

		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>0036095</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Lexington of Schaumburg</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>675 South Roselle Rd</u> <u>Schaumburg</u> <u>60193</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(847) 351-5500</u> Fax # <u>(847) 352-8592</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) _____																																						
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	(Title) _____																																																
	(Signed) _____																																																
	(Date) _____																																																
Date of Initial License for Current Owners: <u>3/3/90</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td>IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other</td><td></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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		☐	Trust		_____																																												
		☐	Other		_____																																												
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																															
Name: <u>Amanda Springborn</u>																																																	
Telephone Number: <u>(314) 925-3838</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Lexington of Schaumburg # 0036095 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	411,108	35,319	2,827	449,254		449,254		449,254			1
2	Food Purchase		377,098		377,098		377,098	(824)	376,274			2
3	Housekeeping	444,385	38,555		482,940		482,940	353	483,293			3
4	Laundry		22,444		22,444		22,444		22,444			4
5	Heat and Other Utilities			245,406	245,406		245,406	8,637	254,043			5
6	Maintenance	37,347		214,668	252,015		252,015	74,649	326,664			6
7	Other (specify):* Mgmt Co. - Allocated							11,301	11,301			7
8	TOTAL General Services	892,840	473,416	462,901	1,829,157		1,829,157	94,116	1,923,273			8
	B. Health Care and Programs											
9	Medical Director			38,750	38,750		38,750		38,750			9
10	Nursing and Medical Records	5,517,921	426,877	74,713	6,019,511		6,019,511	39,223	6,058,734			10
10a	Therapy											10a
11	Activities	176,735	25,966	13,755	216,456		216,456		216,456			11
12	Social Services	167,134		3,292	170,426		170,426		170,426			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co. - Allocated							5,117	5,117			15
16	TOTAL Health Care and Programs	5,861,790	452,843	130,510	6,445,143		6,445,143	44,340	6,489,483			16
	C. General Administration											
17	Administrative	128,794		1,798,227	1,927,021		1,927,021	(1,737,775)	189,246			17
18	Directors Fees											18
19	Professional Services			281,565	281,565		281,565	22,449	304,014			19
20	Dues, Fees, Subscriptions & Promotions			54,997	54,997		54,997	14,155	69,152			20
21	Clerical & General Office Expenses	183,644	25,172	45,394	254,210		254,210	772,391	1,026,601			21
22	Employee Benefits & Payroll Taxes			1,261,872	1,261,872		1,261,872		1,261,872			22
23	Inservice Training & Education			13,532	13,532		13,532	392	13,924			23
24	Travel and Seminar							1,184	1,184			24
25	Other Admin. Staff Transportation			2,718	2,718		2,718	12,905	15,623			25
26	Insurance-Prop.Liab.Malpractice			401,627	401,627		401,627	4,999	406,626			26
27	Other (specify):* Mgmt Co. - Allocated							113,348	113,348			27
28	TOTAL General Administration	312,438	25,172	3,859,932	4,197,542		4,197,542	(795,952)	3,401,590			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,067,068	951,431	4,453,343	12,471,842		12,471,842	(657,496)	11,814,346			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			145,841	145,841		145,841	371,241	517,082			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,321	50,321		50,321	389,445	439,766			32
33	Real Estate Taxes							625,628	625,628			33
34	Rent-Facility & Grounds			2,010,570	2,010,570		2,010,570	(2,005,383)	5,187			34
35	Rent-Equipment & Vehicles			104,719	104,719		104,719	2,460	107,179			35
36	Other (specify):*											36
37	TOTAL Ownership			2,311,451	2,311,451		2,311,451	(616,609)	1,694,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		568,507	1,424,576	1,993,083		1,993,083		1,993,083			39
40	Barber and Beauty Shops			18,650	18,650		18,650		18,650			40
41	Coffee and Gift Shops			4,520	4,520		4,520		4,520			41
42	Provider Participation Fee			426,870	426,870		426,870		426,870			42
43	Other (specify):* Non-Allowable Cos	86,998		336,891	423,889		423,889	(423,889)				43
44	TOTAL Special Cost Centers	86,998	568,507	2,211,507	2,867,012		2,867,012	(423,889)	2,443,123			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,154,066	1,519,938	8,976,301	17,650,305		17,650,305	(1,697,994)	15,952,311			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	(824)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,701)	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	2,998	30		9
10	Interest and Other Investment Income	(29,002)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,574)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,113)	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	(256,322)	43		24
25	Fund Raising, Advertising and Promotional	(21,745)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(480)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		43		28
29	Other-Attach Schedule See Page 5A	107,976	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (223,817)		\$	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)	(1,474,177)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,474,177)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,697,994)		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	\$ (15,317)	43	1
2	X-Rays-Part A	(13,628)	43	2
3	Diagnostics Managed Care	(2,981)	43	3
4	Trust Fees	(85)	43	4
5	Marketing Software	(6,498)	19	5
6	Collections & Out of Period Legal	(7,222)	19	6
7	Marketing Salary	(86,998)	43	7
8	Unrealized loss on FMV swap	259,585	43	8
9	Non-Allowable Tax Consulting	(1,562)	19	9
10	Capitalize R/M over 2500\$	(13,250)	6	10
11	Lobbying Dues	(2,226)	20	11
12	Non-Allowable Finance Charge	(1,842)	32	12
13				13
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	107,976		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	\$	Sambell of Schaumburg Limited Partnership	**	\$ 200	\$ 200	1
2	V	30	Depreciation		Sambell of Schaumburg Limited Partnership	**	260,331	260,331	2
3	V	32	Amortization of mortgage costs		Sambell of Schaumburg Limited Partnership	**	2,717	2,717	3
4	V	32	Interest expense		Sambell of Schaumburg Limited Partnership	**	397,950	397,950	4
5	V	33	Property taxes		Sambell of Schaumburg Limited Partnership	**	618,570	618,570	5
6	V	34	Rental expense	2,010,570	Sambell of Schaumburg Limited Partnership	**		(2,010,570)	6
7	V	43	Trust fees		Sambell of Schaumburg Limited Partnership	**	85	85	7
8	V	43	Unrealized gain FMV swap	259,585	Sambell of Schaumburg Limited Partnership	**		(259,585)	8
9	V								9
10	V		** The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Sambell of Schaumburg Ltd. Ptsp.						10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,270,155			\$ 1,279,853	\$ * (990,302)	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.	**	\$ 353	\$ 353	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,786	7,786	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	328	328	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	523	523	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	80,159	80,159	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	7,405	7,405	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	335	335	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	11,301	11,301	22
23	V	10 Medical consultant		Royal Management Corp.	**	2,925	2,925	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	36,298	36,298	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	5,117	5,117	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	60,452	60,452	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	16,183	16,183	27
28	V	19 Professional fees		Royal Management Corp.	**	23,723	23,723	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	2,410	2,410	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	13,971	13,971	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	743,570	743,570	31
32	V	21 Bank charges		Royal Management Corp.	**	2,976	2,976	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,055	10,055	33
34	V	21 Postage		Royal Management Corp.	**	3,742	3,742	34
35	V	21 Telephone		Royal Management Corp.	**	11,476	11,476	35
36	V							36
37	V	** The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Royal Management Corp.						37
38	V							38
39	Total		\$			\$ 1,041,088	\$ * 1,041,088	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.	**	\$ 392	\$ 392	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,184	1,184	16
17	V	25	Auto expense		Royal Management Corp.	**	12,905	12,905	17
18	V	26	Insurance general		Royal Management Corp.	**	3,196	3,196	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	113,348	113,348	19
20	V	30	Depreciation		Royal Management Corp.	**	107,912	107,912	20
21	V	32	Interest		Royal Management Corp.	**	17,193	17,193	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,429	2,429	22
23	V	33	Property taxes		Royal Management Corp.	**	7,058	7,058	23
24	V	34	Rent expense		Royal Management Corp.	**	5,187	5,187	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,509	1,509	25
26	V	17	Management fees	1,798,227	Royal Management Corp.	**		(1,798,227)	26
27	V	35	Auto Lease		Royal Management Corp.	**	951	951	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		** The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Royal Management Corp.						37
38	V								38
39	Total			\$ 1,798,227			\$ 273,264	\$ * (1,524,963)	39

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

Facility Name & ID Number

Lexington of Schaumburg

0036095

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 Bloomingdale, Inc.	Bloomingdale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Lexington Square	Lombard	Independent	3
4			Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Life Care of		and Assisted	4
5			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Lombard, LLC		Living Facility	5
6			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Life Care of		Living Facility	7
8			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	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	Schaumburg	Real Estate	11
12					Schaumburg		Property	12
13					Ltd. Ptsp.			13
14					Royal Management	Lombard	Mgmt. Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance	16
17					Services, LLC		Company	17
18					Heron Point	Lombard	Mgmt. Company	18
19					Management Corp.			19
20					Samvest of	Lombard	Lessor	20
21					Lombard II, LLC			21
22					North Heron	Lombard	Finance Company	22
23					Investments, LLC			23
24					Lexington Home	Lombard	Home Health	24
25					Health Care, Inc.			25
26					Lexington Hospice	Lombard	Hospice	26
27					Services, LLC			27
28					Lexington Private	Lombard	Healthcare	28
29					Home Care			29
30					Merit Sleep Mgmt, LL	Lombard	Mgmt. Company	30

Facility Name & ID Number

Lexington of Schaumburg

0036095

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Sambell of	Bloomingtondale	Real Estate	1
2					Bloomingtondale Ltd. Pts		Property	2
3					Sambell of Chicago	Chicago Ridge	Real Estate	3
4					Ridge Ltd. Ptsp.		Property	4
5					Sambell of	Elmhurst	Real Estate	5
6					Elmhurst II Ltd. Ptsp.		Property	6
7					Sambell of	LaGrange	Real Estate	7
8					LaGrange Ltd. Ptsp.		Property	8
9					Lexington Health	Lake Zurich	Real Estate	9
10					Care Systems of		Property	10
11					Lake Zurich Ltd. Ptsp		Real Estate	11
12					Lexington Health	Lombard	Property	12
13					Care Systems of			13
14					Lombard Ltd. Ptsp.			14
15					Lexington Health	Orland Park	Real Estate	15
16					Care Systems of		Property	16
17					Orland Park Ltd. Ptsp			17
18					Sambell of	Streamwood	Real Estate	18
19					Streamwood Ltd. Ptsp		Property	19
20					Lexington Health	Wheeling	Real Estate	20
21					Care Systems of		Property	21
22					Samvest of	Algonquin	Real Estate	22
23					Algonquin Ltd. Ptsp.		Property	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/Officer	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 10,080	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,012	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,350	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	14,004	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	20,005	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,452		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 Schaumburg# 0036095

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	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	3	Housekeeping supplies	Bed Days Available	724,314	10	\$ 3,263	\$ 78,324	\$ 353	1
2	5	Utilities - gas & electric	Bed Days Available	724,314	10	72,000	78,324	7,786	2
3	5	Utilities - water & sewer	Bed Days Available	724,314	10	3,036	78,324	328	3
4	5	Utilities - maintenance office	Bed Days Available	724,314	10	4,835	78,324	523	4
5	6	Management allocation - salaries	Bed Days Available	724,314	10	741,281	741,281	80,159	5
6	6	Repairs & maintenance	Bed Days Available	724,314	10	68,481	78,324	7,405	6
7	6	Scavenger & exterminating	Bed Days Available	724,314	10	3,101	78,324	335	7
8	7	Management allocation - employee	Bed Days Available	724,314	10	104,504	78,324	11,301	8
9	10	Medical consultant	Bed Days Available	724,314	10	27,047	78,324	2,925	9
10	10	Management allocation - salaries	Bed Days Available	724,314	10	335,674	335,674	36,298	10
11	15	Management allocation - employee	Bed Days Available	724,314	10	47,322	78,324	5,117	11
12	17	Management allocation - salaries	Bed Days Available	724,314	10	559,036	559,036	60,452	12
13	19	Computer consultant & supplies	Bed Days Available	724,314	10	149,651	78,324	16,183	13
14	19	Professional fees	Bed Days Available	724,314	10	219,386	78,324	23,723	14
15	20	Dues & subscriptions	Bed Days Available	724,314	10	22,289	78,324	2,410	15
16	20	Advertising - help wanted	Bed Days Available	724,314	10	129,203	78,324	13,971	16
17	21	Management allocation - salaries	Bed Days Available	724,314	10	6,876,284	6,876,284	743,570	17
18	21	Bank charges	Bed Days Available	724,314	10	27,523	78,324	2,976	18
19	21	Office supplies & printing	Bed Days Available	724,314	10	92,982	78,324	10,055	19
20	21	Postage	Bed Days Available	724,314	10	34,606	78,324	3,742	20
21	21	Telephone	Bed Days Available	724,314	10	106,126	78,324	11,476	21
22									22
23									23
24									24
25	TOTALS					\$ 9,627,630	\$ 8,512,275	\$ 1,041,088	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 LLC	X		Mortgage	Varies	5/22/08	7,982,000	6,339,433	01/01/2033	Variable	397,950	2
3												3
4				Finance Charge - Insurance Policy							1,842	4
5												5
	Working Capital											
6	Bank of America		X	Working Capital	Varies	9/30/13	13,700,000	780,000	4/30/2017	Prime/Libor	21,228	6
7	Shareholder	X		Working Capital	Varies	5/11/12	452,000	452,000	Demand	Variable	27,204	7
8												8
9	TOTAL Facility Related						\$ 22,134,000	\$ 7,571,433			\$ 448,224	9
	B. Non-Facility Related*											
10								Amortization of Loan Cost			2,717	10
11								Interest Income offset			(1,798)	11
12								Nonallowable shareholder interest			(27,204)	12
13								See Sch. 9A			17,827	13
14	TOTAL Non-Facility Related						\$				\$ (8,458)	14
15	TOTALS (line 9+line14)						\$ 22,134,000	\$ 7,571,433			\$ 439,766	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 Schaumburg
IDPH License ID Number: 0036095
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				Microsoft Software Interest								47	10		
11				Non-Allowable Finance Charge								(1,842)	11		
12													12		
13				Allocated from Mgmt. Co.								19,622	13		
14	TOTAL Non-Facility Related				\$0.00		\$	0	\$	0			\$	17,827	14

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	583,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2015		\$	571,449	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(11,751)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	627,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	21,240	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Alloc. Fr. Mgmt Co.		7,058	
TOTAL REFUND \$ <u>17,920</u> For <u>**</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(17,920)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	625,628	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	<u>379,311</u>	8		
	2012	<u>397,653</u>	9		
	2013	<u>580,544</u>	10		
	2014	<u>565,184</u>	11		
	2015	<u>571,449</u>	12		
See attached real estate accrual sheet					
** Real estate tax refunds in line 6 are for tax year 2004 and 2012.					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0036095

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>07-27-201-039-000</u>	<u>Land & Building</u>	\$ <u>571,449.00</u>	\$ <u>571,449.00</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>249,002.30</u>	\$ <u>7,058.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>820,451.30</u></u>	\$ <u><u>578,507.00</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,541

B. General Construction Type: Exterior Concrete Frame Steel Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	230,000	1988	\$ 211,532	1
2	Management Company Allocation			22,198	2
3	TOTALS	230,000		\$ 233,730	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	214		1990	1990	\$ 6,091,126	\$	35	\$ 174,032	\$ 174,032	\$ 4,652,536
5			1995	1995	146,217	4,178	35	4,178		85,644
6										
7										
8										
	Improvement Type**									
9	Building improvements		1991		3,521		10			3,491
10	Building improvements		1992		860	25	35	25		606
11	Land improvements		1992		5,764		20			5,764
12	Land improvements		1992		5,000		20			5,000
13	Fan coil units in offices		1996		5,149	147	35	147		3,015
14	Basement rehab		1997		14,697		10			14,697
15	Brick		1997		1,500	43	35	43		833
16	Dining room rehab		1997		6,422		10			6,422
17	Parking lot repave and restripe		1998		2,777		10			2,777
18	Wiring		1998		3,667		10			3,667
19	Retile 2nd and 3rd floor corridors		1998		10,100		10			10,100
20	Plumbing for HVAC		1998		2,263		5			2,263
21	Lobby-floor tile		1999		7,478		10			7,478
22	Wallpaper-labor		1999		9,705		10			9,705
23	New patio		1999		19,039		15			19,039
24	New pay phone/wiring		1999		2,975		10			2,975
25	Roof repairs		2000		9,625		10			9,625
26	Water heater		2000		6,688		10			6,688
27	Automatic door		2000		1,300		10			1,300
28	Rehab project - paint resident rooms, carpet hallways, and tile		2000		52,760		10			52,760
29	Water heater and storage tanks		2001		12,102		10			12,102
30	Garbage area		2001		4,788		20			4,788
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Schaumburg

0036095

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	Roof	2002	\$ 25,600	\$	10	\$	\$	\$ 25,600	37
38	Facility rehab - paint resident rooms, carpet hallways, and tile	2002	327,253	16,363	20	16,363		251,816	38
39	Elevator electronic curtain	2002	4,500		10			4,500	39
40	Elevator upgrade	2002	5,471		10			5,471	40
41	Painting and decorating	2003	13,477		10			13,477	41
42	Electrical improvements	2003	844	42	20	42		550	42
43	Repave parking lot	2004	28,840	721	40	721		8,952	43
44	Dining room remodel - paint	2004	11,387	569	20	569		7,209	44
45	Landscaping	2005	593	30	20	30		342	45
46	HVAC upgrade	2005	17,734	887	20	887		9,830	46
47	Generator upgrade	2005	19,650	983	20	983		11,795	47
48	Window replacement	2005	3,899	195	20	195		2,210	48
49	Flooring replacement	2005	1,483	74	20	74		839	49
50	Lobby, lounge and reception rehab	2005	27,180	1,359	20	1,359		14,949	50
51	Therapy room rehab	2005	35,135	1,757	20	1,757		19,618	51
52	Create first floor therapy room	2005	32,045	1,602	20	1,602		18,958	52
53	Create transitional care unit	2005	29,170	1,458	20	1,458		16,161	53
54	Basement renovation	2005	5,996	300	20	300		3,300	54
55	Countertops	2005	845		5			845	55
56	Interior signs	2005	4,412		5			4,412	56
57	Window treatments	2005	912		5			912	57
58	Wall covering	2005	439		5			439	58
59	Panel Brick Replacement	2006	17,387	869	20	869		8,835	59
60	Landscaping Enhancement	2006	7,608	507	15	507		5,197	60
61	HVAC	2006	12,232	612	20	612		6,171	61
62	Sink	2006	2,331	117	20	117		1,247	62
63	TCU Units	2006	16,379	819	20	819		8,395	63
64	Employee lunch room rehab	2006	8,127	406	20	406		4,264	64
65	Dining room rehab	2006	2,357	118	20	118		1,239	65
66	Basement renovation	2006	9,465	473	20	473		4,888	66
67	Oxygen room rehab	2006	2,664	133	20	133		1,375	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,100,938	\$ 34,787		\$ 208,819	\$ 174,032	\$ 5,387,071	70

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

Facility Name & ID Number Lexington of Schaumburg

0036095

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		\$ 7,100,938	\$ 34,787		\$ 208,819	\$ 174,032	\$ 5,387,071	1
2	Replace Sidewalk	2007	14,625	731	20	731		6,884	2
3	Landscaping	2007	15,700	785	20	785		7,261	3
4	Emergency A/C	2007	15,545	777	20	777		7,446	4
5	1st Floor Remodel - Carpentry, Flooring, Plumbing, Paint	2007	676,072		40	16,902	16,902	157,752	5
6	Bathroom Faucets	2007	12,358	618	20	618		5,613	6
7	Landscaping	2008	10,000	667	15	667		5,780	7
8	Roofing	2008	11,950	598	20	598		4,983	8
9	HVAC-Air tank	2008	2,671	67	40	67		564	9
10	HVAC-Spot Cooler	2008	3,790	95	40	95		760	10
11	Electrical-Fire panel upgrade	2008	71,077	1,777	40	1,777		15,401	11
12	Electrical-Replace Gasket	2008	6,125	613	10	613		5,210	12
13	2nd floor remodel-carpentry, painting, plumbing,electrical	2008	558,949	-	27	20,325	20,325	165,988	13
14	Panel Brick Replacement	2009	184,595	9,230	20	9,230		64,610	14
15	Land Improvements	2009	12,400	620	20	620		4,650	15
16	Parking Lot	2009	4,600	230	20	230		1,725	16
17	Front Entrance Improvements	2009	28,660	717	40	717		5,258	17
18	HVAC Quick Connectors	2009	5,591	140	40	140		1,038	18
19	HVAC Spot Cooler	2009	4,254	106	40	106		786	19
20	1st floor Admin-Tile,electical	2009	11,679	292	40	292		2,044	20
21	Kitchen Plumbing	2009	8,210	821	10	821		6,158	21
22	Fire Alarm Electrical	2009	31,710	793	40	793		5,815	22
23	Glass & Mirror Med Room	2009	2,836	284	10	284		2,201	23
24	2nd Floor Remodel -Carpentry	2009	14,592	730	20	730		5,728	24
25	Patio Pergola	2009	9,505	475	20	475		3,444	25
26	Patio Fence	2009	5,100	255	20	255		1,806	26
27	Landscaping	2009	17,332	1,155	15	1,155		8,663	27
28	3rd Floor Remodel-Carpentry, flooring,electrical,painting	2009	627,866		27	22,832	22,832	165,532	28
29	Landscaping Enhancement	2010	14,885	992	15	992		6,614	29
30	Physician Office carpentry	2010	4,849	177	27	177		1,077	30
31	Kitchen Pantries construction	2010	5,676	207	27	207		1,242	31
32	HVAC Admin Office	2010	7,357	268	27	268		1,642	32
33	Loading Ramp/Foundation Wall	2010	3,000	200	15	200		1,383	33
34	TOTAL (lines 1 thru 33)		\$ 9,504,497	\$ 59,207		\$ 293,298	\$ 234,091	\$ 6,062,129	34

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

Facility Name & ID Number Lexington of Schaumburg

0036095

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,504,497	\$ 59,207		\$ 293,298	\$ 234,091	\$ 6,062,129	1
2	Hallway doors	2010	14,916	1,492	10	1,492		9,076	2
3	Library/Lounge carpentry,electrical,painting,signs	2010	5,009	183	27	183		1,098	3
4	Basement carpentry	2010	3,945	144	27	144		984	4
5	Patio/Pergola	2010	12,005	1,201	10	1,201		7,406	5
6	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	50,935	2,091	27	2,091		22,052	6
7									7
8	Fire Dampers	2011	65,681		27	2,388	2,388	12,141	8
9	Parking Lot Remodel	2011	169,749		27	6,173	6,173	30,865	9
10	Kitchen Hood/duct work	2011	22,604	822	27	822		4,315	10
11	Payroll Office Remodel - Electrical and Wiring	2011	2,696	98	27	98		547	11
12	Metal edging & drain tile	2011	5,442	363	27	363		1,845	12
13	Repair doors on 1st floor	2011	39,986	1,454	27	1,454		7,270	13
14	Office Remodel - carpentry,flooring,electrical,painting,signs	2011	22,584	821	27	821		4,173	14
15	Exhaust Study HVAC	2011	5,736	209	27	209		1,201	15
16	Pipe and fitting	2011	4,375	159	27	159		835	16
17	Laundry Room Remodel - Flooring, Ceiling Tiles and Painting	2011	9,388	341	27	341		1,847	17
18	New Marker Boards	2011	9,887	360	27	360		2,130	18
19	Interior Doors	2011	6,183	225	27	225		1,181	19
20	2nd Floor Doors	2011	27,318	993	27	993		5,296	20
21									21
22	End Air Louvers	2012	3,744		27	136	136	646	22
23	Parking Lot	2012	11,735		27	427	427	2,027	23
24	Kitchen steel hood, floor, sink, drywall and tile	2012	7,307	266	27	266		1,257	24
25	Fire Pump basement	2012	3,461	126	27	126		598	25
26	Replace holding tank	2012	21,985	799	27	799		3,729	26
27	1st floor door opener	2012	8,646	314	27	314		1,387	27
28									28
29	EMR Wiring - Entire Facility	2013	20,058	729	27	729		2,309	29
30	Landscaping - Stump Removal/Trees	2013	42,118		15	2,808	2,808	8,954	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,101,989	\$ 72,397		\$ 318,420	\$ 246,023	\$ 6,197,298	34

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

Facility Name & ID Number Lexington of Schaumburg

0036095

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		\$ 10,101,989	\$ 72,397		\$ 318,420	\$ 246,023	\$ 6,197,298	1
2									2
3	Elevator Renovation - Centrally located	2014	183,936	6,689	27	6,689		14,492	3
4	R/M Reclass: Adding Double Egress Doors (Basement)	2014	3,279		27	121	121	303	4
5	R/M Reclass: Install container fence & garbage container	2014	5,674		15	378	378	945	5
6	R/M Reclass: Cast iron waste line for grease trap (kitchen)	2014	8,000		27	296	296	740	6
7	R/M Reclass: Patching and crack sealing (parking lot)	2014	9,700		20	485	485	1,213	7
8	Kitchen Sewer Line Addition	2014	7,075	193	27	193		579	8
9									9
10	EMR Wiring - Entire Facility	2015	5,896	214	6	214		339	10
11	R/M Reclass: Decorating & Tile for Service Ramp	2015	3,503		20	175	175	263	11
12	R/M Reclass: Striping & Sealing Parking Lot	2015	5,400		20	270	270	405	12
13	R/M Reclass: Landscaping to the Entire property	2015	13,693		15	913	913	1,369	13
14									14
15	Electrical Wiring - Entire Facility	2016	4,474	224	10	224		224	15
16	Chair Rail Installation in First Floor Rooms	2016	11,517	105	28	105		105	16
17	R/M Reclass: Underground sanitary pipe replacement in the lower level entrance to ramp area and back elevator hallway	2016	10,500		15	350	350	350	17
18									18
19	R/M: Rusted end dome caps repair (cutting, grinding, welding) in the mechanical room	2016	2,750		15	92	92	92	19
20									20
21									21
22	Reconcile to book			15			(15)		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)		\$ 10,377,386	\$ 79,837		\$ 328,925	\$ 249,088	\$ 6,218,717	34

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

Facility Name & ID Number Lexington of Schaumburg

0036095

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 12D, Carried Forward		\$ 10,377,386	\$ 79,837		\$ 328,925	\$ 249,088	\$ 6,218,717	1
2									2
3	Building - management company	2002	307,173		40	8,914	8,914	136,294	3
4	HVAC, electrical, security system - management company	2003	2,698		30	633	633	2,143	4
5	Key card system - management company	2004	424		20	21	21	263	5
6	VAV TX controls - management company	2005	129		20	6	6	76	6
7	Interior Signs - management company	2006	94		20	6	6	64	7
8	Building improvements - management company	2008	14,885		20	162	162	6,505	8
9	Building improvements - management company	2009	2,779		20	50	50	1,128	9
10	Building improvements - management company	2010	2,708		20	49	49	1,041	10
11	Building improvements - management company	2011	1,911		20	87	87	489	11
12	Building improvements - management company	2012	6,604		20	12	12	1,129	12
13	Building improvements - management company	2013	4,990		20	355	355	1,187	13
14	Building improvements - management company	2014	2,701		20	263	263	678	14
15	Building improvements - management company	2015	475		20	57	57	87	15
16	Building improvements - management company	2016	7,836		20	220	220	220	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)		\$ 10,732,793	\$ 79,837		\$ 339,760	\$ 259,923	\$ 6,370,021	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	\$ 958,763	\$ 62,400	\$ 76,642	\$ 14,242	5-20	\$ 876,943	71
72	Current Year Purchases	33,418	3,604	3,604	-	5-7	3,604	72
73	Fully Depreciated Assets	744,308			-	5-7	744,308	73
74	Allocated from Mgmt. Co.	637,099		94,269	94,269	5-7	525,692	74
75	TOTALS	\$ 2,373,588	\$ 66,004	\$ 174,515	\$ 108,511		\$ 2,150,547	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		2,807	2,807	5	50,999	79
80	TOTALS			\$ 57,433	\$ -	\$ 2,807	\$ 2,807		\$ 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)	\$ 13,397,545	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 145,841	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 517,082	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 371,241	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,571,567	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				5,187			6
7	TOTAL				\$ 5,187			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: \$ 106,228
- Description: See Sch 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Mgmt. Co.			951	20
21	TOTAL		\$	\$ 951	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.

Facility Name:

Lexington of Schaumburg

IDPH License ID Number:

0036095

Fiscal Year End:

12/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	7,157
Mailing System	323
Printer	3,248
Medical Equip	51,695
Oxygen	42,296
Management Co.	1,509
Total - Line 16	106,228

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.

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	

(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	\$	7,538	\$ 423,142	\$	7,538	\$ 423,142	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,409	133,459		2,409	133,459	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		23,903	862,644	6,387	23,903	869,031	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				546,668		546,668	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				5,331			5,331	12
13	Other (specify): See Sch. 16A	39(2)					15,452		15,452	13
14	TOTAL			\$	33,850	\$ 1,424,576	\$ 568,507	33,850	\$ 1,993,083	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 Schaumburg
IDPH License ID Number: 0036095
Fiscal Year End: 12/31/2016

Schedule 16A

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

		Schedule V	
		Line & Column	
Description		Reference	Amount
Oxygen		39(2)	9,335
DME		39(2)	6,117
Total - Line 13			15,452

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	\$ 1,382,017	\$ 1,456,478	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 894,175)	2,691,554	2,691,554	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115,173	115,173	6
7	Other Prepaid Expenses	17,127	17,127	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	28,505	28,505	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,234,376	\$ 4,308,837	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	80,308	80,308	12
13	Land		233,730	13
14	Buildings, at Historical Cost		6,091,126	14
15	Leasehold Improvements, at Historical Cost	2,000,193	4,641,667	15
16	Equipment, at Historical Cost	513,568	2,431,021	16
17	Accumulated Depreciation (book methods)	(1,370,335)	(8,571,567)	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		44,530	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,223,734	\$ 4,950,815	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,458,110	\$ 9,259,652	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 533,096	\$ 533,096	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,232,000	1,232,000	29
30	Accrued Salaries Payable	486,887	486,887	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,298	13,298	31
32	Accrued Real Estate Taxes(Sch.IX-B)		627,000	32
33	Accrued Interest Payable		29,905	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	8,459,445	3,927,717	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,724,726	\$ 6,849,903	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,339,433	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)	\$	\$ 6,339,433	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,724,726	\$ 13,189,336	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,266,616)	\$ (3,929,684)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,458,110	\$ 9,259,652	48

*(See instructions.)

Facility Name: Lexington of Schaumburg
IDPH License ID Number: 0036095
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
00-10140-00	Cash Patient Trust	22,124	22,124
00-12020-00	PA Audit Settlement	275,695	275,695
00-13040-00	Rent Receivable	0	(4,904,197)
00-13250-00	Due to/from Rehab Care Therapy	0	0
00-13700-00	Due from LLC	0	1,671
00-13850-00	Due from Lexington Fin Serv LLC	486	486
00-14530-00	Prepaid Insurance	44,640	44,640
00-21030-00	COBRA	61	61
00-21040-00	Withholding - Dental Insurance	1,702	1,702
00-21050-00	Withholding - EP/CI/WL	3,395	3,395
00-21085-00	Vision Withholding	280	280
00-21100-00	401K Withholding	4,216	4,216
00-22030-00	Accrued Expenses	148,920	148,920
00-22040-00	Accrued Resident Tax	81,553	81,553
00-22060-00	Accrued Royal / Vesta Mgmt Fees	2,349,802	2,349,802
00-22120-00	Accrued Rent	4,904,197	4,904,197
00-22140-00	Accrued Insurance	28,670	28,670
00-22270-00	Due to Patient Trust Fund	(19,289)	(19,289)
00-22330-00	Advance - Biweekly Part A Payment	(109,324)	(109,324)
00-22360-00	Uncollectible Part A Co Pmts	(86,414)	(86,414)
00-23530-00	Due to - Royal Operations	22,041	22,041
00-23720-00	Due to Republic	3,817	3,817
00-23730-00	Due to Bloomingdale	(1,311)	(1,311)
00-23760-00	Due to Lagrange	0	0
00-23780-00	Due to LHCC Lombard	(160)	(160)
00-23830-00	Due to/from Vesta Management	214	214
00-24345-00	Interest Rate Swap Liability	0	370,798
00-24400-00	Professional Liabilities Claim	784,130	784,130
	Total - Line 36	8,459,445	3,927,717
		-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,030,147)	1
2	Restatements (describe):		2
3	Post closing adjustment	143,839	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,886,308)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,380,308)	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)	\$ (1,380,308)	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)	\$ (5,266,616)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Schaumburg

0036095

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	\$ 23,086,965	1
2	Discounts and Allowances for all Levels	(13,303,073)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,783,892	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,787,179	6
7	Oxygen	74,636	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,861,815	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	5,562	12
13	Barber and Beauty Care	19,255	13
14	Non-Patient Meals	824	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	942,504	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	189,539	19
20	Radiology and X-Ray	18,089	20
21	Other Medical Services	446,719	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,622,492	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,798	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,798	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,269,997	30

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	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,829,157	31
32	Health Care	6,445,143	32
33	General Administration	4,197,542	33
	B. Capital Expense		
34	Ownership	2,311,451	34
	C. Ancillary Expense		
35	Special Cost Centers	2,440,142	35
36	Provider Participation Fee	426,870	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,650,305	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,380,308)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,380,308)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,736,382	44
45	Private Pay - Net Inpatient Revenue	1,052,510	45
46	Medicare - Net Inpatient Revenue	1,081,690	46
47	Other-(specify) <u>Managed Care</u>	913,310	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,783,892	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	1,844	2,235	\$ 156,716	\$ 70.13	1
2	Assistant Director of Nursing	1,533	1,813	75,966	41.90	2
3	Registered Nurses	37,366	45,531	1,538,192	33.78	3
4	Licensed Practical Nurses	30,992	37,560	947,069	25.21	4
5	CNAs & Orderlies	120,173	139,879	2,047,581	14.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,886	2,112	44,333	20.99	9
10	Activity Assistants	10,745	11,961	132,402	11.07	10
11	Social Service Workers	7,650	8,429	167,134	19.83	11
12	Dietician	1,819	1,997	59,809	29.95	12
13	Food Service Supervisor	1,472	2,137	35,982	16.83	13
14	Head Cook	1,762	2,052	37,880	18.46	14
15	Cook Helpers/Assistants	24,334	27,297	277,437	10.16	15
16	Dishwashers					16
17	Maintenance Workers	2,081	2,164	37,347	17.25	17
18	Housekeepers	35,972	42,019	444,385	10.58	18
19	Laundry					19
20	Administrator	1,713	1,983	128,794	64.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,647	12,366	183,644	14.85	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	1,646	2,026	34,636	17.09	31
32	Other Health Care See Sch 20A	24,023	28,650	717,762	25.05	32
33	Other(specify) Marketing	1,492	2,101	86,998	41.41	33
34	TOTAL (lines 1 - 33)	319,152	374,314	\$ 7,154,066 *	\$ 19.11	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	38,750	9(3)	36
37	Medical Records Consultant	Monthly	845	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,738	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	3,292	12(3)	45
46	Other(specify) Pulmonary Exchange	Monthly	38,299	10(3)	46
47	Medical Consultant	Monthly	2,925	10(7)	47
48	See Sch 20B	Monthly	11,606	10(3)	48
49	TOTAL (lines 35 - 48)		\$ 116,159		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	290	8,225	10(3)	52
53	TOTAL (lines 50 - 52)	290	\$ 8,225		53

Facility Name: Lexington of Schaumburg
IDPH License ID Number: 0036095
Fiscal Year End: 12/31/2016

Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Accounts Coordinator	1,860	2,129	34,863	\$ 16.38
Admissions	3,603	4,150	95,332	\$ 22.97
Clinical Coordinator	5,540	6,444	224,254	\$ 34.80
Dietetic Technician	1,812	2,119	46,811	\$ 22.09
MDS	686	1,127	36,865	\$ 32.71
Staffing Coordinator	1,873	2,187	34,223	\$ 15.65
Transitional Care Nurse	1,766	2,050	71,378	\$ 34.82
Unit Secretary	3,242	4,117	47,259	\$ 11.48
Wound Care Coordinator	3,641	4,329	126,778	\$ 29.29
Total - Line 32 Other Health Care (specify):	24,023	28,650	717,762	\$ 25.05

Facility Name:Lexington Health Care Center of Schaumburg, Inc.

IDPH License ID Number:0036095

Fiscal Year End:12/31/2016

Schedule 20B

XVIII. Staffing and Salary Costs
Consulting Services

Description	# of Hrs. Actually Worked	Total Consulting cost of reporting period	Sch V Line and Column Reference
Post Acute Consultant	Monthly	2,456	10(3)
Telemedicine Consultant	Monthly	9,150	10(3)
Total - Consulting Services		11,606	

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	
Patricia Stoudt	Administrator	0	\$ 95,882	Workers' Compensation Insurance		\$ 236,187	IDPH License Fee	\$ 1,990	
Theresa Schultz	Administrator	0	32,912	Unemployment Compensation Insurance		46,839	Advertising: Employee Recruitment	23,623	
				FICA Taxes		530,727	Health Care Worker Background Check		
				Employee Health Insurance		382,928	(Indicate # of checks performed 109)	1,312	
				Employee Meals			Patient Background Checks 581	6,974	
				Illinois Municipal Retirement Fund (IMRF)*			Misc. Dues & Subscriptions	4,238	
				401K Contributions		32,237	Misc. License & Fees	11,225	
				Other Employee Benefits		22,882	Non Allowable Dues	(2,226)	
				Uniform Allowance		3,154	IHCA	5,635	
				Tuition		6,918	Management Company Allocation	16,381	
							Less: Public Relations Expense ()		
							Non-allowable advertising ()		
							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 1,261,872	\$ 69,152		
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			\$ 1,308,636	N/A		\$	Out-of-State Travel	\$	
Management Fees-Vesta Mgmt.			489,591						
Management Fees (Eliminated in Column 7)							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,798,227						
C. Professional Services							Seminar Expense		
Vendor/Payee	Type		Amount				Management Company Allocation	1,184	
Amalgamated Bank	Service Fees		\$ 572						
Attadale	Operations Consulting		9,990						
Cassiday Schade LLP	Legal		119,006						
Duane Morris	Legal		971						
Grabowski Law Center, LLC	Collections		172						
Much Shelist- Collections	Collections		5,310						
RSM US LLP	Accounting		47,598						
Much Shelist- Legal	Legal		12,161						
Personnel Planners	U/C Consulting		780						
Pension Administrations	401K Administration		1,480						
SB2, Inc.	Medicaid Consulting		2,484						
See Sch 21C	Various		81,041						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							Entertainment Expense ()		
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 1,184	

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Lexington of Schaumburg
IDPH License ID Number: 0036095
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Serpico Petrosino	Legal	300
Secretary ff State	Filing Fees	195
SNR Denton	Legal	2,508
Jefferies	Tax Consulting	1,562
Voya	Financial	8
Other	Financial	(3)
Standard and Poor	Financial	668
North Heron Insurance	Insurance Settlement	1,803
Infor	Computer Services	6,320
NTT Data	Computer Services	7,791
Ability Network	Computer Services	5,118
Avatier	Computer Services	172
Cinetec	Computer Services	851
Citrix	Computer Services	702
Corepoint	Computer Services	1,531
DocuSign Inc.	Computer Services	462
E-Health Data Solutions	Computer Services	863
Information Controls	Computer Services	(2,242)
MHC Software	Computer Services	833
OnShift	Computer Services	10,442
Relias	Computer Services	9,592
Salesforce.com	Computer Services	6,498
Softchoice Corporation	Computer Services	4,542
Symbria	Computer Services	2,000
Tableau	Computer Services	411
Availity	Computer Services	267
National Datacare	Computer Services	2,458
Provinet	Computer Services	112
Micro Center	Computer Services	157
Microsoft Licensing	Computer Services	(382)
HealthMEDX Software	Computer Services	15,502
		81,041
	Total (agree to Schedule V, line 19, column 3)	281,565
Less:		
Bank Charges reclassified to Clerical & General	(572)	
Insurance Settlement Reclass	(1,803)	
Non-allowable tax consulting	(1,562)	
Salesforce.com	(6,498)	
Out of Period Legal	(1,741)	
Non-allowable Legal	(5,481)	
Total Disallowance	(17,657)	
Allocated from Real Estate		
Secretary of State	200	
Samvest of Lombard		
Accounting	131	
Filing Fees	10	
	141	
Allocated from Mgmt Co.		
RSM US LLP	Accounting	3,589
Marcum LLP	Accounting	429
Gilson Labus & Silverman	Accounting	111
Illinois Secretary of State	Filing Fees	51
LaSalle Network	Recruiting/Finance	2,495
Callan Associates, Ltd.	Recruiting	13,362
Pension Administrators, Inc.	401K Administration	428
Voya Financial	401K Administration	18
Gene Whitehorn	Medicaid Reimb Specialist	1,927
M. Werner Consulting	Financial Consultant	1,025
M. Rodeghier Consulting	Process Improvement Consultant	78
Wordy.com	Proofreading	69
Computer Services	Computer Consulting	16,183
	39,765	
	Total (agree to Schedule V, line 19, column 8)	304,014

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 - \$5,635</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>61,258</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>426,870</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>-</u> <u>Yes</u> Indicate the amount. \$ <u>824</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>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>