretary of State	Filing Fees	5
	Total (agree to Schedule V, line 19, column 8)	214,360

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 - $4,152**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,806** 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. $ **152,668**
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. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,715**

(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