

		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: 0042739 Facility Name: Lexington Chicago Ridge Address: 10300 Southwest Hwy Chicago Ridge 60415 County: Cook Telephone Number: (708) 425-1100 Fax #: (708) 425-0779 HFS ID Number: Date of Initial License for Current Owners: 5/27/91 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County 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) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 (Date) (Date) (847) 517-7067 Phone # (217) 782-1630
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Facility Name & ID Number Lexington Chicago Ridge

0042739 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,298</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,298</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>19,094</u>	<u>19,094</u>	8
9	SNF/PED					9
10	ICF	<u>35,817</u>	<u>5,403</u>	<u>3,931</u>	<u>45,151</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,817</u>	<u>5,403</u>	<u>23,025</u>	<u>64,245</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.47%

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 ☒ NO ☐ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location? Date started 6/4/91

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date New Construction NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 203 and days of care provided 11,198

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lexington Chicago Ridge # 0042739 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	526,246	36,152	6,127	568,525		568,525		568,525			1
2	Food Purchase		392,290		392,290		392,290	(381)	391,909			2
3	Housekeeping	470,494	49,609		520,103		520,103	335	520,438			3
4	Laundry		21,989		21,989		21,989		21,989			4
5	Heat and Other Utilities			259,096	259,096		259,096	8,193	267,289			5
6	Maintenance	38,226		204,915	243,141		243,141	83,381	326,522			6
7	Other (specify):* Mgmt Co.-Allocated B							10,720	10,720			7
8	TOTAL General Services	1,034,966	500,040	470,138	2,005,144		2,005,144	102,248	2,107,392			8
	B. Health Care and Programs											
9	Medical Director			90,000	90,000		90,000		90,000			9
10	Nursing and Medical Records	6,077,345	546,647	126,348	6,750,340		6,750,340	37,206	6,787,546			10
10a	Therapy											10a
11	Activities	151,131	24,361	10,273	185,765		185,765		185,765			11
12	Social Services	195,449		3,052	198,501		198,501		198,501			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co.-Allocated B							4,854	4,854			15
16	TOTAL Health Care and Programs	6,423,925	571,008	229,673	7,224,606		7,224,606	42,060	7,266,666			16
	C. General Administration											
17	Administrative	145,628		1,885,574	2,031,202		2,031,202	(1,828,230)	202,972			17
18	Directors Fees											18
19	Professional Services			494,797	494,797		494,797	(123,059)	371,738			19
20	Dues, Fees, Subscriptions & Promotions			42,547	42,547		42,547	12,826	55,373			20
21	Clerical & General Office Expenses	257,168	37,762	92,674	387,604		387,604	732,146	1,119,750			21
22	Employee Benefits & Payroll Taxes			1,317,754	1,317,754		1,317,754		1,317,754			22
23	Inservice Training & Education			7,849	7,849		7,849	371	8,220			23
24	Travel and Seminar							1,123	1,123			24
25	Other Admin. Staff Transportation			2,435	2,435		2,435	12,241	14,676			25
26	Insurance-Prop.Liab.Malpractice			474,582	474,582		474,582	143,260	617,842			26
27	Other (specify):* Mgmt Co.-Allocated B							107,522	107,522			27
28	TOTAL General Administration	402,796	37,762	4,318,212	4,758,770		4,758,770	(941,800)	3,816,970			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,861,687	1,108,810	5,018,023	13,988,520		13,988,520	(797,492)	13,191,028			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			129,349	129,349		129,349	330,046	459,395			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,656	24,656		24,656	382,779	407,435			32
33	Real Estate Taxes							736,410	736,410			33
34	Rent-Facility & Grounds			2,163,314	2,163,314		2,163,314	(2,154,794)	8,520			34
35	Rent-Equipment & Vehicles			90,112	90,112		90,112	2,333	92,445			35
36	Other (specify):*											36
37	TOTAL Ownership			2,407,431	2,407,431		2,407,431	(703,226)	1,704,205			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		713,119	2,139,165	2,852,284		2,852,284		2,852,284			39
40	Barber and Beauty Shops			14,170	14,170		14,170		14,170			40
41	Coffee and Gift Shops			4,516	4,516		4,516		4,516			41
42	Provider Participation Fee			430,835	430,835		430,835		430,835			42
43	Other (specify):* Non-Allowable Cos	72,781		572,187	644,968		644,968	(644,968)				43
44	TOTAL Special Cost Centers	72,781	713,119	3,160,873	3,946,773		3,946,773	(644,968)	3,301,805			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,934,468	1,821,929	10,586,327	20,342,724		20,342,724	(2,145,686)	18,197,038			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	(381)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,486)	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	1,220	30		9
10	Interest and Other Investment Income	(2,825)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13,720)	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	(20)	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	(438,429)	43		24
25	Fund Raising, Advertising and Promotional	(29,743)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(524)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	67,258	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (428,680)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(1,717,006)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,717,006)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,145,686)		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	Trust Fees	\$ (195)	43	1
2	Labs - Part A	(58,344)	43	2
3	X-Rays - Part A	(13,381)	43	3
4	Diagnostics Managed Care	(6,510)	43	4
5	Non-Allowable Legal Fees	(14,388)	19	5
6	Marketing Salary	(72,781)	43	6
7	Unrealized loss on FMV swap	252,782	43	7
8	Marketing Offset	(6,498)	19	8
9	Capitalize R/M Expense	(8,800)	6	9
10	Lobbying Dues	(2,638)	20	10
11	Non-Allowable Fee	(75)	20	11
12	Non-Allowable Finance Charge	(1,914)	32	12
13				13
14				14
15				15
16				16
17				17
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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	67,258		49

Facility Name & ID Number Lexington Chicago Ridge # 0042739 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. ☒ 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	6	Repairs & Maintenance	\$	Sambell of Chicago Ridge Limited Partnership	**	\$ 8,800	\$ 8,800	1
2	V	19	Professional Fees		Sambell of Chicago Ridge Limited Partnership	**	200	200	2
3	V	30	Depreciation		Sambell of Chicago Ridge Limited Partnership	**	226,461	226,461	3
4	V	32	Interest expense		Sambell of Chicago Ridge Limited Partnership	**	367,617	367,617	4
5	V	32	Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	1,288	1,288	5
6	V	33	Property tax		Sambell of Chicago Ridge Limited Partnership	**	729,714	729,714	6
7	V	34	Rental expense	2,159,714	Sambell of Chicago Ridge Limited Partnership	**		(2,159,714)	7
8	V	43	Trust fees		Sambell of Chicago Ridge Limited Partnership	**	195	195	8
9	V	43	Unrealized loss on FMV swap	252,782	Sambell of Chicago Ridge Limited Partnership			(252,782)	9
10	V								10
11	V				** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%				11
12	V				of Sambell of Chicago Ridge Limited Partnership				12
13	V								13
14	Total			\$ 2,412,496			\$ 1,334,275	\$ * (1,078,221)	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.	**	\$ 335	\$ 335	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,386	7,386	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	311	311	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	496	496	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	76,038	76,038	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	7,025	7,025	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	318	318	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	10,720	10,720	22
23	V	10 Medical consultant		Royal Management Corp.	**	2,774	2,774	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	34,432	34,432	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	4,854	4,854	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	57,344	57,344	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	15,351	15,351	27
28	V	19 Professional fees		Royal Management Corp.	**	22,504	22,504	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	2,286	2,286	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	13,253	13,253	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	705,349	705,349	31
32	V	21 Bank charges		Royal Management Corp.	**	2,823	2,823	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	9,538	9,538	33
34	V	21 Postage		Royal Management Corp.	**	3,550	3,550	34
35	V	21 Telephone		Royal Management Corp.	**	10,886	10,886	35
36	V							36
37	V							37
38	V	** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.						38
39	Total		\$			\$ 987,573	\$ * 987,573	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.	**	\$ 371	\$ 371	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,123	1,123	16
17	V	25	Auto expense		Royal Management Corp.	**	12,241	12,241	17
18	V	26	Insurance general		Royal Management Corp.	**	3,032	3,032	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	107,522	107,522	19
20	V	30	Depreciation		Royal Management Corp.	**	102,365	102,365	20
21	V	32	Interest		Royal Management Corp.	**	16,309	16,309	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,304	2,304	22
23	V	33	Property taxes		Royal Management Corp.	**	6,696	6,696	23
24	V	34	Rent expense		Royal Management Corp.	**	4,920	4,920	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,431	1,431	25
26	V	17	Management fees	1,885,574	Royal Management Corp.	**	0	(1,885,574)	26
27	V	35	Auto Lease		Royal Management Corp.	**	902	902	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 Chicago Ridge, Inc. own 100% of Royal Management Corp.						38
39	Total			\$ 1,885,574			\$ 259,216	\$ * (1,626,358)	39

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

Facility Name & ID Number

Lexington Chicago Ridge

0042739

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 Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	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 LaGrange, Inc.	LaGrange	Life Care		Assisted Living	4
5			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	of Lombard, LLC		Facility	5
6			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Life Care		Living Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	of Elmhurst, LLC			8
9			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Vesta Management	Lombard	Mgmt. Company	9
10					Group LLC			10
11					Sambell of	Bloomingdale	Real Estate	11
12					Bloomingdale Ltd.		Property	12
13					Ptsp.			13
14					Royal Management	Lombard	Mgmt. Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance Company	16
17					Services II, LLC			17
18					Heron Point	Lombard	Mgmt. Company	18
19					Management Corp			19
20					Samvest of Lombard	Lombard	Lessor	20
21					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								30

Facility Name & ID Number

Lexington Chicago Ridge

0042739

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

Facility Name & ID Number Lexington Chicago Ridge # 0042739 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	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 9,562	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,652	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,869	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	13,284	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	18,977	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 57,344		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 Chicago Ridge# 0042739

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	\$	74,298	\$ 335	1
2	5	Utilities - gas & electric	Bed Days	724,314	10	72,000		74,298	7,386	2
3	5	Utilities - water & sewer	Bed Days	724,314	10	3,036		74,298	311	3
4	5	Utilities - maintenance office	Bed Days	724,314	10	4,835		74,298	496	4
5	6	Management allocation - salaries	Bed Days	724,314	10	741,281	741,281	74,298	76,038	5
6	6	Repairs & maintenance	Bed Days	724,314	10	68,481		74,298	7,025	6
7	6	Scavenger & exterminating	Bed Days	724,314	10	3,101		74,298	318	7
8	7	Management allocation - employee	Bed Days	724,314	10	104,504		74,298	10,720	8
9	10	Medical consultant	Bed Days	724,314	10	27,047		74,298	2,774	9
10	10	Management allocation - salaries	Bed Days	724,314	10	335,674	335,674	74,298	34,432	10
11	15	Management allocation - employee	Bed Days	724,314	10	47,322		74,298	4,854	11
12	17	Management allocation - salaries	Bed Days	724,314	10	559,036	559,036	74,298	57,344	12
13	19	Computer consultant & supplies	Bed Days	724,314	10	149,651		74,298	15,351	13
14	19	Professional fees	Bed Days	724,314	10	219,386		74,298	22,504	14
15	20	Dues & subscriptions	Bed Days	724,314	10	22,289		74,298	2,286	15
16	20	Advertising - help wanted	Bed Days	724,314	10	129,203		74,298	13,253	16
17	21	Management allocation - salaries	Bed Days	724,314	10	6,876,284	6,876,284	74,298	705,349	17
18	21	Bank charges	Bed Days	724,314	10	27,523		74,298	2,823	18
19	21	Office supplies & printing	Bed Days	724,314	10	92,982		74,298	9,538	19
20	21	Postage	Bed Days	724,314	10	34,606		74,298	3,550	20
21	21	Telephone	Bed Days	724,314	10	106,126		74,298	10,886	21
22										22
23										23
24										24
25	TOTALS					\$ 9,627,630	\$ 8,512,275		\$ 987,573	25

Ending: 2/31/2016

((630) 458-4796

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	Lexington Financial						\$				\$	1
2	Services II, L.L.C.	X		Mortgage	Varies	4/30/07	6,908,000		5/1/17	0.0650	367,617	2
3												3
4				Finance Charge - Insurance Policy							1,914	4
5												5
	Working Capital											
6	American Chartered Bank		X	Line of Credit	Varies	3/25/2016	5,600,000	770,000	6/24/2017	Libor +2.5%	22,483	6
7												7
8												8
9	TOTAL Facility Related						\$ 12,508,000	\$ 770,000			\$ 392,014	9
	B. Non-Facility Related*											
10								Amortization of loan cost			1,288	10
11								Interest Income offset			(2,825)	11
12								Allocated from Home Office			18,613	12
13								See Sch 9A			(1,655)	13
14	TOTAL Non-Facility Related						\$				\$ 15,421	14
15	TOTALS (line 9+line14)						\$ 12,508,000	\$ 770,000			\$ 407,435	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 Chicago Ridge
IDPH License ID Number: 0042739
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			\$	0	9
	B. Non-Facility Related*														
10									Line of Credit Fee			208	10		
11									Microsoft			51	11		
12									Non-Allowable Finance Charge			(1,914)	12		
13													13		
14	TOTAL Non-Facility Related				\$0.00		\$	0	\$	0			\$	(1,655)	14

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0042739

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>24-18-200-030-0000</u>	<u>Land & Building</u>	\$ <u>748,590.47</u>	\$ <u>748,590.47</u>
2. <u>24-07-311-012-0000</u>	<u>Land & Building</u>	\$ <u>24,536.52</u>	\$ <u>24,536.52</u>
3. <u>Royal Management Corp (Samvest of Lombard II)</u>		\$ _____	\$ _____
4. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>249,002.30</u>	\$ <u>6,696.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>1,022,129.29</u></u>	\$ <u><u>779,822.99</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: 85,551

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).

N/A

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	31,000	1989	\$ 505,000	1
2	Management Company Allocation			22,198	2
3	TOTALS	31,000		\$ 527,198	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	203		1991	1991	\$ 5,143,342	\$	35	\$ 146,951	\$ 146,951	\$ 3,759,533
5			1995	1995	97,352	2,781	35	2,781		59,798
6										
7										
8										
	Improvement Type**									
9	Leasehold Improvements		1993		2,694	77	35	77		1,810
10	Leasehold Improvements		1994		6,581	188	35	188		4,231
11	Dishwasher hood		1996		2,480		10			2,480
12	Lobby repairs		1996		8,698		10			8,698
13	Basement rehab		1997		24,477		10			24,477
14	Wiring		1998		3,429		10			3,429
15	Handrails		1998		895		15			895
16	Resurface & restripe parking lot		1998		4,450		10			4,450
17	Fire wall		1998		2,169	62	35	62		1,147
18	Foyer floor tile		1999		32,379		10			32,379
19	Wallpapering / painting / decorating		1999		8,833		10			8,832
20	Rebuild garage area		1999		1,762	50	35	50		861
21	Roof repairs		2000		6,240		10			6,240
22	Electrical wiring		2000		3,986	114	35	114		1,880
23	Electrical wiring		2000		2,536	72	35	72		1,192
24	Kitchen rehab		2000		6,623	221	35	221		3,645
25	Automatic doors		2000		1,300		10			1,300
26	Elevator eye sensors		2000		4,500		15			4,500
27	Resurface & restripe parking lot		2001		3,319		10			3,319
28	Door releases		2001		5,200		10			5,200
29	Carpeting		2001		10,022		10			10,022
30	Roof repairs		2002		25,600	1,280	20	1,280		19,247
31	Elevator upgrade		2002		9,865		10			9,865
32	Painting/decorating/carpet/wallpaper		2003		38,165	1,908	20	1,908		26,713
33	Rehab/new office		2003		26,733	1,337	20	1,337		18,716
34	Facility rehab - construction costs, painting & decorating		2003		257,174	12,859	20	12,859		173,595
35	Facility rehab - electrical		2003		12,840	642	20	642		8,667
36	Facility rehab - carpeting		2003		7,800		10			7,800

*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 Chicago Ridge

0042739

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	Facility rehab - floor tile	2003	\$ 3,548	\$ 177	20	\$ 177	\$	\$ 2,391	37
38									38
39	Kickplates/Door protectors	2004	4,095		10			4,095	39
40	Kitchen Fire Protection Upgrade	2004	1,427		10			1,427	40
41	Parking Lot - Paving and Sealcoating	2005	4,375	219	20	219		2,481	41
42	Kitchen Rehab	2005	19,228	961	20	961		10,732	42
43	Lobby/Lounge Reception Area	2005	36,503	1,825	20	1,825		21,140	43
44	Sidewalk - Raise and Support	2005	1,330	67	20	67		753	44
45	Lower Level Therapy Rehab	2005	52,525	2,626	20	2,626		29,762	45
46	Transitional Unit	2005	1,020	51	20	51		565	46
47	Basement Renovation	2005	3,754	188	20	188		2,099	47
48	Landscaping Enhancement	2006	6,463	431	15	431		4,418	48
49	Lhi-Hvac	2006	4,333	217	20	217		2,188	49
50	Rehab Common Areas	2006	7,661	383	20	383		4,022	50
51	Modular Units attached to wall	2006	10,316	516	20	516		5,332	51
52	Cubical Curtains	2006	1,578		5			1,578	52
53	Landscaping	2007	5,000	333	15	333		3,136	53
54	Parking lot	2007	35,969		20	1,819	1,819	16,371	54
55	HVAC	2007	4,580	229	20	229		2,214	55
56	Emergency A/C	2007	30,293	1,515	20	1,515		14,140	56
57	Portable A/C	2007	3,768	188	20	188		1,771	57
58	Employee Lunch Room	2007	3,671	184	20	184		1,687	58
59	Painting	2007	16,150	808	20	808		7,541	59
60	1st floor remodel-carpentry, flooring, plumbing, electrical fixtures	2007	641,616		40	16,225	16,225	146,025	60
61	painting,								61
62	Create first floor therapy	2007	185	9	20	9		90	62
63	Landscaping	2008	19,600	1,307	15	1,307		11,000	63
64	Parking Lot-paving,sealcoating and repairs	2008	44,050	2,203	20	2,203		18,175	64
65	HVAC Sport Cooolers	2008	3,790	95	40	95		760	65
66	Plumbing & Sprinkler Shower room	2008	9,668	483	20	483		3,864	66
67	Common areas-doors and locks	2008	3,162	158	20	158		1,396	67
68	Basement Renovation	2008	7,569	189	40	189		1,670	68
69	2nd Floor Remodel-Carpentry, Flooring, Electrical, painting	2008	578,270		27	21,028	21,028	169,976	69
70	TOTAL (lines 4 thru 69)		\$ 7,326,941	\$ 36,953		\$ 222,976	\$ 186,023	\$ 4,707,720	70

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

Facility Name & ID Number Lexington Chicago Ridge

0042739

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		\$ 7,326,941	\$ 36,953		\$ 222,976	\$ 186,023	\$ 4,707,720	1
2	Land improvements	2009	15,180	1,012	15	1,012		7,337	2
3	Landscaping	2009	3,693	246	15	246		1,825	3
4	Chiller	2009	178,462	8,923	20	8,923		67,666	4
5	Quick connectors/spot cooler	2009	10,244	512	20	512		3,917	5
6	Plumbing & Sprinkler	2009	6,172	154	40	154		1,117	6
7	Chiller Fence	2009	5,350	268	20	268		1,876	7
8	Land improvements-patio pergola	2009	7,930	397	20	397		2,911	8
9	Land improvements patio fence	2009	14,308	715	20	715		5,065	9
10	3rd floor remodel-Carpentry, flooring, electrical, painting, sprinkler system	2009	670,689		27	24,389	24,389	172,755	10
11									11
12	Landscaping Enhancements	2010	4,560	304	15	304		1,875	12
13	Office carpentry, flooring, electrical, painting, plumbing, signs	2010	82,988	2,997	27	2,997		55,172	13
14	Tree removal	2010	12,094	806	15	806		5,105	14
15	Seal Crack Filing and Striping	2010	3,000	200	15	200		1,267	15
16	Parking lot signage, posts and lamps	2010	30,501	1,113	27	1,113		7,254	16
17	HVAC Quick connects	2010	4,043	147	27	147		895	17
18	Pantries-Tile, shelves	2010	2,855	104	27	104		650	18
19	Director of Nursing office painting	2010	8,090	295	27	295		1,770	19
20	1st floor rehab-cabinets, library lounge-art, flooring	2010	4,725	172	27	172		1,073	20
21	2nd floor rehab-painting, flooring	2010	61,521	2,244	27	2,244		13,464	21
22									22
23	Payroll Office Remodel - Electrical	2011	5,439	198	27	198		1,122	23
24	Payroll Office Remodel - Doors & Millwork	2011	10,336	376	27	376		2,037	24
25	Holding Tank	2011	16,400	596	27	596		3,228	25
26	Bulk Pipe - Removal of vent lines	2011	4,380	159	27	159		822	26
27	Remodel Laundry Room - Electrical, Painting & Flooring	2011	7,222	263	27	263		1,381	27
28	2nd Floor Doors	2011	23,290	847	27	847		4,517	28
29	2nd Floor Remodeling - Carpentry (Drywall, finish/trim)	2011	17,949		27	653	653	3,918	29
30	Exterior Painting	2011	3,000		27	109	109	581	30
31	Fire Dampers	2011	20,441		27	743	743	3,777	31
32	Boiler	2011	9,800		27	356	356	2,018	32
33	Parking Lot - seal and stripe	2011	4,300			156	156	819	33
34	TOTAL (lines 1 thru 33)		\$ 8,575,903	\$ 60,001		\$ 272,430	\$ 212,429	\$ 5,084,934	34

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

Facility Name & ID Number Lexington Chicago Ridge

0042739

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		\$ 8,575,903	\$ 60,001		\$ 272,430	\$ 212,429	\$ 5,084,934	1
2	Building Wiring-EMR	2012	13,566		27	493	493	2,137	2
3									3
4	Exterior Lighting	2013	7,418		27	270	270	900	4
5									5
6									6
7	R/M Reclass: Condenser Motor/Fan HVAC Mechanical Room	2014	2,648		20	132	132	330	7
8	R/M Reclass: Elevator Door Restrictor	2014	5,250		10	525	525	1,313	8
9									9
10	R/M Reclass: Stairwell doors 3rd floor south & 2nd floor north	2015	4,146		20	207	207	311	10
11	R/M Reclass: Replace 5 water tubes and sealing O rings basement	2015	3,559		20	178	178	267	11
12	R/M Reclass: Crack sealing and striping parking lot	2015	4,700		27	174	174	261	12
13									13
14	RE Entity: Chair Rail Installations in 1st & 2nd Floor Rooms	2016	26,509		27	161	161	161	14
15	R/M Reclass (RE): Concrete Paving in Parking Lot	2016	8,800		15	293	293	293	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	Reconcile to book depreciation			287			(287)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,652,499	\$ 60,288		\$ 274,863	\$ 214,575	\$ 5,090,907	34

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

Facility Name & ID Number Lexington Chicago Ridge

0042739

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 8,652,499	\$ 60,288		\$ 274,863	\$ 214,575	\$ 5,090,907	1
2 Land improvements - management company	2002	307,173		40	8,456	8,456	136,294	2
3 HVAC, electrical, security system - management company	2003	2,698		30	601	601	2,143	3
4 Key card system - management company	2004	424		20	20	20	263	4
5 VAV TX controls - management company	2005	129		20	6	6	76	5
6 Interior Signs- management company	2006	94		20	6	6	64	6
7 Building - management company	2008	14,885		20	154	154	6,505	7
8 Building - management company	2009	2,779		20	48	48	1,128	8
9 Building - management company	2010	2,708		20	47	47	1,041	9
10 Building - management company	2011	1,911		20	83	83	489	10
11 Building - management company	2012	6,604		20	12	12	1,129	11
12 Building - management company	2013	4,990		20	337	337	1,187	12
13 Building - management company	2014	2,701		20	250	250	678	13
14 Building - management company	2015	475		20	54	54	87	14
15 Building - management company	2016	7,836		20	225	225	225	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)		\$ 9,007,906	\$ 60,288		\$ 285,160	\$ 224,872	\$ 5,242,216	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	\$ 1,252,651	\$ 69,061	\$ 82,167	\$ 13,106	5-10	\$ 935,547	71
72	Current Year Purchases				-			72
73	Fully Depreciated Assets	338,924			-	5-7	338,924	73
74	Allocated from Mgmt. Co.	637,099		89,406	89,406	5-7	525,687	74
75	TOTALS	\$ 2,228,674	\$ 69,061	\$ 171,573	\$ 102,512		\$ 1,800,158	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		2,662	2,662	5	50,999	79
80	TOTALS			\$ 57,433	\$ -	\$ 2,662	\$ 2,662		\$ 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)	\$ 11,821,211	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 129,349	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 459,395	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 330,046	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,093,373	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Parking Space Lease				3,600			5
6	Allocated from Management Company				4,920			6
7	TOTAL				\$ 8,520			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: \$ 91,543
- Description: Copier-\$9,994;Postage-\$323;Printer-\$5,037;Med Eq-\$35,827;Oxygen-\$38,931;Alloc. Mgmt Co.-\$1,431
- (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			902	20
21	TOTAL		\$	\$ 902	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)	\$			

- (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.

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	

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				
					Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	17,104	\$ 508,831	\$	17,104	\$ 508,831	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		5,116	115,518		5,116	115,518	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		26,936	1,497,392		26,936	1,497,392	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				699,998		699,998	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				17,424			17,424	12
13	Other (specify): See Sch 16A	39(2)					13,121		13,121	13
14	TOTAL			\$	49,156	\$ 2,139,165	\$ 713,119	49,156	\$ 2,852,284	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 Chicago Ridge
IDPH License ID Number: 0042739
Fiscal Year End: 12/31/2016

Schedule 16A

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>DME</u>	39(2)					1,547			13
13	Other (specify): <u>Oxygen</u>	39(2)					11,574			
13	Other (specify): <u></u>									
14	TOTAL			\$		\$	\$ 13,121		\$	14

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,129,477	\$ 1,213,727	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,185,314)	3,445,092	3,445,092	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(3,492)	(3,492)	6
7	Other Prepaid Expenses	17,990	17,990	7
8	Accounts Receivable (owners or related parties)	(316)	1,754	8
9	Other(specify): Interest Receivable	20,397	20,397	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,609,148	\$ 4,695,468	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,090	8,090	12
13	Land		527,198	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	1,456,473	3,864,564	15
16	Equipment, at Historical Cost	761,311	2,286,107	16
17	Accumulated Depreciation (book methods)	(1,492,144)	(7,093,373)	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		20,065	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 733,730	\$ 4,755,993	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,342,878	\$ 9,451,461	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 735,152	\$ 735,152	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	770,000	770,000	29
30	Accrued Salaries Payable	558,491	558,491	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,368	32,368	31
32	Accrued Real Estate Taxes(Sch.IX-B)		796,000	32
33	Accrued Interest Payable		31,961	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	8,612,805	3,879,657	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,708,816	\$ 6,803,629	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,470,146	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)	\$	\$ 5,470,146	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,708,816	\$ 12,273,775	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,365,938)	\$ (2,822,314)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,342,878	\$ 9,451,461	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,704,182)	1
2	Restatements (describe):		2
3	Post closing adjustment	(188,878)	3
4	401k Adjustment	207	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,892,853)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,473,085)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,473,085)	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)	\$ (5,365,938)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington Chicago Ridge

0042739

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	\$ 24,933,021	1
2	Discounts and Allowances for all Levels	(15,749,005)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,184,016	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,434,442	6
7	Oxygen	30,822	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,465,264	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	11,194	12
13	Barber and Beauty Care	17,589	13
14	Non-Patient Meals	381	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,142,811	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	487,962	19
20	Radiology and X-Ray	36,245	20
21	Other Medical Services	521,352	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,217,534	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,825	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,825	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)	\$ 18,869,639	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,005,144	31
32	Health Care	7,224,606	32
33	General Administration	4,758,770	33
	B. Capital Expense		
34	Ownership	2,407,431	34
	C. Ancillary Expense		
35	Special Cost Centers	3,515,938	35
36	Provider Participation Fee	430,835	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,342,724	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,473,085)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,473,085)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,266,823	44
45	Private Pay - Net Inpatient Revenue	790,263	45
46	Medicare - Net Inpatient Revenue	1,254,132	46
47	Other-(specify) <u>Managed Care</u>	872,798	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,184,016	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	1,703	2,093	\$ 128,312	\$ 61.31	1
2	Assistant Director of Nursing	2,349	2,799	123,515	44.13	2
3	Registered Nurses	37,071	47,849	1,589,905	33.23	3
4	Licensed Practical Nurses	35,392	45,741	1,183,091	25.87	4
5	CNAs & Orderlies	117,157	142,570	1,926,390	13.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,943	2,221	41,340	18.62	9
10	Activity Assistants	8,706	9,931	109,791	11.06	10
11	Social Service Workers	8,463	10,974	195,449	17.81	11
12	Dietician	3,340	4,037	103,859	25.73	12
13	Food Service Supervisor	1,496	2,303	44,131	19.16	13
14	Head Cook	1,777	2,154	44,346	20.58	14
15	Cook Helpers/Assistants	26,689	32,625	333,911	10.23	15
16	Dishwashers					16
17	Maintenance Workers	1,748	2,204	38,226	17.35	17
18	Housekeepers	34,229	43,815	470,494	10.74	18
19	Laundry					19
20	Administrator	1,728	2,121	145,628	68.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,815	14,006	257,168	18.36	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	1,619	2,010	35,249	17.54	31
32	Other Health Care See Sch 20A	31,728	39,006	1,090,881	27.97	32
33	Other(specify) Marketing	1,771	2,010	72,781	36.21	33
34	TOTAL (lines 1 - 33)	329,722	410,467	\$ 7,934,468 *	\$ 19.33	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	90,000	9(3)	36
37	Medical Records Consultant	Monthly	861	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,594	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,704	11(3)	44
45	Social Service Consultant	Monthly	3,052	12(3)	45
46	Other(specify) Medical Consultant	Monthly	2,774	10(7)	46
47	Pulmonary Exchange	Monthly	98,787	10(3)	47
48	See Sch 20B	Monthly	11,106	10(3)	48
49	TOTAL (lines 35 - 48)		\$ 226,878		49

C. CONTRACT NURSES

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

Facility Name: Lexington Chicago Ridge
IDPH License ID Number: 0042739
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	1,698	2,187	32,408	\$ 14.82
Unit Secretary	8,527	10,663	236,883	\$ 22.21
Accounts Coordinator	1,761	2,163	29,045	\$ 13.43
Admissions	3,671	4,369	116,108	\$ 26.58
Case Manager	2,851	3,306	72,908	\$ 22.06
MDS	3,302	4,105	160,083	\$ 39.00
Clinical Coordinator	5,392	6,766	252,454	\$ 37.31
Transitional Care Nurse	1,782	2,093	70,201	\$ 33.54
Wound Care Coordinator	2,743	3,355	120,793	\$ 36.01
Total - Line 32 Other Health Care (specify):	31,728	39,006	1,090,881	\$ 27.97

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Total - Line 33 Other (specify):	-	-	-	

Schedule 20B

XVIII. Staffing and Salary Costs
B. Consultant Services

Description	# of Hrs. Paid and Accrued	Total Consultant Cost	Ref.
Post Acute Consulting	Monthly	1,956	10(3)
Telemedicine	Monthly	9,150	10(3)
Total - Line 48	Monthly	11,106	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Kristin Mitchell	Administrator	0	\$ 145,628	Workers' Compensation Insurance	\$ 250,164	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	83,646	Advertising: Employee Recruitment	3,906		
				FICA Taxes	596,139	Health Care Worker Background Check			
				Employee Health Insurance	320,909	(Indicate # of checks performed 308)	3,700		
				Employee Meals		Patient Background Checks 926	11,107		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	7,222		
				401K	26,897	Miscellaneous Dues & Subscriptions	7,869		
				Other Employee Benefits	37,434	IHCA	6,678		
				Uniform Allowance	2,565	Less: Non-Allowable Dues	(2,638)		
TOTAL (agree to Schedule V, line 17, col. 1)						Management Company Allocation	15,539		
(List each licensed administrator separately.)				\$ 145,628		Less: Public Relations Expense	()		
B. Administrative - Other						Non-allowable advertising	()		
Description			Amount			Yellow page advertising	()		
Management Fees-Royal Operating			\$ 1,322,244						
Management Fees-Vesta Mgmt.			563,330						
Management Fees (Eliminated in Column 7)									
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,885,574						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
American Chartered Bank	Financial		\$ 39,885	N/A			Out-of-State Travel	\$	
Attadale Partners	Operations Consulting		9,990						
Cash Receipts	Collections		6,688						
Cassiday Schade	Legal		156,289				In-State Travel		
Duane Morris	Legal		1,094						
Filpi & Filpi	Legal		100						
Grabowski Law Center	Collections		3,576						
Generation Law	Legal		874				Seminar Expense		
Much Shelist	Legal		3,012						
North Heron Insurance	Insurance		140,228						
Personnel Planners	U/C Consulting		2,325				Management Company Allocation	1,123	
See Schedule 21C	See Schedule 21C		130,736				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)							(agree to Sch. V,		
(For legal fee disclosure, see page 39 of instructions)				\$ 494,797			TOTAL	line 24, col. 8)	
								\$ 1,123	

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Lexington Chicago Ridge
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Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Pension Administrators	401K Administration	1,300
RSM US LLP	Accounting	41,798
SB2, Inc.	Medicaid Consulting	2,484
Scott & Kraus	Legal	98
Secretary of State	Filing Fees	100
Serpico, Petrosino, Dipiero & O'Shea	Legal	1,950
Jefferies	Tax Consulting	1,949
Ability Network	Computer Services	5,980
Availity	Computer Services	252
Avatier	Computer Services	193
Cinetec	Computer Services	851
Citrix	Computer Services	702
Corepoint	Computer Services	1,531
DocuSign	Computer Services	462
E-Health	Computer Services	863
HealthMedx	Computer Services	16,038
Infor	Computer Services	8,004
MHC Software	Computer Services	1,005
Microcenter	Computer Services	157
Microsoft	Computer Services	898
National Datacare	Computer Services	2,335
NTT Data	Computer Services	8,116
OnShift	Computer Services	8,898
Provinet	Computer Services	112
Relias Learning	Computer Services	11,036
Salesforce	Computer Services	6,498
Softchoice	Computer Services	4,516
Symbria	Computer Services	2,200
Tableau Software	Computer Services	411
Total (agree to Schedule V, line 19, column 3)		494,797
Less:		
Salesforce		(6,498)
Non-Allowable Legal		(14,388)
Reclass to Insurance Settlement		(140,228)
Allocated from Real Estate		
Secretary of State		200
		200
Samvest of Lombard		
Accounting		124
Filing Fees		9
		133
Allocated from Mgmt Co.		
RSM US LLP	Accounting	3,405
Marcum LLP	Accounting	407
Gilson Labus & Silverman	Accounting	105
Illinois Secretary of State	Filing Fees	49
LaSalle Network	Recruiting/Finance	2,367
Callan Associates, Ltd.	Recruiting	12,677
Pension Administrators, Inc.	401K Administration	406
Voya Financial	401K Administration	17
Gene Whitehorn	Medicaid Reimb Specialist	1,827
M. Werner Consulting	Financial Consultant	972
M. Rodeghier Consulting	Process Improvement Consultant	74
Wordy.com	Proofreading	65
Computer Services	Computer Consulting	15,351
		37,722
Total (agree to Schedule V, line 19, column 8)		371,738

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 - \$4,040

(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? N/A

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 65,583 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. \$ 430,835
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 381

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: 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