

		FOR BHF USE					

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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: <u>0028860</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Lexington Hlth Cr Ctr Lombrd</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>2100 South Finley Rd</u> <u>Lombard</u> <u>60148</u>																									
Number City Zip Code																									
County: <u>Dupage</u>																									
Telephone Number: <u>(630) 495-4000</u> Fax # <u>(630) 495-2809</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>10/09/84</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u>																									
Email Address: _____																									

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 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 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	486,166	33,330	3,112	522,608		522,608		522,608			1
2	Food Purchase		363,253		363,253		363,253	(20)	363,233			2
3	Housekeeping	427,483	35,919		463,402		463,402	369	463,771			3
4	Laundry		25,546		25,546		25,546		25,546			4
5	Heat and Other Utilities			267,183	267,183		267,183	9,041	276,224			5
6	Maintenance	37,112		210,854	247,966		247,966	79,225	327,191			6
7	Other (specify):* Mgmt Co.-Allocated B							11,829	11,829			7
8	TOTAL General Services	950,761	458,048	481,149	1,889,958		1,889,958	100,444	1,990,402			8
	B. Health Care and Programs											
9	Medical Director			75,400	75,400		75,400		75,400			9
10	Nursing and Medical Records	4,818,067	400,718	320,676	5,539,461		5,539,461	41,055	5,580,516			10
10a	Therapy											10a
11	Activities	193,486	17,394	5,542	216,422		216,422		216,422			11
12	Social Services	188,414		3,052	191,466		191,466		191,466			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co.-Allocated B							5,356	5,356			15
16	TOTAL Health Care and Programs	5,199,967	418,112	404,670	6,022,749		6,022,749	46,411	6,069,160			16
	C. General Administration											
17	Administrative	131,409		1,736,935	1,868,344		1,868,344	(1,673,659)	194,685			17
18	Directors Fees											18
19	Professional Services			336,870	336,870		336,870	(34,301)	302,569			19
20	Dues, Fees, Subscriptions & Promotions			29,064	29,064		29,064	14,533	43,597			20
21	Clerical & General Office Expenses	194,963	24,036	37,618	256,617		256,617	807,886	1,064,503			21
22	Employee Benefits & Payroll Taxes			1,142,422	1,142,422		1,142,422		1,142,422			22
23	Inservice Training & Education			9,754	9,754		9,754	410	10,164			23
24	Travel and Seminar							1,239	1,239			24
25	Other Admin. Staff Transportation			1,419	1,419		1,419	13,508	14,927			25
26	Insurance-Prop.Liab.Malpractice			386,870	386,870		386,870	18,811	405,681			26
27	Other (specify):* Mgmt Co.-Allocated B							118,645	118,645			27
28	TOTAL General Administration	326,372	24,036	3,680,952	4,031,360		4,031,360	(732,928)	3,298,432			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,477,100	900,196	4,566,771	11,944,067		11,944,067	(586,073)	11,357,994			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			193,814	193,814		193,814	333,270	527,084			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,030	39,030		39,030	(3,247)	35,783			32
33	Real Estate Taxes							187,335	187,335			33
34	Rent-Facility & Grounds			1,631,947	1,631,947		1,631,947	(1,626,518)	5,429			34
35	Rent-Equipment & Vehicles			75,468	75,468		75,468	2,574	78,042			35
36	Other (specify):*											36
37	TOTAL Ownership			1,940,259	1,940,259		1,940,259	(1,106,586)	833,673			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		372,156	1,311,361	1,683,517		1,683,517		1,683,517			39
40	Barber and Beauty Shops			16,126	16,126		16,126		16,126			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			428,615	428,615		428,615		428,615			42
43	Other (specify):* Non-Allowable Cos	37,516		375,091	412,607		412,607	(412,607)				43
44	TOTAL Special Cost Centers	37,516	372,156	2,131,193	2,540,865		2,540,865	(412,607)	2,128,258			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,514,616	1,272,352	8,638,223	16,425,191		16,425,191	(2,105,266)	14,319,925			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(20)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,055)	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	39,541	30		9
10	Interest and Other Investment Income	(100,487)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,907)	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	(16,252)	43		18
19	Entertainment				19
20	Contributions	(1,030)	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	(244,854)	43		24
25	Fund Raising, Advertising and Promotional	(25,922)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(22,978)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(157,344)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (552,308)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,552,958)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,552,958)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,105,266)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics managed care	\$ (3,040)	43	1
2	Labs - Part A	(22,943)	43	2
3	X-Rays - Part A	(15,112)	43	3
4	Marketing Salary	(37,516)	43	4
5	Trust Fees	(530)	43	5
6	State Replacement Tax	(15)	43	6
7	Reclass Repairs & Maintenance to LHI	(12,781)	6	7
8	Collections	(44,166)	19	8
9	Out of Period Legal	(8,043)	19	9
10	Tax Consulting	(2,106)	19	10
11	Salesforce.com Marketing	(6,491)	19	11
12	Non-Allowable Dues & Subscription	(2,764)	20	12
13	Non-Allowable Finance Charge Interest	(1,837)	32	13
14				14
15				15
16				16
17				17
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(157,344)		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 Lombard Ltd. Ptsp.	**	\$ 200	\$ 200	1
2	V	20	Licenses & Permits		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	150	150	2
3	V	30	Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	180,775	180,775	3
4	V	32	Interest Expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	78,539	78,539	4
5	V	33	Property Taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	179,947	179,947	5
6	V	34	Rental Expense	1,631,947	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**		(1,631,947)	6
7	V	43	State Replacement Tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	15	15	7
8	V	43	Trust Fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.		530	530	8
9	V	43	Penalties		Lexington Health Care Systems of Lombard Ltd. Ptsp.		2	2	9
10	V	21	Admin & General		Lexington Health Care Systems of Lombard Ltd. Ptsp.		2	2	10
11	V				** The owners of Lexington Health Care Center of Lombard, Inc. own				11
12	V				100% of Lexington Health Care Systems of Lombard Limited Partnership.				12
13	V								13
14	Total			\$ 1,631,947			\$ 440,160	\$ * (1,191,787)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 369	\$	369 15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	8,150		8,150 16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	344		344 17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	547		547 18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	83,904		83,904 19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	7,751		7,751 20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	351		351 21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	11,829		11,829 22
23	V	10 Medical consultant		Royal Management Corp.	**	3,061		3,061 23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	37,994		37,994 24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	5,356		5,356 25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	63,276		63,276 26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	16,939		16,939 27
28	V	19 Professional fees		Royal Management Corp.	**	24,832		24,832 28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	2,523		2,523 29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	14,624		14,624 30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	778,316		778,316 31
32	V	21 Bank charges		Royal Management Corp.	**	3,115		3,115 32
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,524		10,524 33
34	V	21 Postage		Royal Management Corp.	**	3,917		3,917 34
35	V	21 Telephone		Royal Management Corp.	**	12,012		12,012 35
36	V							36
37	V							37
38	V	** The owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total		\$			\$ 1,089,734	\$ *	1,089,734 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.	**	\$ 410	\$ 410	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,239	1,239	16
17	V	25	Auto expense		Royal Management Corp.	**	13,508	13,508	17
18	V	26	Insurance general		Royal Management Corp.	**	3,345	3,345	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	118,645	118,645	19
20	V	30	Depreciation		Royal Management Corp.	**	112,954	112,954	20
21	V	32	Interest		Royal Management Corp.	**	17,996	17,996	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,542	2,542	22
23	V	33	Property taxes		Royal Management Corp.	**	7,388	7,388	23
24	V	34	Rent expense		Royal Management Corp.	**	5,429	5,429	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,579	1,579	25
26	V	17	Management fees	1,736,935	Royal Management Corp.	**		(1,736,935)	26
27	V	35	Auto Lease		Royal Management Corp.	**	995	995	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 Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total			\$ 1,736,935			\$ 286,030	\$ * (1,450,905)	39

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

Facility Name & ID Number

Lexington Hlth Cr Ctr Lombrd

0028860

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

Facility Name & ID Number

Lexington Hlth Cr Ctr Lombrd

0028860

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 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 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	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 10,552	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,340	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,787	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	14,658	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	20,940	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 63,276		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 Hlth Cr Ctr Lombrd# 0028860

Report Period Beginning:

01/01/2016Ending: 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 ☒ NO ☐

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

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

((630) 458-4700

Fax Number

((630) 458-4796

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	3	Housekeeping supplies	Bed Days	724,314	10	\$ 3,263	\$	81,984	\$ 369	1
2	5	Utilities - gas & electric	Bed Days	724,314	10	72,000		81,984	8,150	2
3	5	Utilities - water & sewer	Bed Days	724,314	10	3,036		81,984	344	3
4	5	Utilities - maintenance office	Bed Days	724,314	10	4,835		81,984	547	4
5	6	Management allocation - salaries	Bed Days	724,314	10	741,281	741,281	81,984	83,904	5
6	6	Repairs & maintenance	Bed Days	724,314	10	68,481		81,984	7,751	6
7	6	Scavenger & exterminating	Bed Days	724,314	10	3,101		81,984	351	7
8	7	Management allocation - employee	Bed Days	724,314	10	104,504		81,984	11,829	8
9	10	Medical consultant	Bed Days	724,314	10	27,047		81,984	3,061	9
10	10	Management allocation - salaries	Bed Days	724,314	10	335,674	335,674	81,984	37,994	10
11	15	Management allocation - employee	Bed Days	724,314	10	47,322		81,984	5,356	11
12	17	Management allocation - salaries	Bed Days	724,314	10	559,036	559,036	81,984	63,276	12
13	19	Computer consultant & supplies	Bed Days	724,314	10	149,651		81,984	16,939	13
14	19	Professional fees	Bed Days	724,314	10	219,386		81,984	24,832	14
15	20	Dues & subscriptions	Bed Days	724,314	10	22,289		81,984	2,523	15
16	20	Advertising - help wanted	Bed Days	724,314	10	129,203		81,984	14,624	16
17	21	Management allocation - salaries	Bed Days	724,314	10	6,876,284	6,876,284	81,984	778,316	17
18	21	Bank charges	Bed Days	724,314	10	27,523		81,984	3,115	18
19	21	Office supplies & printing	Bed Days	724,314	10	92,982		81,984	10,524	19
20	21	Postage	Bed Days	724,314	10	34,606		81,984	3,917	20
21	21	Telephone	Bed Days	724,314	10	106,126		81,984	12,012	21
22										22
23										23
24										24
25	TOTALS					\$ 9,627,630	\$ 8,512,275		\$ 1,089,734	25

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 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 ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	23	Inservice Training	Bed Days	724,314	10	\$ 3,621	\$	81,984	\$ 410	1
2	24	Travel and Seminar	Bed Days	724,314	10	10,947		81,984	1,239	2
3	25	Auto expense	Bed Days	724,314	10	119,337		81,984	13,508	3
4	26	Insurance general	Bed Days	724,314	10	29,556		81,984	3,345	4
5	27	Management allocation - employee	Bed Days	724,314	10	1,048,208		81,984	118,645	5
6	30	Depreciation	Bed Days	724,314	10	997,930		81,984	112,954	6
7	32	Interest	Bed Days	724,314	10	158,994		81,984	17,996	7
8	32	Amortization of mortgage costs	Bed Days	724,314	10	22,462		81,984	2,542	8
9	33	Property taxes	Bed Days	724,314	10	65,273		81,984	7,388	9
10	34	Rent expense	Bed Days	724,314	10	47,968		81,984	5,429	10
11	35	Equipment rental	Bed Days	724,314	10	13,953		81,984	1,579	11
12	35	Auto Lease	Bed Days	724,314	10	8,793		81,984	995	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	\$		\$ 286,030	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							\$				\$	1
2												2
3												3
4				Finance Charge - Insurance Policy							1,837	4
5												5
	Working Capital											
6	Bank of America		X	Line of Credit	Varies	4/30/12	2500000	650,000	4/30/2017	Prime/Libor	19,570	6
7	Shareholder Loan	X		Capital Improvements	Varies	7/16/08	499000	499,000	Demand	Prime	17,574	7
8	Shareholder Loan	X		Working Capital	Varies	4/30/08	2230000	2,230,000	Demand	Prime	78,539	8
9	TOTAL Facility Related						\$ 5,229,000	\$ 3,379,000			\$ 117,520	9
	B. Non-Facility Related*											
10								Microsoft Software Interest			49	10
11								Offset of Shareholder Interest			(96,113)	11
12								Interest Income Offset			(4,374)	12
13								See Sch 9A			18,701	13
14	TOTAL Non-Facility Related						\$				\$ (81,737)	14
15	TOTALS (line 9+line14)						\$ 5,229,000	\$ 3,379,000			\$ 35,783	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 Hlth Cr Ctr Lombrd
IDPH License ID Number: 0028860
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**		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			9
	B. Non-Facility Related*												
10								Amortization of mortgage cost				2,542	10
11								Allocation of Management Costs				17,996	11
12								Non Allowable Finance Charge				(1,837)	12
13													13
14	TOTAL Non-Facility Related				\$0.00		\$	0	\$	0			14

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Lombard, Inc. COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0028660

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)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>06-19-307-002</u>	<u></u>	\$ <u>186,771.78</u>	\$ <u>186,771.78</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>249,002.30</u>	\$ <u>7,388.00</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>435,774.08</u></u>	\$ <u><u>194,159.78</u></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 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 providecopies of their original **second installment** tax bill.

A. Square Feet: 78,770

B. General Construction Type: Exterior Concrete BlockFrame SteelNumber of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility☒ (b) Rent from a Related Organization.☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment☒ (b) Rent equipment from a Related Organization.☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square feet

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	30,000	1984	\$ 616,761	1
2	Management Company Allocation			22,198	2
3	TOTALS	30,000		\$ 638,959	3

HFS 3745 (N-4-99)

IL478-2471

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	215		1984	1984	\$ 3,661,472	\$	35	\$ 104,614	\$ 104,614	\$ 3,371,605
5	9		1995	1995	284,156	8,119	35	8,119		166,435
6										
7										
8										
	Improvement Type**									
9	Building Improvements			1990	96,219		10			96,218
10	Leasehold Improvements Additions			1995	71,493		10			71,493
11	Building Improvements			1994	20,200		10			20,200
12	Building Improvements			1995	14,535	415	35	415		8,926
13	Building Improvements - dishwasher hood			1996	2,748		10			2,748
14	Building Improvements - outside painting			1996	11,308		10			11,308
15	Building Improvements - dining room			1996	3,752		10			3,752
16	Leasehold Improvements			1992	16,299	466	35	466		11,413
17	Leasehold Improvements			1994	21,836		10			21,836
18	Leasehold Improvements - 2nd floor			1996	19,319		10			18,353
19	Leasehold Improvements - bathroom rehat			1996	9,216		10			8,909
20	Leasehold Improvements - fan coil repairs			1996	6,669	191	35	191		3,879
21	Land Improvements			1993	2,985		15			2,985
22	Land Improvements			1995	4,596		15			4,595
23	Capitalized Repairs			1986	1,730		10			1,730
24	Building Improvements - basement			1996	18,993		10			18,993
25	Leasehold Improvements - Corner Guards			1997	520		10			520
26	Leasehold Improvements - Corridor flooring			1997	10,380		10			10,380
27	BI: Kitchen Rehab			1998	2,494		10			2,494
28	Wiring for MDS project			1998	3,365		10			3,365
29	Install Fire Sprinklers in Mechanical Rms			1998	4,600	131	35	131		2,428
30	Tile for Lobby			1998	20,530		10			20,530
31	Walk in Freezers/Coolers			1998	3,183	91	35	91		1,683
32	Fire Wall Repairs			1998	12,411	355	35	355		6,564
33	Underground storage tank			1998	2,613		10			2,613
34	Repave parking lot			1999	7,625		15			7,625
35	Lounge Floor Tile			1999	2,963		10			2,963
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 Hlth Cr Ctr Lombrd

0028860

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Rewire Building	1999	\$ 9,083	\$ 260	35	\$ 260	\$	\$ 4,546	37
38	Heat exchanger for water heater	1999	1,660		5			1,660	38
39	Compressor and tank for freezer	1999	2,924		5			2,924	39
40	Plumbing Improvements	2000	2,833		10			2,833	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		1,038	41
42	Water heater repairs	2000	3,831		5			3,831	42
43	Automatic door	2000	4,556	130	35	130		2,146	43
44	Install sprinklers	2001	6,082		10			6,082	44
45	Infrared curtains for elevator	2001	4,500		10			4,500	45
46	Elevator upgrade	2002	3,006		5			3,006	46
47	Condensor	2002	2,679		5			2,679	47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		20,592	48
49	Plumbing loop repairs	2003	6,125		10			6,125	49
50	Fire alarm panel/call system	2003	8,495	425	20	425		5,913	50
51	Facility Rehab - Painting	2003	6,872		10			6,872	51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		19,188	52
53	Nurse call system	2003	49,451	2,473	20	2,473		32,353	53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		3,930	54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		220,136	55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		193,426	56
57	Floor Tile	2003	58,720	2,936	20	2,936		41,104	57
58	Carpeting/cove base	2003	29,518		10			29,518	58
59	Water heater	2004	9,209		10			9,209	59
60	Kitchen sewer and dishroom	2004	31,233	1,562	20	1,562		18,873	60
61	Landscaping	2005	3,255	163	20	163		1,860	61
62	HVAC	2005	8,028	401	20	401		4,479	62
63	Kitchen sewer, dishroom and ceiling	2005	22,924	1,146	20	1,146		13,275	63
64	Lobby and reception redecorating - painting/wallpaper	2005	37,999	1,900	20	1,900		22,167	64
65	Rehab therapy room - electrical, carpet, tile	2005	66,393	3,320	20	3,320		38,732	65
66	Rehab 1st floor therapy room - electrical, carpet, tile	2005	39,341	1,967	20	1,967		22,948	66
67	Wallpaper, tile, electrical for transitional unit	2005	22,946	1,147	20	1,147		13,478	67
68	Window treatments	2005	8,053	403	20	403		4,667	68
69	Tile, flooring, and wallpaper	2005	57,699	2,885	20	2,885		33,418	69
70	TOTAL (lines 4 thru 69)		\$ 5,504,063	\$ 63,761		\$ 168,375	\$ 104,614	\$ 4,704,051	70

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd

0028860

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	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		\$ 5,504,063	\$ 63,761		\$ 168,375	\$ 104,614	\$ 4,704,051	1
2	Countertops	2005	845		5			845	2
3	Curtains and blinders	2005	4,672		5			4,672	3
4	Mini scroll	2005	527		5			527	4
5	Medical Records Storage/Office Room	2006	5,901	148	40	148		1,504	5
6	Office Remodel	2006	5,537	138	40	138		1,380	6
7	Piping	2006	4,511	301	15	301		3,110	7
8	HVAC	2006	7,985	200	40	200		2,000	8
9	Emergency A/C	2006	9,385	235	40	235		2,350	9
10	Adm Office-HVAC	2006	6,421	161	40	161		1,676	10
11	Sink installation	2006	2,561	64	40	64		688	11
12	Land Improvements Patio	2006	23,736	1,582	15	1,582		16,348	12
13	Brick Pavers	2007	8,500	567	15	567		5,481	13
14	Landscaping	2007	16,420	821	20	821		7,731	14
15	Parking Lot	2007	13,219	661	20	661		6,224	15
16	Roof	2007	9,800	490	20	490		4,778	16
17	HVAC	2007	8,197	410	20	410		3,895	17
18	LHI-Emergency A/C	2007	11,126	556	20	556		5,097	18
19	LHI-Plumbing & Sprinkler	2007	6,799	680	10	680		6,290	19
20	Automatic Doors in Common Areas	2007	20,874	1,044	20	1,044		9,831	20
21	Tike System & Foundation	2007	4,500	225	20	225		2,044	21
22	Exterior of Building Painting	2007	16,600	830	20	830		7,678	22
23	Landscaping	2008	21,600	1,440	15	1,440		12,600	23
24	Parking Lot	2008	9,625	481	20	481		4,129	24
25	Roof Repair	2008	11,001	550	20	550		4,583	25
26	HVAC	2008	20,164	1,102	20	1,102		9,361	26
27	Sink and Toilet	2008	4,000	400	10	400		3,467	27
28	Elevator Upgrades	2008	171,955	4,299	40	4,299		35,467	28
29	Metal Doors	2008	3,907	195	20	195		1,707	29
30	Basement Renovation	2008	25,195	1,260	20	1,260		10,920	30
31	Trash Compactor	2008	11,590	580	20	580		4,930	31
32	Painting Gazebo	2008	4,450	223	20	223		1,876	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,975,666	\$ 83,404		\$ 188,018	\$ 104,614	\$ 4,887,240	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd

0028860

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	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		\$ 5,975,666	\$ 83,404		\$ 188,018	\$ 104,614	\$ 4,887,240	1
2	2nd floor remodel-Electric, flooring,painting	2008	561,165		27	20,406	20,406	164,949	2
3	Kitchen Upgrade-Carpentry, painting, plumbing	2008	18,364		27	668	668	5,400	3
4	1st floor remodel-painting, electrical, flooring,plumbing	2008	547,836		27	19,921	19,921	177,629	4
5	Irrigation System	2009	14,235	949	15	949		7,038	5
6	Landscaping Enhancements	2009	22,005	1,467	15	1,467		11,003	6
7	Roof	2009	139,578	6,979	20	6,979		51,761	7
8	Fan Coil	2009	5,607	280	20	280		2,171	8
9	Quick Connectors	2009	5,300	265	20	265		2,032	9
10	Room Convector	2009	4,962	248	20	248		1,798	10
11	Nurse Call System	2009	35,509	1,291	27	1,291		9,464	11
12	Electrical key pad	2009	5,995	218	27	218		1,617	12
13	PT Room Countertops	2009	4,050	147	27	147		1,042	13
14	2nd floor remodel-Electric, flooring,painting	2009	2,935	107	27	107		838	14
15	Patio Pergola	2009	10,849	542	20	542		3,885	15
16	Landscaping/Retaining wall	2010	4,741	316	15	316		2,054	16
17	Ejector Pump	2010	6,983	466	15	466		3,028	17
18	Parking lot repair/signs	2010	8,970	533	15	533		4,738	18
19	Repair Roof	2010	24,000	1,200	20	1,200		7,300	19
20	Key pad entrance	2010	3,085	308	10	308		2,080	20
21	Canopy	2010	2,567	257	10	257		1,691	21
22	Exhaust HVAC	2010	4,003	146	27	146		900	22
23	Drainline	2010	4,130	151	27	151		918	23
24	Pantry carpentry,electrical,plumbing	2010	7,566	276	27	276		1,771	24
25	Paint over bed lights	2010	6,319	231	27	231		1,539	25
26	Library/Lounge carpentry,painting,signs	2010	8,441	308	27	308		1,951	26
27	Second floor doors	2010	3,144	314	10	314		2,120	27
28	Med Room carpentry,plumbing	2010	7,678	280	27	280		1,797	28
29	Patio Pergola	2010	11,695		5			11,695	29
30	Stamped concrete	2010	15,862	1,057	15	1,057		7,047	30
31	Office carpentry,flooring,electrical,painting,plumbing,signs	2010	64,446	1,793	27	1,793		32,454	31
32	3rd floor remodel-carpentry,plumbing,electrical,painting	2010	753,399		27	60,085	60,085	395,559	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,291,085	\$ 103,533		\$ 309,227	\$ 205,694	\$ 5,806,509	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd

0028860

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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,291,085	\$ 103,533		\$ 309,227	\$ 205,694	\$ 5,806,509	1
2									2
3	Office Remodel - carpentry,plumbing,electrical,painting	2011	11,187	407	27	407		2,306	3
4	Front Entrance remodel of kitchen doors	2011	3,584	130	27	130		650	4
5	Remodel Shower Room - Carpentry, Flooring, Electrical,	2011	53,886	1,959	27	1,959		10,285	5
6	-Plumbing, Showers, Millwork & Painting								6
7	Boiler Coll HVAC	2011	3,175	115	27	115		634	7
8	Roof Top Unit HVAC	2011	40,890	1,487	27	1,487		7,807	8
9	Fire Dampers HVAC	2011	67,012	2,437	27	2,437		12,388	9
10	Remodel Laundry Room - Electrical, Painting and Flooring	2011	9,814	357	27	357		1,934	10
11	Replace Doors on 1st Floor	2011	57,237	2,081	27	2,081		10,578	11
12	Replace doors on 2nd Floor	2011	39,952	1,453	27	1,453		7,749	12
13	Doctors office-keys, painting, flooring	2012	5,484	199	27	199		415	13
14	Generator Exhaust	2012	21,590	785	27	785		3,663	14
15	Sprinklers in building - Front Canopy & Lobby Area	2012	11,558	420	27	420		1,750	15
16	Replace sanitary pipe	2012	5,800	211	27	211		967	16
17	Replace lights, mirrors in 1st floor resident rooms	2012	10,962	399	27	399		1,795	17
18	Replacement faucets in 1st floor resident rooms	2012	6,410	233	27	233		1,029	18
19	EMR Wiring- Entire Facility	2012	18,690	680	27	680		2,833	19
20									20
21	Fence- Entire Facility	2013	5,840	389	15	389		1,232	21
22	Sprinkler Heads- Entire Facility	2013	25,361	922	27	922		3,381	22
23	Holding Tank- Kitchen	2013	25,724	935	27	935		2,805	23
24									24
25	R/M Reclass: Generator transfer switch in Mechanical Room	2014	4,681		12	390	390	975	25
26	R/M Reclass: Landscaping for flowers around main entrance	2014	2,840		15	189	189	474	26
27									27
28	Add EMR Wiring 1st floor	2015	5,268	192	27	192		303	28
29	Replaced four boilers in boiler room	2015	173,357	6,304	27	6,304		6,829	29
30	R/M Reclass: Sealcoating and paving parking lot	2015	4,200		20	210	210	315	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,905,588	\$ 125,628		\$ 332,111	\$ 206,483	\$ 5,889,606	34

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

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

1	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 12D, Carried Forward		\$ 8,905,588	\$ 125,628		\$ 332,111	\$ 206,483	\$ 5,889,606	1
2								2
3 Chair Rail Installation in First and Second Floor Rooms	2016	10,199		27				3
4 R&M Reclass: Doors Installation on: 2nd and 3rd Floors North Si	2016	5,786		10	289	289	289	4
5 and South Side Shower Entrances								5
6 R/M Reclass: Underground Sanitary Pipe Replacement in the Low	2016	2,500		15	83	83	83	6
7 Level Entrance to Ramp Area and Back Elevator Hallway								7
8 R/M Reclass: Fire Pump Overhaul and New Gauge Tap and Gaug	2016	4,495		15	150	150	150	8
9 Installation in the Fire Pump Room in the Basement								9
10								10
11 Reconcile to book			301			(301)		11
12								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 8,928,568	\$ 125,929		\$ 332,633	\$ 206,704	\$ 5,890,129	34

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

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	
1 Totals from Page 12E, Carried Forward		\$ 8,928,568	\$ 125,929		\$ 332,633	\$ 206,704	\$ 5,890,129	1
2								2
3 Building-management company	2002	307,173		40	9,331	9,331	136,294	3
4 HVAC, electrical, security system-management company	2003	2,698		30	663	663	2,143	4
5 Key card system-management company	2004	424		20	22	22	263	5
6 VAV TX controls-management compnay	2005	129		20	7	7	76	6
7 Building Improvements-management company	2006	94		20	6	6	64	7
8 Building Improvements-management company	2008	14,885		20	170	170	6,505	8
9 Building Improvements-management company	2009	2,779		20	53	53	1,128	9
10 Building Improvements-management company	2010	2,708		20	51	51	1,041	10
11 Building Improvements-management company	2011	1,911		20	91	91	489	11
12 Building Improvements-management company	2012	6,604		20	13	13	1,129	12
13 Building Improvements-management company	2013	4,990		20	371	371	1,187	13
14 Building Improvements-management company	2014	2,701		20	276	276	678	14
15 Building Improvements-management company	2015	475		20	59	59	87	15
16 Building Improvements-management company	2016	7,836		20	225	225	225	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)		\$ 9,283,975	\$ 125,929		\$ 343,971	\$ 218,042	\$ 6,041,438	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	\$ 729,509	\$ 66,864	\$ 80,475	\$ 13,611	5-10	\$ 656,530	71
72	Current Year Purchases	11,858	1,021	1,021	-	7	1,021	72
73	Fully Depreciated Assets	708,213			-	5 - 7	708,213	73
74	Allocated from Mgmt. Co.	637,099		98,679	98,679	5 - 7	525,687	74
75	TOTALS	\$ 2,086,679	\$ 67,885	\$ 180,175	\$ 112,290		\$ 1,891,450	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.			57,433		2,938	2,938	5	50,999	79
80	TOTALS			\$ 57,433	\$ -	\$ 2,938	\$ 2,938		\$ 50,999	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,067,046	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 193,814	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 527,084	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 333,270	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,983,887	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Compar				5,429			6
7	TOTAL				\$ 5,429			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 77,047 Description: Copier: \$7,302, Postage: \$240, Printer: \$4,760, Oxygen: \$21,292, Med Equip: \$41,874, Mgmt Alloc.: \$1,579
(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			995	20
21	TOTAL		\$	\$ 995	21

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2017 | \$ |
| 13. | /2018 | \$ |
| 14. | /2019 | \$ |

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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		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	\$	9,117	\$ 394,937	\$	9,117	\$ 394,937	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,539	156,341		2,539	156,341	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		16,670	759,171		16,670	759,171	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				365,875		365,875	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				912			912	12
13	Other (specify): See Sch 16A	39(2)					6,281		6,281	13
14	TOTAL			\$	28,326	\$ 1,311,361	\$ 372,156	28,326	\$ 1,683,517	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 Hlth Cr Ctr Lombrd
IDPH License ID Number: 0028860
Fiscal Year End: 12/31/2016

Schedule 16A

XIV. Special Services (Direct Cost)
Line 13 Other (specify)

Description	Ref	Amount
Oxygen	39(2)	5,572
DME	39(2)	709
Total - Line 13		6,281

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	\$ 1,983,126	\$ 2,346,718	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,037,257)	3,673,965	3,673,965	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,348	154,348	6
7	Other Prepaid Expenses	14,563	14,563	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): PA Interest Receivable	11,700	11,700	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,837,702	\$ 6,201,294	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		638,959	13
14	Buildings, at Historical Cost		3,661,472	14
15	Leasehold Improvements, at Historical Cost	3,089,202	5,622,503	15
16	Equipment, at Historical Cost	493,852	2,144,112	16
17	Accumulated Depreciation (book methods)	(1,913,613)	(7,983,887)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,669,441	\$ 4,083,159	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,507,143	\$ 10,284,453	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 399,460	\$ 399,460	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	650,000	650,000	29
30	Accrued Salaries Payable	485,126	485,126	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,844	22,844	31
32	Accrued Real Estate Taxes(Sch.IX-B)		192,375	32
33	Accrued Interest Payable		6,889	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	3,203,803	1,112,493	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,761,233	\$ 2,869,187	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	499,000	2,729,000	39
40	Mortgage Payable			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)	\$ 499,000	\$ 2,729,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,260,233	\$ 5,598,187	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,246,910	\$ 4,686,266	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,507,143	\$ 10,284,453	48

*(See instructions.)

Facility Name: Lexington Hlth Cr Ctr Lombrd
IDPH License ID Number: 0028860
Fiscal Year End: 12/31/2016

Schedule 17A

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

Account No.	Description	Operating	After Consolidation
00-10140-00	Cash Patient Trust	12,738	12,738
00-13040-00	Rent Receivable	0	(2,093,310)
00-14530-00	Prepaid Insurance	43,339	43,339
00-21030-00	COBRA	(3,517)	(3,517)
00-21040-00	Withholding - Dental Insurance	(1,426)	(1,426)
00-21050-00	Withholding - EP/CI/WL	(29,470)	(29,470)
00-21060-00	Withholding - Short Term Disability	19,789	19,789
00-21065-00	Life Insurance Withholding	9,993	9,993
00-21085-00	Vision Withholding	(357)	(357)
00-21100-00	401K Withholding	(838)	(838)
00-22030-00	Accrued Expenses	252,316	252,316
00-22040-00	Accrued Resident Tax	81,386	81,386
00-22060-00	Accrued Royal / Vesta Mgmt Fees	39,107	39,107
00-22120-00	Accrued Rent	2,093,310	2,093,310
00-22140-00	Accrued Insurance	27,766	27,766
00-22270-00	Due to Patient Trust Fund	(11,021)	(11,021)
00-22330-00	Advance - Biweekly Part A Payment	5,076	5,076
00-22360-00	Uncollectible Part A Co Pmts	(52,467)	(52,467)
00-23530-00	Due to - Royal Operations	21,699	21,699
00-23720-00	Due to/from Republic Construction	3,634	3,634
00-23730-00	Due to Bloomingdale	(820)	(820)
00-23750-00	Due to LHCC Elmhurst	53	53
00-23760-00	Due to LaGrange	981	981
00-23780-00	Due to/from LHC System of Lombard	(2,000)	0
00-23830-00	Due to/from Square Lombard	(228,192)	(228,192)
00-23850-00	Due to/from Schaumburg	160	160
00-24400-00	Professional Liabilities Claims	922,564	922,564
Total - Line 36		3,203,803	1,112,493

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,667,959	1
2	Restatements (describe):		2
3	Post closing adjustment	10,653	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,678,612	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	198,298	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	(630,000)	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)	\$ (431,702)	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)	\$ 2,246,910	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd

0028860

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 22,110,488	1
2	Discounts and Allowances for all Levels	(11,102,792)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,007,696	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,412,012	6
7	Oxygen	6,801	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,418,813	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	18,887	13
14	Non-Patient Meals	20	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	634,207	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	184,449	19
20	Radiology and X-Ray	25,248	20
21	Other Medical Services	329,795	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,192,606	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,374	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,374	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)	\$ 16,623,489	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,889,958	31
32	Health Care	6,022,749	32
33	General Administration	4,031,360	33
	B. Capital Expense		
34	Ownership	1,940,259	34
	C. Ancillary Expense		
35	Special Cost Centers	2,112,250	35
36	Provider Participation Fee	428,615	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,425,191	40
41	Income before Income Taxes (line 30 minus line 40)**	198,298	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 198,298	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,004,676	44
45	Private Pay - Net Inpatient Revenue	1,952,359	45
46	Medicare - Net Inpatient Revenue	1,676,002	46
47	Other-(specify) <u>Managed Care</u>	374,659	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,007,696	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

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	1,748	2,088	\$ 127,367	\$ 61.00	1
2	Assistant Director of Nursing	2,922	3,795	145,963	38.46	2
3	Registered Nurses	35,640	43,595	1,473,448	33.80	3
4	Licensed Practical Nurses	25,284	30,817	809,968	26.28	4
5	CNAs & Orderlies	96,612	113,421	1,668,787	14.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,821	2,146	44,335	20.66	9
10	Activity Assistants	10,176	11,846	149,151	12.59	10
11	Social Service Workers	8,398	9,525	188,414	19.78	11
12	Dietician	1,846	2,128	47,886	22.50	12
13	Food Service Supervisor	1,793	2,162	47,176	21.82	13
14	Head Cook	1,868	2,162	64,443	29.81	14
15	Cook Helpers/Assistants	26,201	30,359	326,661	10.76	15
16	Dishwashers					16
17	Maintenance Workers	1,823	2,098	37,112	17.69	17
18	Housekeepers	32,658	38,929	427,483	10.98	18
19	Laundry					19
20	Administrator	1,697	2,037	131,409	64.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,234	10,047	194,963	19.41	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	1,176	1,551	25,692	16.56	31
32	Other Health C: <u>Memory Care</u>	18,352	23,106	566,842	24.53	32
33	Other(specify) <u>Marketing</u>	1,021	1,024	37,516	36.64	33
34	TOTAL (lines 1 - 33)	279,270	332,835	\$ 6,514,616 *	\$ 19.57	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		\$		35
36	Medical Director	Monthly	75,400	9(3)	36
37	Medical Records Consultant	Monthly	406	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,362	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	2,352	11(3)	44
45	Social Service Consultant	Monthly	2,880	12(3)	45
46	Other(specify) <u>Pulmonary</u>	Monthly	34,018	10(3)	46
47	<u>Post Acute Consultant</u>	Monthly	1,956	10(3)	47
48	<u>See Sch 20B</u>	Monthly	12,211	10(3) & 10(7)	48
49	TOTAL (lines 35 - 48)		\$ 141,585		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	161	\$ 10,271	10(3)	50
51	Licensed Practical Nurses	1,173	50,987	10(3)	51
52	Certified Nurse Assistants/Aides	10,502	201,525	10(3)	52
53	TOTAL (lines 50 - 52)	11,836	\$ 262,783		53

Facility Name: Lexington Hlth Cr Ctr Lombrd
IDPH License ID Number: 0028860
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
Accounts Coordinator	1,906	2,367	32,885	\$ 13.89
Admissions	3,076	3,884	85,627	\$ 22.04
Clinical Coordinator	2,648	3,344	118,309	\$ 35.38
Dietetic Technician	1,736	2,042	35,479	\$ 17.37
MDS	2,985	3,892	137,630	\$ 35.37
Staffing Coordinator	1,646	2,059	31,430	\$ 15.27
Transitional Care Nurse	1,325	1,697	57,097	\$ 33.64
Unit Secretary	3,030	3,820	68,384	\$ 17.90
Total - Line 32 Other Health Care (specify):	18,352	23,106	566,842	\$ 24.53

Facility Name: Lexington Hlth Cr Ctr Lombrd
IDPH License ID Number: 0028860
Fiscal Year End: 12/31/2016

Schedule 20B

XVIII. Staffing and Salary Costs
Line 48 Other Consultants (specify):

	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
Telemedicine Consultant	Monthly	9,150	10(3)
Medical Consultant	Monthly	3,061	10(7)
Total Line 48		12,211	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Danielle Gilbert	Administrator	0	\$ 64,238
Patricia Stoudt	Administrator	0	67,171
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 131,409
B. Administrative - Other			
Description			Amount
Management Fees-Royal Operating		\$	1,267,788
Management Fees-Vesta Mgmt.			469,147
Eliminated in Column 7			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$	1,736,935
C. Professional Services			
Vendor/Payee	Type		Amount
Attadale	Operations Consulting	\$	9,990
Cassiday Schade, LLP	Legal		135,118
Grabowski Law Center, LLC	Collections		360
RSM US LLP	Accounting		40,877
Much Shelist- Legal	Legal		7,635
Much Shelist- Collections	Collections		43,806
Personnel Planners	U/C Consulting		2,325
Pension Administrators	401K Administration		1,100
Duane Morris	Legal		328
SB2, Inc.	Medicaid Consulting		2,484
Secretary of State	Filing Fees		125
See Schedule 21C	Various		92,722
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$	336,870
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	224,152
Unemployment Compensation Insurance			51,936
FICA Taxes			481,774
Employee Health Insurance			324,903
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)* 401K			22,663
Other Employee Benefits			35,371
Uniform Allowance			1,623
TOTAL (agree to Schedule V, line 22, col.8)		\$	1,142,422
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			6,720
Health Care Worker Background Check (Indicate # of checks performed)	11		130
Patient Background Checks	46		546
Miscellaneous Licenses & Fess			4,880
Miscellaneous Dues & Subscriptions			8,475
Less: Non-Allowable Dues			(2,764)
Management Company Allocation			17,297
IHCA / AHCA			6,323
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)		\$	43,597
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			
Management Company Allocation			1,239
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)		\$	1,239

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Lexington Hlth Cr Ctr Lombrd
IDPH License ID Number: 0028860
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Jefferies	Tax Consulting	2,106
Voya	Financial	5
North Heron Insurance	Insurance Settlement	15,466
Infor	Computer Services	3,657
MHC	Computer Services	873
NTT Data	Computer Services	7,428
Rec Amort Oth Ppd=10/16	Computer Services	566
Ability	Computer Services	5,980
Availity	Computer Services	252
Avatier	Computer Services	177
Cinetec	Computer Services	851
Citrix	Computer Services	702
CorePoint	Computer Services	1,567
DocuSign	Computer Services	462
eHealth	Computer Services	863
HlthMedx	Computer Services	15,055
Info Control	Computer Services	2,481
Nat'l Data Care	Computer Services	1,002
On Shift	Computer Services	10,536
Provinet	Computer Services	112
Quote	Computer Services	(900)
Relias	Computer Services	9,594
Sales Force	Computer Services	6,491
Soft Choice	Computer Services	10,136
Sophos	Computer Services	(5,766)
Sybria	Computer Services	2,200
Tableau Software Inc.	Computer Services	411
Natinoal Datacare Corp.	Computer Services	742
Microcenter	Computer Services	78
Microsoft Sales Tax Refund	Computer Services	(405)
Total of Above		92,722
Total (agree to Schedule V, line 19, column 3)		336,870
Less:		
Insurance Settlement Reclass		(15,466)
Non-allowable tax consulting		(2,106)
Salesforce.com		(6,491)
Out of Period Legal		(8,043)
Non-allowable Legal		(44,166)
Total Disallowance		(76,272)
Allocated from Real Estate		
Secretary of State		200
Samvest of Lombard		
Accounting		137
Filing Fees		10
		147
Allocated from Mgmt Co.		
RSM US LLP	Accounting	3,757
Marcum LLP	Accounting	449
Gilson Labus & Silverman	Accounting	116
Illinois Secretary of State	Filing Fees	54
LaSalle Network	Recruiting/Finance	2,612
Callan Associates, Ltd.	Recruiting	13,988
Pension Administrators, Inc.	401K Administration	448
Voya Financial	401K Administration	18
Gene Whitehorn	Medicaid Reimb Specialist	2,017
M. Werner Consulting	Financial Consultant	1,073
M. Rodeghier Consulting	Process Improvement Consultant	81
Wordy.com	Proofreading	72
Computer Services	Computer Consulting	16,939
		41,624
Total (agree to Schedule V, line 19, column 8)		302,569

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

IHCA & AHCA - \$6,323
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
5-7 Years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 56,424 Line 10(2)
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 428,615
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ -
Yes
Indicate the amount. \$ 20
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes