

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0039768</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Lexington of Lake Zurich</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>930 South Rand Road</u> <u>Lake Zurich</u> <u>60047</u>																									
Number City Zip Code																									
County: <u>Lake</u>																									
Telephone Number: <u>(847) 726-1200</u> Fax # <u>(847) 726-1265</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>08/20/94</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:																									
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u>																									
Email Address: _____																									

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

Facility Name & ID Number Lexington of Lake Zurich # 0039768 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	421,638	34,338	10,688	466,664		466,664		466,664			1
2	Food Purchase		392,818		392,818		392,818	(1,430)	391,388			2
3	Housekeeping	436,843	49,544		486,387		486,387	335	486,722			3
4	Laundry		23,102		23,102		23,102		23,102			4
5	Heat and Other Utilities			232,618	232,618		232,618	8,193	240,811			5
6	Maintenance	43,115		199,906	243,021		243,021	74,439	317,460			6
7	Other (specify):* Mgmt Co.-Allocated B							10,720	10,720			7
8	TOTAL General Services	901,596	499,802	443,212	1,844,610		1,844,610	92,257	1,936,867			8
	B. Health Care and Programs											
9	Medical Director			52,750	52,750		52,750		52,750			9
10	Nursing and Medical Records	5,669,172	421,184	93,812	6,184,168		6,184,168	37,206	6,221,374			10
10a	Therapy											10a
11	Activities	165,011	22,958	5,566	193,535		193,535		193,535			11
12	Social Services	178,286		3,052	181,338		181,338		181,338			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	6,012,469	444,142	155,180	6,611,791		6,611,791	42,060	6,653,851			16
	C. General Administration											
17	Administrative	130,292		1,789,286	1,919,578		1,919,578	(1,731,942)	187,636			17
18	Directors Fees											18
19	Professional Services			288,993	288,993		288,993	14,033	303,026			19
20	Dues, Fees, Subscriptions & Promotions			39,949	39,949		39,949	12,630	52,579			20
21	Clerical & General Office Expenses	166,789	30,743	49,407	246,939		246,939	732,146	979,085			21
22	Employee Benefits & Payroll Taxes			1,313,156	1,313,156		1,313,156		1,313,156			22
23	Inservice Training & Education			9,275	9,275		9,275	371	9,646			23
24	Travel and Seminar							1,123	1,123			24
25	Other Admin. Staff Transportation			7,570	7,570		7,570	12,241	19,811			25
26	Insurance-Prop.Liab.Malpractice			402,078	402,078		402,078	11,034	413,112			26
27	Other (specify):* Mgmt Co.-Allocated B							107,522	107,522			27
28	TOTAL General Administration	297,081	30,743	3,899,714	4,227,538		4,227,538	(840,842)	3,386,696			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,211,146	974,687	4,498,106	12,683,939		12,683,939	(706,525)	11,977,414			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			127,990	127,990		127,990	341,207	469,197			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,343	40,343		40,343	403,709	444,052			32
33	Real Estate Taxes							171,621	171,621			33
34	Rent-Facility & Grounds			1,594,925	1,594,925		1,594,925	(1,590,005)	4,920			34
35	Rent-Equipment & Vehicles			80,168	80,168		80,168	2,333	82,501			35
36	Other (specify):*											36
37	TOTAL Ownership			1,843,426	1,843,426		1,843,426	(671,135)	1,172,291			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		524,767	1,258,760	1,783,527		1,783,527		1,783,527			39
40	Barber and Beauty Shops			24,889	24,889		24,889		24,889			40
41	Coffee and Gift Shops			2,827	2,827		2,827		2,827			41
42	Provider Participation Fee			422,979	422,979		422,979		422,979			42
43	Other (specify):* Non-Allowable Cos	69,157		273,934	343,091		343,091	(343,091)				43
44	TOTAL Special Cost Centers	69,157	524,767	1,983,389	2,577,313		2,577,313	(343,091)	2,234,222			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,280,303	1,499,454	8,324,921	17,104,678		17,104,678	(1,720,751)	15,383,927			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	(1,430)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,936)	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	921	30		9
10	Interest and Other Investment Income	(21,033)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10,215)	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	(25)	43		18
19	Entertainment				19
20	Contributions	(2,530)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(165,332)	43		24
25	Fund Raising, Advertising and Promotional	(31,428)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(575)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	127,059	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (114,524)		\$	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)	(1,606,227)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,606,227)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,720,751)		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	Labs-Part A	\$ (28,113)	43	1
2	X-Rays-Part A	(23,360)	43	2
3	Diagnostics Managed Care	(2,420)	43	3
4	Trust Fees	(159)	43	4
5	Marketing Software	(6,495)	19	5
6	Collections & Out of Period Legal	(7,892)	19	6
7	Marketing Salary	(69,157)	43	7
8	Non-Allowable Tax Consulting	(1,783)	19	8
9	Unrealized Loss on FMV Swap	278,289	43	9
10	Chamber of Commerce Dues	(2,909)	21	10
11	Relcass RM to LHI	(8,942)	6	11
12				12
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42				42
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45				45
46				46
47				47
48				48
49	Total	127,059		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 Lake Zurich Ltd Ptsp	**	\$ 350	\$ 350	1
2	V	30	Depreciation		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	237,922	237,922	2
3	V	32	Interest Expense		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	404,714	404,714	3
4	V	32	Amortization of Mortgage Costs		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	1,415	1,415	4
5	V	33	Property Taxes		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	164,925	164,925	5
6	V	34	Rental Expense	1,594,925	Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**		(1,594,925)	6
7	V	43	Trust Fees		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	160	160	7
8	V	43	Unrealized loss on FMV swap	278,291	Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**		(278,291)	8
9	V								9
10	V								10
11	V								11
12	V		** The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Lexington Health Care Systems						12
13	V		of Lake Zurich Limited Partnership.						13
14	Total			\$ 1,873,216			\$ 809,486	\$ * (1,063,730)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	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		** The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management Corp.						37
38	V								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	1,789,286	Royal Management Corp.	**		(1,789,286)	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		** The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management Corp.						36
37	V								37
38	V								38
39	Total			\$ 1,789,286			\$ 259,216	\$ * (1,530,070)	39

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

Facility Name & ID Number

Lexington of Lake Zurich

0039768

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Lexington of Lake Zurich

0039768

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

Facility Name & ID Number Lexington of Lake Zurich # 0039768 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 of Lake Zurich# 0039768

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 Available	724,314	10	\$ 3,263	\$	74,298	\$ 335	1
2	5	Utilities - gas & electric	Bed Days Available	724,314	10	72,000		74,298	7,386	2
3	5	Utilities - water & sewer	Bed Days Available	724,314	10	3,036		74,298	311	3
4	5	Utilities - maintenance office	Bed Days Available	724,314	10	4,835		74,298	496	4
5	6	Management allocation - salaries	Bed Days Available	724,314	10	741,281	741,281	74,298	76,038	5
6	6	Repairs & maintenance	Bed Days Available	724,314	10	68,481		74,298	7,025	6
7	6	Scavenger & exterminating	Bed Days Available	724,314	10	3,101		74,298	318	7
8	7	Management allocation - employee	Bed Days Available	724,314	10	104,504		74,298	10,720	8
9	10	Medical consultant	Bed Days Available	724,314	10	27,047		74,298	2,774	9
10	10	Management allocation - salaries	Bed Days Available	724,314	10	335,674	335,674	74,298	34,432	10
11	15	Management allocation - employee	Bed Days Available	724,314	10	47,322		74,298	4,854	11
12	17	Management allocation - salaries	Bed Days Available	724,314	10	559,036	559,036	74,298	57,344	12
13	19	Computer consultant & supplies	Bed Days Available	724,314	10	149,651		74,298	15,351	13
14	19	Professional fees	Bed Days Available	724,314	10	219,386		74,298	22,504	14
15	20	Dues & subscriptions	Bed Days Available	724,314	10	22,289		74,298	2,286	15
16	20	Advertising - help wanted	Bed Days Available	724,314	10	129,203		74,298	13,253	16
17	21	Management allocation - salaries	Bed Days Available	724,314	10	6,876,284	6,876,284	74,298	705,349	17
18	21	Bank charges	Bed Days Available	724,314	10	27,523		74,298	2,823	18
19	21	Office supplies & printing	Bed Days Available	724,314	10	92,982		74,298	9,538	19
20	21	Postage	Bed Days Available	724,314	10	34,606		74,298	3,550	20
21	21	Telephone	Bed Days Available	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, LLC	X		Mortgage	Varies	4/30/07	7,606,000	6,023,176	5/1/2017	0.0650	404,714	2	
3												3	
4								Finance Charge - Insurance Policy			1,946	4	
5												5	
	Working Capital												
6	Shareholders	X		Working Capital	None	Varies	270,033	1,758,420	Demand	Prime +1	17,410	6	
7	American Chartered Bank		X	Line of Credit	Varies	6/29/13	5,600,000	720,000	6/24/2017	Libor +2.5%	19,870	7	
8												8	
9	TOTAL Facility Related						\$ 13,476,033	\$ 8,501,596				\$ 443,941	9
	B. Non-Facility Related*												
10								Microsoft Financing			48	10	
11								Amortization of Loan Cost			1,415	11	
12								Interest Income offset			(1,677)	12	
13								See Sch 9A			325	13	
14	TOTAL Non-Facility Related						\$	\$				\$ 111	14
15	TOTALS (line 9+line14)						\$ 13,476,033	\$ 8,501,596				\$ 444,052	15

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

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

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

Facility Name: Lexington of Lake Zurich
IDPH License ID Number: 0039768
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								Non-Allowable shareholder interest		(17,410)			10		
11								Line of Credit Fee			1,068		11		
12								Non-Allowable Finance Charge			(1,946)		12		
13								Home Office Allocation			18,613		13		
14	TOTAL Non-Facility Related				\$0.00		\$	0	\$	0			\$	325	14

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Lake Zurich, Inc. COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0039768

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>14-28-100-020</u>	<u>Nursing Facility</u>	\$ <u>154,983.00</u>	\$ <u>154,983.00</u>
2. <u>14-29-200-033</u>	<u>Nursing Facility</u>	\$ <u>14,539.00</u>	\$ <u>14,539.00</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
4. <u>05-01-202-021</u>		\$ <u>249,002.30</u>	\$ <u>6,696.00</u>
5. _____		\$ _____	\$ _____
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
TOTALS		\$ <u><u>418,524.30</u></u>	\$ <u><u>176,218.00</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: 78,901

B. General Construction Type: Exterior BrickFrame 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	250,344	1990	\$ 495,000	1
2	Management Company Allocation			20,117	2
3	TOTALS	250,344		\$ 515,117	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		1994	1994	\$ 6,418,907	\$	40	\$ 160,473	\$ 160,473	\$ 3,583,892
5										
6										
7										
8										
	Improvement Type**									
9	Land Improvements		1994		10,701		10			10,701
10	Land Improvements		1994		13,330		10			13,330
11	Leasehold Improvements		1994		4,737		15			4,737
12	Leasehold Improvements		1995		4,005		15			4,005
13	Land Improvements		1995		3,221		10			3,221
14	Building Improvements		1995		3,019		40	75	75	1,657
15	Building Improvements		1995		64,500	1,654	39	1,654		35,905
16	Patio		1996		1,168		15			1,168
17	Compressor		1996		5,145		10			5,145
18	Road sidewalk		1997		18,094		20	905	905	17,645
19	Foundation/Sprinkler		1997		2,068	59	35	59		1,151
20	Flagpoles		1997		1,573		15			1,573
21	Basement rehab		1998		12,867		10			12,867
22	MDS Telnet wiring		1998		3,365		10			3,365
23	Flag Pole		1998		787		15			787
24	Resurface/restripe parking lot		1998		4,977		10			4,977
25	Transfer 10 beds from shelter care		1998		2,260	57	40	57		1,030
26	1st floor lobby tile		1999		12,153		10			12,153
27	Parking lot repair		2000		3,740		10			3,740
28	Roof repair		2000		10,770		10			10,770
29	Automatic door		2000		1,300		10			1,300
30	Kitchen rehab		2000		16,886		10			16,886
31	Compressor		2001		4,350		10			4,350
32	Boiler vent		2001		3,228		10			3,228
33	Fire pump		2001		1,766		10			1,766
34	Kitchen rehab		2001		721		10			721
35	Elevator infrared curtains		2001		4,500		10			4,500
36	Therapy Room Rehab		2004		64,473	3,224	20	3,224		39,761

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Lake Zurich

0039768

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	
37 Elevator Upgrade	2004	\$ 3,487	\$ 174	20	\$ 174	\$	\$ 2,104	37
38 HVAC Compressor	2004	11,845	592	20	592		7,253	38
39 Sidewalk, raise and support	2005	700	35	20	35		397	39
40 Pavement for parking lot	2005	6,650	333	20	333		3,855	40
41 Water softner	2005	2,635	132	20	132		1,572	41
42 Plumbing and sprinkler	2005	4,469	223	20	223		2,659	42
43 Lobby and lounge rehab	2005	44,560	2,228	20	2,228		26,550	43
44 Therapy room rehab	2005	1,721	86	20	86		968	44
45 First floor therapy room	2005	42,424	2,121	20	2,121		24,786	45
46 Transitional unit	2005	9,898	495	20	495		5,610	46
47 Countertop	2005	845		5			845	47
48 Wallcovering	2005	439		5			439	48
49 Panel Brick Replacement	2006	16,001	800	20	800		8,334	49
50 Landscaping Improvement	2006	4,640		5			4,640	50
51 HVAC	2006	3,999	366	10	366		3,999	51
52 Kitchen Rehab	2006	2,553	66	10	66		2,553	52
53 Wall Mounted Cabinets	2006	10,451	697	10	697		10,451	53
54 Therapy room rehab	2006	2,829	235	10	235		2,829	54
55 Solo step install	2006	3,689	307	10	307		3,689	55
56 Transitional unit	2006	31,685	1,584	20	1,584		15,973	56
57 Employee Lunchroom rehab	2006	1,766	115	10	115		1,766	57
58 Fine Dining	2006	22,517	1,126	20	1,126		11,635	58
59 Land Improvements	2006	5,374	358	15	358		3,670	59
60 Emergency AC	2006	7,564	756	10	756		7,561	60
61 Wood Flooring	2006	1,526		10	152	152	1,526	61
62 HVAC	2007	2,716	272	10	272		2,583	62
63 Emergency AC	2007	18,731	1,873	10	1,873		17,794	63
64 First floor remodel-carpentry, flooring, plumbing, painting, fixtures	2007	701,565		40	17,539	17,539	171,005	64
65 Landscaping	2008	15,920	1,061	15	1,061		9,461	66
67 Parking Lot Repairs	2008	4,224	211	20	211		1,741	67
68 Roof	2008	33,700	1,685	20	1,685		14,463	68
69 Employee Locker Rooms	2008	3,732	93	40	93		767	69
70 TOTAL (lines 4 thru 69)		\$ 7,723,466	\$ 23,018		\$ 202,162	\$ 179,144	\$ 4,179,809	70

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

Facility Name & ID Number Lexington of Lake Zurich

0039768

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		\$ 7,723,466	\$ 23,018		\$ 202,162	\$ 179,144	\$ 4,179,809	1
2	Second floor remodel - carpentry, electrical, flooring,	2008	555,633		27	20,205	20,205	170,059	2
3	painting								3
4	Irrigation System	2009	15,335	1,022	15	1,022		7,495	4
5	Landscaping Enhancements	2009	8,276	552	15	552		4,094	5
6	Quick connects	2009	7,611	381	20	381		2,794	6
7	HVAC Chiller	2009	102,185	5,109	20	5,109		38,318	7
8	HVAC-1st floor admin office	2009	7,295	365	20	365		2,585	8
9	2nd floor remodel	2009	9,331	339	27	339		2,712	9
10	Basement Office	2009	2,755	100	27	100		725	10
11	Patio Pergola	2009	8,905	445	20	445		3,263	11
12	3rd floor remodel-Carpentry,plumbing,electrical,handrails	2009	398,350		27	14,485	14,485	103,809	12
13	painting,alarm system								13
14									14
15									15
16									16
17	Med Room Remodel-painting,flooring	2010	5,531	202	27	202		1,262	17
18	Office carpentry,flooring,electrical,painting,plumbing,signs	2010	51,465	4,149	27	4,149		24,894	18
19	Exhaust System	2010	83,215	3,035	27	3,035		18,210	19
20	Office spot cooler	2010	3,456	126	27	126		767	20
21	Ceiling insulations	2010	2,640	96	27	96		608	21
22	Remodel pantry-shelves	2010	4,402	161	27	161		1,006	22
23	Paint over bed lights	2010	5,512	201	27	201		1,206	23
24	Exterior Door	2010	2,618	95	27	95		578	24
25	Remodel Library/Lounge and physician office-flooring,	2010	7,796	284	27	284		1,735	25
26	art framing,flooring								26
27	2nd floor remodel-carpentry,plumbing,electrical	2010	4,838	176	27	176		1,189	27
28	Concrete repair-ramp & railing	2010	10,029	669	15	669		4,181	28
29	Office remodel-doors, carpentry, locks	2011	20,714	753	27	753		4,089	29
30	Landscaping Enhancements	2011	4,987	332	15	332		1,909	30
31	Fire pump and drain line	2011	8,360	304	27	304		1,546	31
32	Laundry room remodel-painting, tile	2011	7,835	285	27	285		1,520	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,062,540	\$ 42,199		\$ 256,033	\$ 213,834	\$ 4,580,363	34

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

Facility Name & ID Number Lexington of Lake Zurich

0039768

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		\$ 9,062,540	\$ 42,199		\$ 256,033	\$ 213,834	\$ 4,580,363	1
2	Locker Room-paint, cabinets	2011	7,504	273	27	273		1,456	2
3	2nd floor remodel-doors and locks	2011	17,692	643	27	643		3,429	3
4	HVAC Chiller	2011	99,609		27	3,622	3,622	19,619	4
5	Parking lot-Stripe and seal	2011	51,148		20	2,557	2,557	13,424	5
6									6
7	Building wiring	2012	25,124		27	914	914	3,882	7
8	Replace pipe kitchen	2012	4,202		27	153	153	700	8
9									9
10	Update Dishwashing Area in Kitchen: Tile, Drywall	2013	10,078		27	366	366	1,191	10
11									11
12	Landscaping - adding trees main entrance	2014	10,152		15	56	56	168	12
13									13
14	Repair condensor coil in kitchen cooler	2014	3,402		20	170	170	425	14
15	2nd floor shower room - install handrails	2014	4,234		27	156	156	390	15
16									16
17	EMR Entire Buidling Wiring	2015	5,315	193	27	193		306	17
18	R/M Reclass: Fire Alarm Inspection	2015	2,547		20	127	127	191	18
19	R/M Reclass: Add Insulation to emergency exhaust pip in hallway	2015	3,100		20	155	155	233	19
20	R/M Reclass: Paving and coating parking lot	2015	5,500		20	275	275	413	20
21									21
22	Paving and Seal Coating in Parking Lot	2016	2,500	10	20	10		10	22
23	Electrical Work - Throughout Facility	2016	4,253	18	20	18		18	23
24	Physical Therapy Rm. - Surfacing, Plumbing, Drywall, Wiring, Pa	2016	3,654	66	28	66		66	24
25	Resident Rooms - Installing Chair Rails in First Floor Rooms	2016	6,192	52	10	52		52	25
26	R/M Reclass: Radiator Repair - removing, re-cored, reinstalling, a	2016	8,942		15	298	298	298	26
27	filling with new coolant								27
28									28
29									29
30									30
31									31
32	Reconcile book depreciation			(362)			362		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,337,689	\$ 43,092		\$ 266,138	\$ 223,046	\$ 4,626,635	34

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

Facility Name & ID Number Lexington of Lake Zurich

0039768

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 12C, Carried Forward		\$ 9,337,689	\$ 43,092		\$ 266,138	\$ 223,046	\$ 4,626,635	1
2									2
3	Building - management company	2002	278,376		40	8,456	8,456	123,517	3
4	HVAC, electrical, security system - management company	2003	2,445		30	601	601	1,942	4
5	Key card system - management company	2004	384		20	20	20	239	5
6	VAV TX controls - management company	2005	117		20	6	6	69	6
7	Building improvements - management company	2006	85		20	6	6	58	7
8	Building improvements - management company	2008	13,490		20	154	154	5,895	8
9	Building improvements - management company	2009	2,518		20	48	48	1,022	9
10	Building improvements - management company	2010	2,454		20	47	47	943	10
11	Building improvements - management company	2011	1,732		20	83	83	443	11
12	Building improvements - management company	2012	5,985		20	12	12	1,022	12
13	Building improvements - management company	2013	4,522		20	337	337	1,076	13
14	Building improvements - management company	2014	2,447		20	250	250	614	14
15	Building improvements - management company	2015	430		20	54	54	79	15
16	Building improvements - management company	2016	7,102		20	204	204	204	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)		\$ 9,659,776	\$ 43,092		\$ 276,416	\$ 233,324	\$ 4,763,758	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	\$ 934,703	\$ 84,294	\$ 100,092	\$ 15,798	5-10	\$ 837,572	71
72	Current Year Purchases	6,637	604	604	-	5-7	604	72
73	Fully Depreciated Assets	864,064			-	5-7	864,064	73
74	Allocated from Mgmt. Co.	577,372		89,423	89,423	5-7	476,403	74
75	TOTALS	\$ 2,382,776	\$ 84,898	\$ 190,119	\$ 105,221		\$ 2,178,644	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.			52,049	-	2,662	2,662	5	46,218	79
80	TOTALS			\$ 52,049	\$ -	\$ 2,662	\$ 2,662		\$ 46,218	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,609,718	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 127,990	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 469,197	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 341,207	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,988,620	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number	Lexington of Lake Zurich
--------------------------------------	---------------------------------

0039768

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				4,920			6
7	TOTAL				\$ 4,920			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: \$ 81,598 Description: Copier-\$7,609, Mail Sys-\$243,Printer-\$4,409; Med Equip.-\$28,540, Oxy Equip.-\$39,367, Mgmt. Co.-\$1,431
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	\$	7,062	\$ 375,756	\$	7,062	\$ 375,756	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,039	85,245		3,039	85,245	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2)(3)	hrs		20,246	780,455	4,516	20,246	784,971	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				493,066		493,066	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39(3)				17,304			17,304	12
13	Other (specify): <u>See Sch. 16A</u>	39(2)					27,185		27,185	13
14	TOTAL			\$	30,347	\$ 1,258,760	\$ 524,767	30,347	\$ 1,783,527	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 of Lake Zurich
IDPH License ID Number: 0039768
Fiscal Year End: 12/31/2016

Schedule 16A

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

Description	Units	Amount
Oxygen		10,211
DME		16,974
Total - Line 13		27,185

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	\$ 1,488,851	\$ 1,629,142	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 751,579)	1,736,656	1,736,656	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	165,355	165,355	6
7	Other Prepaid Expenses	14,247	14,247	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	17,582	17,582	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,422,691	\$ 3,562,982	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,906	8,906	12
13	Land		515,117	13
14	Buildings, at Historical Cost		6,418,908	14
15	Leasehold Improvements, at Historical Cost	1,016,755	3,240,868	15
16	Equipment, at Historical Cost	776,577	2,434,825	16
17	Accumulated Depreciation (book methods)	(1,174,860)	(6,988,620)	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		22,052	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 627,378	\$ 5,652,056	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,050,069	\$ 9,215,038	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 487,749	\$ 487,749	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,478,420	2,478,420	29
30	Accrued Salaries Payable	612,512	612,512	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,740	28,740	31
32	Accrued Real Estate Taxes(Sch.IX-B)		177,000	32
33	Accrued Interest Payable		35,186	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	9,247,351	2,361,797	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 12,854,772	\$ 6,181,404	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,023,176	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)	\$	\$ 6,023,176	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,854,772	\$ 12,204,580	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,804,703)	\$ (2,989,542)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,050,069	\$ 9,215,038	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,397,880)	1
2	Restatements (describe):		2
3	Post closing adjustment	359,768	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,038,112)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,766,591)	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)	\$ (1,766,591)	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)	\$ (8,804,703)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Lake Zurich

0039768

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	\$ 20,984,785	1
2	Discounts and Allowances for all Levels	(11,685,229)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,299,556	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,522,183	6
7	Oxygen	36,242	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,558,425	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	1,353	12
13	Barber and Beauty Care	28,404	13
14	Non-Patient Meals	1,430	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	810,506	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	189,734	19
20	Radiology and X-Ray	24,124	20
21	Other Medical Services	422,878	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,478,429	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,677	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,677	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)	\$ 15,338,087	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,844,610	31
32	Health Care	6,611,791	32
33	General Administration	4,227,538	33
	B. Capital Expense		
34	Ownership	1,843,426	34
	C. Ancillary Expense		
35	Special Cost Centers	2,154,334	35
36	Provider Participation Fee	422,979	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,104,678	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,766,591)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,766,591)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,987,414	44
45	Private Pay - Net Inpatient Revenue	1,652,051	45
46	Medicare - Net Inpatient Revenue	681,763	46
47	Other-(specify) <u>Managed Care</u>	978,328	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,299,556	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 not 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	1,696	2,162	\$ 140,197	\$ 64.84	1
2	Assistant Director of Nursing	1,750	2,102	103,585	49.29	2
3	Registered Nurses	44,072	54,166	1,914,181	35.34	3
4	Licensed Practical Nurses	17,897	22,541	655,842	29.10	4
5	CNAs & Orderlies	114,745	137,656	2,081,314	15.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,099	2,332	31,316	13.43	9
10	Activity Assistants	11,359	12,991	133,695	10.29	10
11	Social Service Workers	8,253	9,080	178,286	19.63	11
12	Dietician	2,776	3,169	66,479	20.98	12
13	Food Service Supervisor	1,812	2,108	43,069	20.43	13
14	Head Cook	1,768	2,049	36,292	17.71	14
15	Cook Helpers/Assistants	21,368	24,626	275,798	11.20	15
16	Dishwashers					16
17	Maintenance Workers	1,768	2,170	43,115	19.87	17
18	Housekeepers	37,353	41,843	436,843	10.44	18
19	Laundry					19
20	Administrator	1,811	2,310	130,292	56.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,163	10,227	166,789	16.31	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	1,960	2,481	48,084	19.38	31
32	Other Health Care See Sch 20A	22,314	27,780	725,970	26.13	32
33	Other(specify) Marketing	2,022	2,546	69,157	27.16	33
34	TOTAL (lines 1 - 33)	304,987	364,339	\$ 7,280,303 *	\$ 19.98	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	52,750	9(3)	36
37	Medical Records Consultant	Monthly	423	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,444	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	Monthly	35,040	10(3)	47
48	See Sch 20B	Monthly	12,106	10(3)	48
49	TOTAL (lines 35 - 48)		\$ 125,293		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				51
52	Certified Nurse Assistants/Aides	1,375	31,799	10(3)	52
53	TOTAL (lines 50 - 52)	1,375	\$ 31,799		53

Facility Name: Lexington of Lake Zurich
IDPH License ID Number: 0039768
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	1,590	1,859	31,957	\$ 17.19
Unit Secretary	3,497	4,677	84,355	\$ 18.03
Accounts Coordinator	1,859	2,191	31,214	\$ 14.25
Admissions	4,455	5,675	130,068	\$ 22.92
MDS	5,256	6,410	203,593	\$ 31.76
Clinical Coordinator	1,736	2,102	71,515	\$ 34.03
Dietetic Technician	275	307	4,873	\$ 15.87
Transitional Care Nurse	1,721	2,162	75,707	\$ 35.02
Wound Care Coordinator	1,927	2,397	92,687	\$ 38.67
Total - Line 32 Other Health Care (specify):	22,314	27,780	725,970	\$ 26.13

Facility Name: Lexington Health Care Center of Lake Zurich, Inc.
IDPH License ID Number: 0039768
Fiscal Year End: 12/31/2016

Schedule 20B

XVIII. Staffing and Salary Costs
B. Consultant Services
Line 48

Description	# of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Sch V Line & Column Reference
Post Acute Consultant	Monthly	2,956	10(3)
Telemedicine Consultant	Monthly	9,150	10(3)
Total - Line 48		12,106	

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			
Pauline Constantino	Administrator	0	\$ 130,292	Workers' Compensation Insurance	\$ 246,271	IDPH License Fee	\$ 1,990			
				Unemployment Compensation Insurance	70,757	Advertising: Employee Recruitment	3,980			
				FICA Taxes	543,927	Health Care Worker Background Check				
				Employee Health Insurance	367,848	(Indicate # of checks performed 483)	5,800			
				Employee Meals		Patient Background Checks 365	4,376			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	4,512			
				401K	41,707	Miscellaneous Dues & Subscriptions	14,836			
				Other Employee Benefits	33,436	Less: Non-Allowable Dues	(2,909)			
				Uniform Allowance	(1,061)	Allocated from Mgmt Co.	12,630			
				Tuition	10,271	IHCA	7,364			
						Less: Public Relations Expense	()			
						Non-allowable advertising	()			
						Yellow page advertising	()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 130,292	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 52,579		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
Management Fees-Royal Operating			\$ 1,329,060	N/A		\$	Out-of-State Travel	\$		
Management Fees-Vesta Mgmt.			460,226							
Eliminated in column 7							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)			Seminar Expense			
C. Professional Services							Allocated from Mgmt Co.			
Vendor/Payee	Type		Amount							
Cash Receipts	Collections		\$ 510							
Cassiday Schade, LLP	Legal		86,653							
Generation Law	Legal		4,351							
Grabowski Law Center	Collections		1,270							
Much Shelist	Collections		4,869							
RSM US LLP	Accounting		41,520							
Much Shelist	Legal		4,093							
Duane Morris	Legal		1,204							
Personal Planners	U/C Consulting		1,230							
Pension Administration Inc.	401K Administration		590							
Secretary of State	Filing Fees		100							
See Schedule 21C	See Schedule 21C		142,603							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 288,993	TOTAL			Entertainment Expense ()		
								(agree to Sch. V, line 24, col. 8)		
								TOTAL 1,123		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Lexington of Lake Zurich
IDPH License ID Number: 0039768
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Attadale	Operations Consulting	9,990
Voya	Financial	6
Jefferies	Tax Consulting	1,783
American Chartered Bank	Financial	39,710
SB2, Inc.	Medicaid Consulting	2,484
Ability Network	Computer Services	5,980
Avality	Computer Services	252
Avatier	Computer Services	159
Cinetec	Computer Services	851
Citrix	Computer Services	702
Corepoint	Computer Services	1,472
Docusign	Computer Services	462
E-Health Data Solutions	Computer Services	863
Healthmedx	Computer Services	15,650
Infor	Computer Services	6,556
Information Controls	Computer Services	2,230
MHC Software	Computer Services	836
Microsoft	Computer Services	774
National Datacare	Computer Services	2,855
NTT Data	Computer Services	6,659
OnShift	Computer Services	9,678
Provinet	Computer Services	112
Relias Learning	Computer Services	8,783
Salesforce	Computer Services	6,495
Softchoice Corporation	Computer Services	4,296
Symbria	Computer Services	2,200
Tableu Software	Computer Services	411
North Heron Insurance	Insurance Settlement	8,002
Scott & Kraus	Legal	108
Accruals	Various	2,244
	Subtotal	142,603
Total (agree to Schedule V, line 19, column 3)		288,993
Less:		
Insurance Settlement Reclaim		(8,002)
Salesforce.com		(6,495)
Non-Allowable Legal		(7,892)
Non-Allowable Tax Consulting Fees		(1,783)
		(24,172)
Allocated from Real Estate		
Secretary of State		350
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)		303,026

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>IHCA - \$7,364</u>
(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?	<u>Yes</u> <u>Yes</u>
(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?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>5 Years</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>48,023</u> Line <u>10(2)</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	<u>N/A</u>
(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.	\$ <u>422,979</u>
(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.	<u>No</u>
(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?	<u>Yes</u>
(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.	<u>No</u>
(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?	\$ <u>N/A</u> <u>Yes</u> Indicate the amount. \$ <u>1,430</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. 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. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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.	<u>No</u> <u>No</u> \$ <u>N/A</u> <u>0</u> <u>Adequate records have been maintained</u> <u>N/A</u> <u>N/A</u> <u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(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	<u>Yes</u>