



Facility Name & ID Number Lexington Hlth C Ctr Blmngdl

# 0035188 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	166	Skilled (SNF)	166	60,590	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			14,399	14,399	8
9	SNF/PED					9
10	ICF	32,522	4,129		36,651	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,522	4,129	14,399	51,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.25%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 05/01/89

J. Was the facility purchased or leased after January 1, 1978?

YES  Date New Construction NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 166 and days of care provided 8,926

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name &amp; ID Number

Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

**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
	<b>A. General Services</b>										
1	Dietary	387,593	38,315	5,849	431,757		431,757		431,757		1
2	Food Purchase		304,798		304,798		304,798	(14,708)	290,090		2
3	Housekeeping	317,928	38,707		356,635		356,635	217	356,852		3
4	Laundry	53,063	21,175		74,238		74,238		74,238		4
5	Heat and Other Utilities			213,889	213,889		213,889	6,328	220,217		5
6	Maintenance	48,748		219,171	267,919		267,919	37,434	305,353		6
7	Other (specify):* <b>Mgmt. Co. Alloc. Ben</b>							8,333	8,333		7
8	<b>TOTAL General Services</b>	807,332	402,995	438,909	1,649,236		1,649,236	37,604	1,686,840		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,250	36,250		36,250		36,250		9
10	Nursing and Medical Records	4,208,172	324,124	52,834	4,585,130		4,585,130	36,430	4,621,560		10
10a	Therapy										10a
11	Activities	224,653	21,593	4,098	250,344		250,344		250,344		11
12	Social Services	108,905		4,304	113,209		113,209		113,209		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Mgmt. Co. Alloc. Ben</b>							4,597	4,597		15
16	<b>TOTAL Health Care and Programs</b>	4,541,730	345,717	97,486	4,984,933		4,984,933	41,027	5,025,960		16
	<b>C. General Administration</b>										
17	Administrative	147,105		1,434,566	1,581,671		1,581,671	(1,381,492)	200,179		17
18	Directors Fees										18
19	Professional Services			194,334	194,334		194,334	14,418	208,752		19
20	Dues, Fees, Subscriptions & Promotions			39,550	39,550		39,550	3,128	42,678		20
21	Clerical & General Office Expenses	220,530	21,915	39,419	281,864		281,864	540,091	821,955		21
22	Employee Benefits & Payroll Taxes			962,177	962,177		962,177	14,703	976,880		22
23	Inservice Training & Education			9,175	9,175		9,175	507	9,682		23
24	Travel and Seminar			215	215		215	889	1,104		24
25	Other Admin. Staff Transportation			3,004	3,004		3,004	10,603	13,607		25
26	Insurance-Prop.Liab.Malpractice			491,828	491,828		491,828	2,709	494,537		26
27	Other (specify):* <b>Mgmt. Co. Alloc. Ben</b>							82,645	82,645		27
28	<b>TOTAL General Administration</b>	367,635	21,915	3,174,268	3,563,818		3,563,818	(711,799)	2,852,019		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,716,697	770,627	3,710,663	10,197,987		10,197,987	(633,168)	9,564,819		29

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

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

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl

#0035188

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			193,278	193,278		193,278	335,110	528,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,294	18,294		18,294	270,058	288,352			32
33	Real Estate Taxes							158,090	158,090			33
34	Rent-Facility & Grounds			1,236,609	1,236,609		1,236,609	(1,228,752)	7,857			34
35	Rent-Equipment & Vehicles			66,194	66,194		66,194	2,139	68,333			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,514,375	1,514,375		1,514,375	(463,355)	1,051,020			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		395,173	1,523,689	1,918,862		1,918,862		1,918,862			39
40	Barber and Beauty Shops			21,387	21,387		21,387		21,387			40
41	Coffee and Gift Shops			2,969	2,969		2,969	(2,431)	538			41
42	Provider Participation Fee			347,736	347,736		347,736		347,736			42
43	Other (specify):* <b>Non-Allowable Co</b>	76,801		123,850	200,651		200,651	(200,651)				43
44	<b>TOTAL Special Cost Centers</b>	76,801	395,173	2,019,631	2,491,605		2,491,605	(203,082)	2,288,523			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,793,498	1,165,800	7,244,669	14,203,967		14,203,967	(1,299,605)	12,904,362			45

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

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning: 01/01/2015

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**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,635)	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	5,153	30		9
10	Interest and Other Investment Income	(461)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9,701)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,042)	43		24
25	Fund Raising, Advertising and Promotional	(24,923)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,236)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	43,835	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (36,015)		\$	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	2	
		Amount	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)	(1,263,590)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,263,590)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,299,605)		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	2	3	4	
		Yes	No	Amount	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					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Radiology	\$ (21,861)	43	1
2	Laboratory	(17,452)	43	2
3	Disallow Marketing Software	(7,228)	19	3
4	Trust Fees	(50)	43	4
5	Collection Fees	(732)	19	5
6	Nonallowable Marketing Salaries	(76,801)	43	6
7	Out of period & nonallowable legal	(4,347)	19	7
8	Education and training marketing	(215)	24	8
9	Unrealized loss on FMV swap	203,735	43	9
10	Capitalizing R&M to LHI	(26,433)	6	10
11	Disallowed Lobbying	(599)	20	11
12	Dues & Subscriptions Marketing	(25)	20	12
13	Gift Shop Income Offset	(2,431)	41	13
14	Nonallowable Finance Charge	(1,726)	32	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		43,835	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 Bloomingdale Limited Partnership	**	\$ 2,800	\$ 2,800	1
2	V	30 Depreciation Expense		Sambell of Bloomingdale Limited Partnership	**	244,894	244,894	2
3	V	32 Amortization of Mortgage Cost		Sambell of Bloomingdale Limited Partnership	**	2,171	2,171	3
4	V	32 Interest	76,427	Sambell of Bloomingdale Limited Partnership	**	331,450	255,023	4
5	V	33 Property Tax		Sambell of Bloomingdale Limited Partnership	**	152,409	152,409	5
6	V	34 Rent	1,232,409	Sambell of Bloomingdale Limited Partnership	**		(1,232,409)	6
7	V	43 Trust Fees		Sambell of Bloomingdale Limited Partnership	**	50	50	7
8	V	43 Unrealized loss on FMV of Swap	203,735	Sambell of Bloomingdale Limited Partnership	**		(203,735)	8
9	V							9
10	V							10
11	V			** The owners of Lexington Health Care Center of Bloomingdale, Inc.				11
12	V			own 100% of Sambell of Bloomingdale Limited Partnership				12
13	V							13
14	Total		\$ 1,512,571			\$ 733,774	\$ * (778,797)	14

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

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl# 0035188Report Period Beginning: 01/01/2015 Ending: 12/31/2015

## 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.	**	\$ 217	\$	217	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	5,626		5,626	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	233		233	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	469		469	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	57,620		57,620	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	6,005		6,005	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	242		242	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	8,333		8,333	22	
23	V	10 Medical consultant		Royal Management Corp.	**	4,647		4,647	23	
24	V	10 Management allocation - salaries		Royal Management Corp.	**	31,783		31,783	24	
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	4,597		4,597	25	
26	V	17 Management allocation - salaries		Royal Management Corp.	**	53,074		53,074	26	
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	14,566		14,566	27	
28	V	19 Professional fees		Royal Management Corp.	**	9,816		9,816	28	
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,841		1,841	29	
30	V	20 Advertising - help wanted		Royal Management Corp.	**	1,911		1,911	30	
31	V	21 Management allocation - salaries		Royal Management Corp.	**	518,362		518,362	31	
32	V	21 Bank charges		Royal Management Corp.	**	1,853		1,853	32	
33	V	21 Office supplies & printing		Royal Management Corp.	**	7,434		7,434	33	
34	V	21 Postage		Royal Management Corp.	**	3,327		3,327	34	
35	V	21 Telephone		Royal Management Corp.	**	8,658		8,658	35	
36	V								36	
37	V	** The owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.								37
38	V								38	
39	Total		\$			\$ 740,614	\$ *	740,614	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.	**	\$ 507	\$	507	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	1,104		1,104	16	
17	V	25 Auto expense		Royal Management Corp.	**	10,603		10,603	17	
18	V	26 Insurance general		Royal Management Corp.	**	2,709		2,709	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	82,645		82,645	19	
20	V	30 Depreciation		Royal Management Corp.	**	85,063		85,063	20	
21	V	32 Interest		Royal Management Corp.	**	13,342		13,342	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	1,709		1,709	22	
23	V	33 Property taxes		Royal Management Corp.	**	5,681		5,681	23	
24	V	34 Rent expense		Royal Management Corp.	**	3,657		3,657	24	
25	V	35 Equipment rental		Royal Management Corp.	**	1,211		1,211	25	
26	V	17 Management fees	1,434,566	Royal Management Corp.	**			(1,434,566)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	928		928	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 Bloomingdale, Inc. own 100% of Royal Management Corp.								36
37	V								37	
38	V								38	
39	Total		\$ 1,434,566			\$ 209,159	\$ *	(1,225,407)	39	

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

Facility Name &amp; ID Number

Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

Facility Name & ID Number

Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning:

01/01/2015

Ending:

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VII. RELATED PARTIES

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

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

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl # 0035188 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

## 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	\$ 7,672	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,376	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,168	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	13,402	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	19,146	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 52,764		13

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

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

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning:

01/01/2015

Ending: 2/31/2015

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping supplies	Bed Days Available	723,430	10	\$ 2,585	\$ 0	60,590	\$ 217	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,169	0	60,590	5,626	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	2,778	0	60,590	233	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	5,597	0	60,590	469	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	687,966	687,966	60,590	57,620	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	71,704	0	60,590	6,005	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	2,893	0	60,590	242	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	99,498	0	60,590	8,333	8
9	10	Medical consultant	Bed Days Available	723,430	10	55,482	0	60,590	4,647	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	379,485	379,485	60,590	31,783	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	54,884	0	60,590	4,597	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	633,695	633,695	60,590	53,074	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	173,912	0	60,590	14,566	13
14	19	Professional fees	Bed Days Available	723,430	10	117,198	0	60,590	9,816	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	21,979	0	60,590	1,841	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	22,821	0	60,590	1,911	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	6,189,117	6,189,117	60,590	518,362	17
18	21	Bank charges	Bed Days Available	723,430	10	22,129	0	60,590	1,853	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	88,755	0	60,590	7,434	19
20	21	Postage	Bed Days Available	723,430	10	39,720	0	60,590	3,327	20
21	21	Telephone	Bed Days Available	723,430	10	103,369	0	60,590	8,658	21
22										22
23										23
24										24
25	TOTALS					\$ 8,842,736	\$ 7,890,263		\$ 740,614	25

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning:

01/01/2015

Ending: 2/31/2015

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	23	Inservice Training	Bed Days Available	723,430	10	\$ 6,055	\$ 60,590	\$ 507	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	13,182	60,590	1,104	2
3	25	Auto expense	Bed Days Available	723,430	10	126,592	60,590	10,603	3
4	26	Insurance general	Bed Days Available	723,430	10	32,340	60,590	2,709	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	986,762	60,590	82,645	5
6	30	Depreciation	Bed Days Available	723,430	10	1,015,630	60,590	85,063	6
7	32	Interest	Bed Days Available	723,430	10	159,306	60,590	13,342	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	20,406	60,590	1,709	8
9	33	Property taxes	Bed Days Available	723,430	10	67,835	60,590	5,681	9
10	34	Rent expense	Bed Days Available	723,430	10	43,669	60,590	3,657	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,465	60,590	1,211	11
12	35	Auto Lease	Bed Days Available	723,430	10	11,086	60,590	928	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,497,328	\$	\$ 209,159	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Lexington Financial						\$	\$		\$	1						
2	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,375,000	5,251,296	1/1/2033	Variable	331,450						
3											3						
4				Finance Charge - Insurance Policy							1,726						
5											5						
<b>Working Capital</b>																	
6	Bank of America		X	Working Capital	Varies	9/30/13	13,700,000	570,000	9/30/16	Prime/Libor	16,568						
7											7						
8											8						
9	<b>TOTAL Facility Related</b>						\$ 20,075,000	\$ 5,821,296			\$ 349,744						
<b>B. Non-Facility Related*</b>																	
10											(76,888)						
11											(1,726)						
12											2,171						
13											15,051						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (61,392)						
15	<b>TOTALS (line 9+line14)</b>						\$ 20,075,000	\$ 5,821,296			\$ 288,352						

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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2014 report.				\$	<b>175,200</b>	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.)	2014			\$	<b>172,357</b>	2
3. Under or (over) accrual (line 2 minus line 1).				\$	<b>(2,843)</b>	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<b>166,800</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$		5
			Allocated from Management Co.		<b>5,681</b>	
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. <b>TOTAL REFUND \$ 11,548 For 14 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	<b>(11,548)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<b>158,090</b>	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2010	<b>133,694</b>	8	<b>FOR BHF USE ONLY</b>		
	2011	<b>157,453</b>	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$	13
	2012	<b>163,116</b>	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2013	<b>169,987</b>	11	15	LESS REFUND FROM LINE 6 \$	15
	2014	<b>172,357</b>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<a href="#">See attached real estate accrual sheet</a>						

**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.**



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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**PLEASE NOTE:** *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

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

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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	<u>Resident Care</u>	<u>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>17,012</u>	<u>2</u>
3	<b>TOTALS</b>	<b>43,000</b>		<b>\$ 419,560</b>	<b>3</b>

**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	82	1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 2,271,787	4
5	9	1992	1992	178,974		35	5,114	5,114	122,729	5
6	75	1994	1994	2,022,894		35	57,797	57,797	1,242,634	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Capitalized repairs	1989		9,080		10			9,080	9
10	Building Improvements	1990		3,674		10			3,674	10
11	Building Improvements	1991		2,586		10			2,586	11
12	Building Improvements	1992		3,154		10			2,997	12
13	Building Improvements	1993		1,582		10			1,503	13
14	Building Improvements	1994		15,734		10			15,734	14
15	Land Improvements	1994		1,381		10			1,381	15
16	Land Improvements	1995		1,074		15			1,068	16
17	Building Improvements	1995		1,288		35	37	37	773	17
18	Building Improvements	1995		9,433	270	35	270		5,535	18
19	Building Improvements	1995		43,839	1,252	35	1,252		25,667	19
20	Concrete flooring, fire doors, tile, sprinkler heads, and basement renovation	1996		8,706		15			3,606	21
22	Land improvements	1996		7,858		15			7,858	22
23										23
24	Resident room heaters	1997		3,563	102	35	102		1,936	24
25	Automatic doors	1997		12,950	370	35	370		6,691	25
26	Basement renovation	1997		59,358		10			59,358	26
27	Land Improvement - outdoor flagpoles	1997		1,574		15			1,574	27
28	1st Floor Remodel (Nurses Station/Lounge)	1998		76,487		10			76,487	28
29	Wiring for MDS	1998		4,506		10			4,506	29
30	Flag Pole	1998		787		10			787	30
31	Resurface/Stripe Parking Lot	1998		9,777		10			9,777	31
32	Kitchen tile/paint	1999		718		10			718	32
33	1st Floor Remodel	1999		3,296		10			3,296	33
34	Roof repairs	2000		5,748	192	15	193	1	5,748	34
35	Sump pump	2000		2,534		10			2,534	35
36	Sump pump basin repair	2000		6,307		10			6,307	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

## 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	Automatic door closers	2000	\$ 1,300	\$ 43	15	\$ 41	\$ (2)	\$ 1,300	37
38	Infrared curtains for elevator doors	2001	3,000		10			3,000	38
39	Ejector pump	2002	3,050		5			3,050	39
40	Lift station pump	2002	3,359		5			3,359	40
41	New asphalt parking lot	2003	16,450		10			16,450	41
42	Roof repairs	2003	2,900		10			2,900	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		2,485	43
44	Kitchen remodel	2003	7,188	359	20	359		4,460	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		38,686	45
46	Floor tile	2003	16,305	815	20	815		10,597	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		45,782	47
48	Rehab-floor tile	2003	8,117	406	20	406		4,905	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		25,798	49
50	Foundation repair	2003	4,800	240	20	240		2,980	50
51	Parking lot	2004	24,550		10			24,550	51
52	Kitchen walk-in cooler floor	2004	7,161		10			7,161	52
53	Old Towne rehab	2004	13,967	698	20	698		7,854	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		115,787	54
55	Create first floor therapy room	2004	185	9	20	9		81	55
56	Transitional unit	2005	213	11	20	11		98	56
57	Landscaping	2005	8,814	441	20	441		4,483	57
58	Roof repairs	2005	3,250	163	20	163		1,656	58
59	HVAC upgrade	2005	7,048	352	20	352		3,639	59
60	Kitchen repair	2005	1,631	82	20	82		859	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		9,950	61
62	Window treatments	2005	3,606		5			3,606	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		3,939	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		21,071	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		18,291	65
66	Basement renovation	2005	14,176	709	20	709		7,089	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,126,921	\$ 31,320		\$ 179,459	\$ 148,139	\$ 4,294,197	70

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

## XI. OWNERSHIP COSTS (continued)

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

1	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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,126,921	\$ 31,320		\$ 179,459	\$ 148,139	\$ 4,294,197	1
2	Landscaping Enhancement	2006	7,084	472	15	472		4,406	2
3	Install Kitchen Sink	2006	2,915	146	20	146		1,423	3
4	Common area rehab	2006	2,382	119	20	119		1,151	4
5	Paint Building Exterior	2006	19,500		5			19,500	5
6	Patio	2006	53,305	3,554	15	3,554		32,281	6
7	Retaining Wall	2007	2,950	197	15	197		1,707	7
8	Roof Repair	2007	17,050	853	20	853		7,463	8
9	Air Conditioning units	2007	4,338	217	20	217		1,935	9
10	Paver walk and stairway	2007	10,500	525	20	525		4,550	10
11	Fire exit stairways	2007	9,379	469	20	469		3,830	11
12	Landscaping	2008	35,147	2,343	15	2,343		16,596	12
13	Parking Lot - Seal & Striping	2008	6,460	323	20	323		2,423	13
14	Roof	2008	15,300	765	20	765		5,865	14
15	HVAC - Spot Coolers	2008	5,589	140	40	140		980	15
16	Electrical - Storage Room	2008	4,768	238	20	238		1,765	16
17	Electrical - Fire Alarm Panel	2008	118,395	5,920	20	5,920		41,933	17
18	1st floor remodel-Carpentry,Flooring,Electrical,Parking fixtures	2008	557,202		27	20,262	20,262	155,342	18
19	Lawn Irrigation	2009	14,435	962	15	962		6,093	19
20	Landscaping	2009	12,950	863	15	863		5,322	20
21	Roof	2009	49,330	2,467	20	2,467		15,213	21
22	Front Entrance	2009	19,392	485	40	485		2,991	22
23	HVAC-Window unit	2009	41,315	4,131	10	4,131		27,885	23
24	HVAC Quick connectors	2009	7,058	706	10	706		4,765	24
25	Lift pump	2009	14,783	1,478	10	1,478		9,114	25
26	Fire alarm panel	2009	93,279	4,664	20	4,664		28,373	26
27	Pantry Cabinets	2009	3,523	352	10	352		2,171	27
28	Therapy Room counter tops-carpentry	2009	2,500	250	10	250		1,688	28
29	Patio Pergola	2009	7,930	397	20	397		2,514	29
30	Patio Stamped Concrete	2009	13,901	927	15	927		5,948	30
31	Lobby 1st floor remodel-Carpentry,doors frames,electrical painting,wallpaper	2009	52,018		27	1,892	1,892	11,352	31
32									32
33	OT Remodel-carpentry,electrical	2010	791,224		27	62,223	62,223	321,486	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,122,823	\$ 65,283		\$ 297,799	\$ 232,516	\$ 5,042,262	34

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

Facility Name &amp; ID Number Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 8,122,823	\$ 65,283		\$ 297,799	\$ 232,516	\$ 5,042,262	1
2									2
3	Lawn irrigation system	2010	5,503	367	15	367		2,018	3
4	Roof work	2010	15,268	557	27	557		3,063	4
5	HVAC Chiller	2010	84,004	3,064	27	3,064		15,831	5
6	Pantry-shelves	2010	23,805	868	27	868		4,702	6
7	Wanderguard	2010	3,747	137	27	137		719	7
8	Concrete work	2010	7,080	258	27	258		1,333	8
9	Automatic Doors	2010	4,903	490	10	490		2,695	9
10	Physician office carpentry and electrical update	2010	4,677	171	27	171		869	10
11	Library/Lounge-art, painting	2010	13,763	502	27	502		2,636	11
12	Pergola and patio wall	2010	21,186	1,693	27	2,940	1,247	21,186	12
13	Office carpentry and electrical changes	2010	5,744	209	27	209		1,080	13
14	Pavroll office-painting, carpentry	2011	18,505	673	27	673		2,804	14
15	Mulch stone and perennials	2011	4,364	291	15	291		1,212	15
16	Admissions office-painting, carpentry	2011	2,868	104	27	104		433	16
17	Parking lot lights	2011	6,070	221	27	221		921	17
18	Roof work	2011	93,530	3,401	27	3,401		13,887	18
19	Front entrance-awning, doors	2011	11,869	432	27	432		2,087	19
20	Duct extension	2011	3,476	126	27	126		620	20
21	HVAC unit	2011	23,400	851	27	851		3,546	21
22	Fluid pump	2011	8,400	305	27	305		1,475	22
23	Plumbing valves	2011	9,257	337	27	337		1,376	23
24	Laundry room-painting, electrical, tile	2011	8,386	305	27	305		1,296	24
25	Elevator-electrical work	2011	60,523	2,201	27	2,201		9,171	25
26	VCT Floor OT-painting, electrical, carpentry	2011	49,344	1,794	27	1,794		7,326	26
27									27
28	Front entrance door	2012	5,387	196	27	196		653	28
29	Sprinklers building	2012	6,500	236	27	236		747	29
30	Washing machine slab	2012	3,500	127	27	127		455	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,627,881	\$ 85,199		\$ 318,962	\$ 233,763	\$ 5,146,403	34

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

Facility Name &amp; ID Number Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 8,627,881	\$ 85,199		\$ 318,962	\$ 233,763	\$ 5,146,403	1
2	Generator Exhaust Pipe - Rooftop	2013	9,715	177	27	353	176	883	2
3	EMR Wiring - Entire Facility	2013	14,022	42	27	510	468	1,062	3
4									4
5	A/C GAS UNIT - HVAC mechanical room	2014	30,091	274	27	274		548	5
6	R/M - Remodel and relocating kitchen sink	2014	5,205		10	521	521	781	6
7	replaced pipes concrete and tile								7
8									8
9									9
10	Furnace in Shower Room	2015	11,971	145	27	145		145	10
11	EMR Wiring - Entire Facility	2015	6,233	19	27	19		19	11
12	R&M - Asphalt work in the parking lot	2015	5,800		20	145	145	145	12
13	R&M - PTAC, Heat Pump, Cooling, Heating and	2015	20,633		27	382	382	382	13
14	Control systems replacement in mechanical								14
15	room								15
16									16
17	Reconcile to book depreciation			4,092			(4,092)		17
18									18
19	Building - management company	2002	235,417		40	6,808	6,808	97,454	19
20	HVAC, electrical, security system - management company	2003	2,068		30	484	484	1,579	20
21	Key card system - management company	2004	325		20	16	16	185	21
22	VAV TX controls - management company	2005	99		20	5	5	54	22
23	Interior Signs - management company	2006	72		20	5	5	44	23
24	Building improvements - management company	2008	11,408		20	307	307	4,727	24
25	Building improvements - management company	2009	2,130		20	38	38	748	25
26	Building improvements - management company	2010	2,075		20	38	38	709	26
27	Building improvements - management company	2011	1,465		20	67	67	307	27
28	Building improvements - management company	2012	5,061		20	9	9	677	28
29	Building improvements - management company	2013	3,825		20	271	271	631	29
30	Building improvements - management company	2014	2,070		20	201	201	312	30
31	Building improvements - management company	2015	364		20	22	22	22	31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,997,930	\$ 89,948		\$ 329,582	\$ 239,634	\$ 5,257,817	34

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

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	\$ 765,425	\$ 95,966	\$ 114,649	\$ 18,683	5	\$ 617,912	71
72	Current Year Purchases	66,381	7,364	7,364		5-7	7,364	72
73	Fully Depreciated Assets	362,391				5	362,391	73
74	Allocated from Mgmt. Co.	480,605		74,539	74,539	5-7	338,709	74
75	TOTALS	\$ 1,674,802	\$ 103,330	\$ 196,552	\$ 93,222		\$ 1,326,376	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.			43,055		2,254	2,254	5	38,683	79
80	TOTALS			\$ 43,055	\$	\$ 2,254	\$ 2,254		\$ 38,683	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)	\$ 11,135,347	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 193,278	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 528,388	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 335,110	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,622,876	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Parking space lease				4,200			5
6	Allocated from Mgmt. Co.				3,657			6
7	TOTAL				\$ 7,857			7

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. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

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: \$ 67,405 Description: Copier-\$7,812, Mail Sys-\$431, Printer-\$3,770, Med Eq.-\$28,777, Oxy Eq.-\$25,404, Mgmt. Co.-\$1,211

(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.			928	20
21	TOTAL		\$	\$ 928	21

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

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

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl # 0035188 Report Period Beginning: 01/01/2015 Ending: 12/31/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (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.)**

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	11,489	\$ 446,490	\$	11,489	\$ 446,490	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,134	160,431		3,134	160,431	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		15,352	904,749		15,352	904,749	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				378,176		378,176	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39(3)				12,019			12,019	12
13	Other (specify): <u>See Sch 16A</u>	39(2)					16,997		16,997	13
14	<b>TOTAL</b>			\$	29,975	\$ 1,523,689	\$ 395,173	29,975	\$ 1,918,862	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name: Lexington Hlth C Ctr Blmngdl  
IDPH License ID Number: 0035188  
Fiscal Year End: 12/31/2015

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

<u>Description</u>	<u>Line Ref.</u>	<u>Amount</u>
Oxygen	39(2)	4,643
DME	39(2)	4,729
Rehab Supplies	39(2)	7,625
<b>Total - Line 12</b>	<b>-</b>	<b>16,997</b>

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,203,044	\$ 1,245,646	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>107,168</u> )	2,346,353	2,346,353	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,960	5,960	7
8	Accounts Receivable (owners or related parties)		1,230,638	8
9	Other(specify): <u>PA Interest Receivable</u>	25,153	25,153	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,580,510	\$ 4,853,750	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,261	64,261	12
13	Land		419,560	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	2,087,448	3,815,199	15
16	Equipment, at Historical Cost	664,579	1,717,857	16
17	Accumulated Depreciation (book methods)	(1,499,301)	(6,622,876)	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 (specify)			22
23	Other(specify): <u>Mortgage Cost, net</u>		37,744	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,316,987	\$ 4,614,476	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,897,497	\$ 9,468,226	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 526,042	\$ 526,042	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	570,000	570,000	29
30	Accrued Salaries Payable	607,667	607,667	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,008	6,008	31
32	Accrued Real Estate Taxes(Sch.IX-B)		166,800	32
33	Accrued Interest Payable		26,295	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	2,055,807	947,483	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,765,524	\$ 2,850,295	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,251,296	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,251,296	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,765,524	\$ 8,101,591	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,131,973	\$ 1,366,635	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,897,497	\$ 9,468,226	48

\*(See instructions.)

**Facility Name:** Lexington Hlth C Ctr Blmngdl  
**IDPH License ID Number:** 0035188  
**Fiscal Year End:** 12/31/2015

**Schedule 17A**

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

		<b>Operating</b>	<b>After Consolidation</b>
<b>Description</b>			
00-13040-00	Sambel Rent Receivable	-	(1,613,137)
00-13410-00	DUE TO/FROM EASTGATE MANOR	71	71
00-13700-00	Due from LLC 1	-	1,369
00-14530-00	PREPAID INSURANCE	20,880	20,880
00-14770-00	ESCROW - INSURANCE	(70,470)	(70,470)
00-21100-00	401K WITHHOLDING	(292)	(292)
00-22030-00	ACCRUED EXPENSES	28,529	28,529
00-22040-00	ACCRUED RESIDENT TAX	43,601	43,601
00-22060-00	ACCRUED ROYL / VESTA MGMT FEES	32,806	32,806
00-22120-00	ACCRUED RENT	1,613,137	1,613,137
00-22140-00	ACCRUED INSURANCE	13,047	13,047
00-22270-00	DUE TO PATIENT TRUST FUND	(113,898)	(113,898)
00-22330-00	ADVANCE - BIWEEKLY PART A PAYM	(34,048)	(34,048)
00-22360-00	UNCOLLECTIBLE PART A CO PVTS	(7,255)	(7,255)
00-23530-00	DUE TO - ROYAL OPERATIONS	14,712	14,712
00-23720-00	DUE TO REPUBLIC	1,680	1,680
00-23760-00	Due to LaGrange	60	60
	Due to Schaumburg		
00-23800-00		1,292	1,292
	DUE/TO FROM VESTA		
00-23830-00		10,157	10,157
00-24345-00	Sambel Interest Rate Swap Liability	-	503,444
00-24400-00	PROFESSIONAL LIABILITIES CLAIMS	501,798	501,798
<b>Total - Line 36</b>		<b>2,055,807</b>	<b>947,483</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,503,551	1
2	Restatements (describe):		2
3	Post closing adjustment	(114,450)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,389,101	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(257,128)	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)	\$ (257,128)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,131,973	24 *

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

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 17,358,261	1
2	Discounts and Allowances for all Levels	(9,853,165)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,505,096</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,368,444	6
7	Oxygen	12,929	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 5,381,373</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,431	12
13	Barber and Beauty Care	20,596	13
14	Non-Patient Meals	5	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	565,020	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	159,804	19
20	Radiology and X-Ray	36,228	20
21	Other Medical Services	275,825	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,059,909</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	461	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 461</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 13,946,839</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,649,236	31
32	Health Care	4,984,933	32
33	General Administration	3,563,818	33
<b>B. Capital Expense</b>			
34	Ownership	1,514,375	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,143,869	35
36	Provider Participation Fee	347,736	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 14,203,967</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(257,128)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (257,128)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 5,518,332	44
45	Private Pay - Net Inpatient Revenue	940,808	45
46	Medicare - Net Inpatient Revenue	851,782	46
47	Other-(specify) <u>Managed Care</u>	194,174	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 7,505,096</b>	<b>49</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

^ - Entity is a cash basis taxpayer

Facility Name & ID Number Lexington Hlth C Ctr Blmngdl

# 0035188

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

**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	1,730	2,127	\$ 131,798	\$ 61.96	1
2	Assistant Director of Nursing	22,928	28,375	815,674	28.75	2
3	Registered Nurses	24,152	30,561	954,180	31.22	3
4	Licensed Practical Nurses	22,362	27,884	743,503	26.66	4
5	CNAs & Orderlies	89,875	108,076	1,533,090	14.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,763	12,214	167,115	13.68	10
11	Social Service Workers	4,126	4,925	108,905	22.11	11
12	Dietician	1,618	1,921	33,154	17.26	12
13	Food Service Supervisor	1,514	1,930	43,792	22.69	13
14	Head Cook	1,572	1,930	32,382	16.78	14
15	Cook Helpers/Assistants	21,739	26,142	278,265	10.64	15
16	Dishwashers					16
17	Maintenance Workers	2,444	2,697	48,748	18.07	17
18	Housekeepers	24,757	29,691	317,928	10.71	18
19	Laundry	4,948	5,602	53,063	9.47	19
20	Administrator	1,763	2,460	147,105	59.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,154	12,928	220,530	17.06	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	1,469	1,835	29,927	16.31	31
32	Other Health C: <u>Memory Care</u>	2,407	3,045	57,538	18.90	32
33	Other(specify) <u>Marketing</u>	2,045	2,455	76,801	31.28	33
34	TOTAL (lines 1 - 33)	250,366	306,798	\$ 5,793,498 *	\$ 18.88	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 36,250	9(3)	36
37	Medical Records Consultant	Monthly 715	10(3)	37
38	Nurse Consultant	Monthly 4,943	10(3)	38
39	Pharmacist Consultant	Monthly 10,935	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	12 2,386	11(3)	44
45	Social Service Consultant	12 4,304	12(3)	45
46	Other(specify) <u>Pulmonary</u>	Monthly 28,678	10(3)	46
47	<u>Medical Consultant</u>	Monthly 4,647	10(7)	47
48	<u>See Sch 20B</u>	Monthly 7,563	10(3)	48
49	TOTAL (lines 35 - 48)	24 \$ 100,421		49

**C. CONTRACT NURSES**

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

Facility Name: Lexington Hlth C Ctr Blmngdl  
IDPH License ID Number: 0035188  
Fiscal Year End: 12/31/2015

**Schedule 20B**

**XVIII. SUPPORT SCHEDULES**

**Consultant Services**

Description	# of Hrs. Paid and Accrued	Total Consultant Cost	Ref.
Post Acute Consulting	Monthly	563	10(3)
Telemedicine	Monthly	7,000	10(3)
<b>Total - Line 48</b>	<b>0</b>	<b>7,563</b>	



**Facility Name:** Lexington Hlth C Ctr Blmngdl  
**IDPH License ID Number:** 0035188  
**Fiscal Year End:** 12/31/2015

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
Ability Network	Computer Services	3,018
Avatier	Computer Services	335
Bank of America (P KNIGHT)	Computer Services	100
Business Software Inc.	Computer Services	979
Citrix	Computer Services	534
Corepoint	Computer Services	1,511
Docusign Inc.	Computer Services	829
E-Health Data Solutions	Computer Services	3,450
Information Controls	Computer Services	2,099
Infor(US) Inc.	Computer Services	7,244
Inpriva Inc.	Computer Services	99
MHC Software	Computer Services	632
OnShift	Computer Services	5,000
Relias	Computer Services	6,540
Salesforce.com	Computer Services	7,228
Symbria	Computer Services	2,400
Tableau	Computer Services	407
Trisys	Computer Services	96
Availity	Computer Services	198
Centino	Computer Services	110
Greenshades Software	Computer Services	71
HealthMedx	Computer Services	1,004
National Datacare	Computer Services	2,200
Provinet	Computer Services	409
Softchoice Corporation	Computer Services	2,105
Amazon Marketplace	Computer Services	167
Bank of America (P KNIGHT)	Computer Services	59
Home Depot	Computer Services	1

Softchoice Corporation	Computer Services	1,323
Microsoft Licensing	Computer Services	5,131
Softchoice Corporation	Computer Services	929
HealthMEDX Software	Computer Services	9,791
RSM US LLP (McGladrey)	Computer Services	4,170
Genesis Technologies	Computer Services	4,002
	<b>Total (agree to Schedule V, line 19, column 3)</b>	<b><u>74,171</u></b>

Schedule V, line 19 column 3 **194,334**

Less:		
Bank Charges reclassified to Clerical & General	(457)	
Collection Fees	(732)	
Salesforce.com	(7,228)	
Out of Period Legal	(3)	
Non-allowable Legal	(4,344)	
Total Disallowance	<b><u>(12,764)</u></b>	

Legal allocated from Real Estate  
Secretary of State 2,800

Samvest of Lombard		
Accounting	95	
Filing Fees	7	
	<b><u>102</u></b>	

Allocated from Mgmt Co.		
Much Shelist	Legal	31
McGladrey LLP	Accounting	1,100
Frost, Ruttenberg & Rothblatt, P.C	Accounting	413
Gilson Labus & Silverman	Accounting	2,264
Illinois Secretary of State	Filing Fees	39
LaSalle Network	Recruiting/Finance	2,608
Pension Administrators, Inc.	401K Administration	361
Gene Whitehorn	Medicaid Reimb Specialist	1,324
M. Werner Consulting	Financial Consultant	1,565
Personnel Planners	Unemployment Consultant	9
Computer Services	Computer Consulting	14,566
	<b><u>24,280</u></b>	

**Total (agree to Schedule V, line 19, column 8) 208,752**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												N/A
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$911
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 20-27
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,196 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 347,736  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,703 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? 0
  - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.