

Facility Name & ID Number Lexington of Elmhurst

0037317 Report Period Beginning: 1/01/2015 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	145	Skilled (SNF)	145	52,925	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	145	TOTALS	145	52,925	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			20,295	20,295	8
9	SNF/PED					9
10	ICF	8,242	8,049		16,291	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,242	8,049	20,295	36,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.13%

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 11/12/91

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 142 and days of care provided 15,382

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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 & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

1/01/2015

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
	A. General Services										
1	Dietary	526,973	25,451	4,753	557,177		557,177	557,177			1
2	Food Purchase		245,283		245,283		245,283	(19,232)	226,051		2
3	Housekeeping	271,608	30,490		302,098		302,098	189	302,287		3
4	Laundry	44,759	13,523		58,282		58,282		58,282		4
5	Heat and Other Utilities			208,852	208,852		208,852	5,526	214,378		5
6	Maintenance	46,891		170,219	217,110		217,110	43,313	260,423		6
7	Other (specify):* Mgmt Co. Alloc. Bene							7,279	7,279		7
8	TOTAL General Services	890,231	314,747	383,824	1,588,802		1,588,802	37,075	1,625,877		8
	B. Health Care and Programs										
9	Medical Director			69,500	69,500		69,500		69,500		9
10	Nursing and Medical Records	3,902,657	435,598	212,731	4,550,986		4,550,986	31,822	4,582,808		10
10a	Therapy										10a
11	Activities	115,223	22,268	5,123	142,614		142,614		142,614		11
12	Social Services	156,741		5,349	162,090		162,090		162,090		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co. Alloc. Bene							4,015	4,015		15
16	TOTAL Health Care and Programs	4,174,621	457,866	292,703	4,925,190		4,925,190	35,837	4,961,027		16
	C. General Administration										
17	Administrative	183,133		1,291,798	1,474,931		1,474,931	(1,245,438)	229,493		17
18	Directors Fees										18
19	Professional Services			282,278	282,278		282,278	(1,373)	280,905		19
20	Dues, Fees, Subscriptions & Promotions			94,733	94,733		94,733	2,352	97,085		20
21	Clerical & General Office Expenses	138,622	24,289	38,920	201,831		201,831	471,366	673,197		21
22	Employee Benefits & Payroll Taxes			971,392	971,392		971,392	15,503	986,895		22
23	Inservice Training & Education			9,577	9,577		9,577	443	10,020		23
24	Travel and Seminar			165	165		165	964	1,129		24
25	Other Admin. Staff Transportation			3,108	3,108		3,108	9,261	12,369		25
26	Insurance-Prop.Liab.Malpractice			263,401	263,401		263,401	2,366	265,767		26
27	Other (specify):* Mgmt Co. Alloc. Bene							72,190	72,190		27
28	TOTAL General Administration	321,755	24,289	2,955,372	3,301,416		3,301,416	(672,366)	2,629,050		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,386,607	796,902	3,631,899	9,815,408		9,815,408	(599,454)	9,215,954		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 of Elmhurst

#0037317

Report Period Beginning:

1/01/2015

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	
	D. Ownership											
30	Depreciation			166,215	166,215	166,215	254,095	420,310				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,513	1,513	1,513	261,709	263,222				32
33	Real Estate Taxes						82,674	82,674				33
34	Rent-Facility & Grounds			1,013,711	1,013,711	1,013,711	(1,010,516)	3,195				34
35	Rent-Equipment & Vehicles			104,756	104,756	104,756	1,869	106,625				35
36	Other (specify):*											36
37	TOTAL Ownership			1,286,195	1,286,195	1,286,195	(410,169)	876,026				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		738,432	2,119,424	2,857,856	2,857,856		2,857,856				39
40	Barber and Beauty Shops			19,748	19,748	19,748		19,748				40
41	Coffee and Gift Shops			1,071	1,071	1,071	(117)	954				41
42	Provider Participation Fee			205,724	205,724	205,724		205,724				42
43	Other (specify):* Non-Allowable Co	107,230		181,448	288,678	288,678	(288,678)					43
44	TOTAL Special Cost Centers	107,230	738,432	2,527,415	3,373,077	3,373,077	(288,795)	3,084,282				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,493,837	1,535,334	7,445,509	14,474,680	14,474,680	(1,298,418)	13,176,262				45

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

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0037317

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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	(3,729)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,842)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,349	30		9
10	Interest and Other Investment Income	(4,080)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,083)	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	(13,107)	43		18
19	Entertainment		43		19
20	Contributions	(1,600)	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	(38,567)	43		24
25	Fund Raising, Advertising and Promotional	(36,598)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,211)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(29,778)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,246)		\$	30

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)	(1,153,172)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,153,172)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,298,418)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 1/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (21,513)	43	1
2	X-Rays-Part A	(40,632)	43	2
3	Diagnostics Managed Care	(10,291)	43	3
4	Trust Fees	(50)	43	4
5	Marketing Software	(7,208)	19	5
6	Collection Fees	(11,214)	19	6
7	Out of Period Legal Fees	(213)	19	7
8	Marketing Salary	(107,230)	43	8
9	Unrealized loss on FMV swap	190,440	43	9
10	IDPH Fine	(1,430)	19	10
11	Gift Shop Income	(117)	21	11
12	Dues & Subscriptions Marketing	(25)	20	12
13	Chamber of commerce dues	(324)	20	13
14	Non-Allowable IHCA Dues	(577)	20	14
15	Capitalize improvements over \$2,500	(12,476)	6	15
16	Non-Allowable Finance Charge	(1,513)	32	16
17	Additional Non-Allowable Legal Fees	(5,405)	19	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	Total		(29,778)	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 Elmhurst II Limited Partnership	**	\$ 2,800	\$ 2,800	1
2	V	30 Depreciation		Sambell of Elmhurst II Limited Partnership	**	178,444	178,444	2
3	V	32 Interest expense		Sambell of Elmhurst II Limited Partnership	**	250,749	250,749	3
4	V	32 Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	3,405	3,405	4
5	V	33 Property taxes		Sambell of Elmhurst II Limited Partnership	**	77,711	77,711	5
6	V	34 Rental expense	1,013,711	Sambell of Elmhurst II Limited Partnership	**		(1,013,711)	6
7	V	43 Unrealized loss on FMV swap	190,440	Sambell of Elmhurst II Limited Partnership	**		(190,440)	7
8	V	43 Trust fees		Sambell of Elmhurst II Limited Partnership	**	50	50	8
9	V	43 State Replacement Tax	4	Sambell of Elmhurst II Limited Partnership	**		(4)	9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				12
13	V			of Sambell of Elmhurst II Limited Partnership				13
14	Total		\$ 1,204,155			\$ 513,159	\$ * (690,996)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 189	\$	189	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,914		4,914	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	203		203	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	409		409	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	50,331		50,331	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,246		5,246	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	212		212	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	7,279		7,279	22
23	V	10 Medical consultant		Royal Management Corp.	**	4,059		4,059	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	27,763		27,763	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	4,015		4,015	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	46,360		46,360	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	12,723		12,723	27
28	V	19 Professional fees		Royal Management Corp.	**	8,574		8,574	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,608		1,608	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	1,670		1,670	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	452,786		452,786	31
32	V	21 Bank charges		Royal Management Corp.	**	1,619		1,619	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	6,493		6,493	33
34	V	21 Postage		Royal Management Corp.	**	2,906		2,906	34
35	V	21 Telephone		Royal Management Corp.	**	7,562		7,562	35
36	V								36
37	V								37
38	V	** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 646,921	\$ *	646,921	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.	**	\$ 443	\$	443	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	964		964	16	
17	V	25 Auto expense		Royal Management Corp.	**	9,261		9,261	17	
18	V	26 Insurance general		Royal Management Corp.	**	2,366		2,366	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	72,190		72,190	19	
20	V	30 Depreciation		Royal Management Corp.	**	74,302		74,302	20	
21	V	32 Interest		Royal Management Corp.	**	11,655		11,655	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	1,493		1,493	22	
23	V	33 Property taxes		Royal Management Corp.	**	4,963		4,963	23	
24	V	34 Rent expense		Royal Management Corp.	**	3,195		3,195	24	
25	V	35 Equipment rental		Royal Management Corp.	**	1,058		1,058	25	
26	V	17 Management fees	1,291,798	Royal Management Corp.	**			(1,291,798)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	811		811	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 Elmhurst, Inc. own 100% of Royal Management Corp.								36
37	V								37	
38	V								38	
39	Total		\$ 1,291,798			\$ 182,701	\$ *	(1,109,097)	39	

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

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0037317

Report Period Beginning:

1/01/2015

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

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

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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					Lexington Home	Lombard	Home Health	1
2					Health Care, Inc.			2
3					Lexington Hospice	Lombard	Hospice	3
4					Services, LLC			4
5					Lexington Private	Lombard	Healthcare	5
6					Home Care			6
7					Merit Sleep	Lombard	Mgmt. Company	7
8					Management, LLC			8
9								9
10								10
11					Samvest of	Algonquin	Real Estate	11
12					Algonquin Ltd. Pts		Property	12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/01/2015 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	\$ 6,701	L 17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,696	L 17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,261	L 17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	11,707	L 17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	16,724	L 17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 46,089		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 Elmhurst

0037317

Report Period Beginning:

1/01/2015

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	52,925	\$ 189	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,169	0	52,925	4,914	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	2,778	0	52,925	203	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	5,597	0	52,925	409	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	687,966	687,966	52,925	50,331	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	71,704	0	52,925	5,246	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	2,893	0	52,925	212	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	99,498	0	52,925	7,279	8
9	10	Medical consultant	Bed Days Available	723,430	10	55,482	0	52,925	4,059	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	379,485	379,485	52,925	27,763	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	54,884	0	52,925	4,015	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	633,695	633,695	52,925	46,360	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	173,912	0	52,925	12,723	13
14	19	Professional fees	Bed Days Available	723,430	10	117,198	0	52,925	8,574	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	21,979	0	52,925	1,608	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	22,821	0	52,925	1,670	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	6,189,117	6,189,117	52,925	452,786	17
18	21	Bank charges	Bed Days Available	723,430	10	22,129	0	52,925	1,619	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	88,755	0	52,925	6,493	19
20	21	Postage	Bed Days Available	723,430	10	39,720	0	52,925	2,906	20
21	21	Telephone	Bed Days Available	723,430	10	103,369	0	52,925	7,562	21
22										22
23										23
24										24
25	TOTALS					\$ 8,842,736	\$ 7,890,263		\$ 646,921	25

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

1/01/2015

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	\$ 52,925	\$ 443	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	13,182	52,925	964	2
3	25	Auto expense	Bed Days Available	723,430	10	126,592	52,925	9,261	3
4	26	Insurance general	Bed Days Available	723,430	10	32,340	52,925	2,366	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	986,762	52,925	72,190	5
6	30	Depreciation	Bed Days Available	723,430	10	1,015,630	52,925	74,302	6
7	32	Interest	Bed Days Available	723,430	10	159,306	52,925	11,655	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	20,406	52,925	1,493	8
9	33	Property taxes	Bed Days Available	723,430	10	67,835	52,925	4,963	9
10	34	Rent expense	Bed Days Available	723,430	10	43,669	52,925	3,195	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,465	52,925	1,058	11
12	35	Auto Lease	Bed Days Available	723,430	10	11,086	52,925	811	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	\$	\$ 182,701	25

Facility Name & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

1/01/2015

Ending:

12/31/2015

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			
	A. Directly Facility Related																
	Long-Term																
1	Lexington Financial						\$	\$		\$	1						
2	Services II, L.L.C.	X		Mortgage	Varies	4/30/07	5,391,000	3,821,854	5/1/17	0.0650	250,749	2					
3												3					
4												4					
5										Finance Charge - Insurance Policy	1,513	5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 5,391,000	\$ 3,821,854			\$ 252,262	9					
	B. Non-Facility Related*																
10										Amortization of Loan Cost	4,898	10					
11										Interest Income Offset	(4,080)	11					
12										Allocated from Home Office	11,655	12					
13										Remove Non-Allowable Finance Charge	(1,513)	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 10,960	14					
15	TOTALS (line 9+line14)						\$ 5,391,000	\$ 3,821,854			\$ 263,222	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.)

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 2014 report.			\$ 78,000	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		\$ 76,511	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ (1,489)	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 79,200	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.)			\$	5	
		Allocated from Management Co.	4,963		
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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 82,674	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>68,387</u>	8		
	2011	<u>69,831</u>	9		
	2012	<u>73,433</u>	10		
	2013	<u>75,652</u>	11		
	2014	<u>76,511</u>	12		
See attached real estate accrual sheet					
				FOR BHF USE ONLY	
				13	13
				14	14
				15	15
				16	16

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Elmhurst, Inc. COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0037317

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 2014 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 2014.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>06-14-317-008</u>	<u>Land & Building</u>	\$ <u>76,511.06</u>	\$ <u>76,511.06</u>
2.	<u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-021</u>	<u>Land & Building</u>	\$ _____	\$ <u>4,963.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>76,511.06</u></u>	\$ <u><u>81,474.06</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 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: 52,608 B. General Construction Type: Exterior Concrete Block 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).

Lexington Square Life Care of Elmhurst, Inc.: Retirement Community: 342 units

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>55,000</u>	<u>1991</u>	<u>\$ 1,277,670</u>	1
2	<u>Management Company Allocation</u>			<u>14,836</u>	2
3	TOTALS	55,000		\$ 1,292,506	3

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

1/01/2015

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	133		1991	1991	\$ 4,110,586	\$	35	\$ 117,445	\$ 117,445	\$ 2,831,455	4
5	12		1995	1995	73,302	2,095	35	2,095		43,267	5
6			2001	2001							6
7											7
8											8
	Improvement Type**										
9	Building Improvement		1992		693	20	35	20		462	9
10	Land Improvement		1995		7,500		15			7,500	10
11	Fan Coil Units		1996		4,904	140	35	140		2,731	11
12	Patio		1996		2,322		15			2,322	12
13	Basement rehab		1997		17,151		10			17,151	13
14	Baseboards		1997		3,129		10			3,129	14
15	Wiring		1998		3,090		10			3,090	15
16	Lobby Tile		1999		19,354		10			19,354	16
17	Patio		1999		4,196		15			4,196	17
18	Automatic Door		2000		1,300		10			1,300	18
19	Wallpaper		2000		6,853		10			6,853	19
20	Patio		2000		1,242	40	15	40		1,242	20
21	Storage closet for HVAC		2000		3,745	123	15	123		3,745	21
22	Fire pump system		2001		4,140		10			4,140	22
23	Door releases		2001		4,420		10			4,420	23
24	Infrared curtains for elevators		2001		3,000		10			3,000	24
25	Parking lot		2002		2,532		10			2,532	25
26	Kitchen tile and plumbing		2002		9,661		10			9,661	26
27	Elevator upgrade		2002		2,596		5			2,596	27
28	Facility Rehab-Painting/wallpaper/carpeting		2003		175,251		10			175,251	28
29	Facility Rehab-Floor tile/room upgrade		2003		38,140	1,907	20	1,907		24,632	29
30	Facility Rehab-Carpeting		2003		7,861		10			7,861	30
31	Parking lot		2004		2,000		5			2,000	31
32	Roof		2004		15,000	750	20	750		8,563	32
33	Landscaping		2005		5,396	270	20	270		2,834	33
34	Paint for building		2005		9,000	675	10	675		9,000	34
35	Roof		2005		14,300	715	20	715		7,269	35
36											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 Elmhurst

0037317

Report Period Beginning:

1/01/2015

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	
37	HVAC upgrade	2005	\$ 3,230	\$ 162	20	\$ 162	\$	\$ 1,727	37
38	Sprinkler system	2005	1,060	53	20	53		543	38
39	Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		15,065	39
40	Window treatment	2005	1,932	66	10	66		1,932	40
41	Cubicle curtains	2005	820		5			820	41
42	Countertop	2005	845		5			845	42
43	HVAC	2006	3,793	190	20	190		1,725	43
44	Automatic Door Lock	2006	2,784	139	20	139		1,251	44
45	Storeroom Door Lock	2006	1,904	95	20	95		871	45
46	Service Door	2006	2,545	127	20	127		1,143	46
47	Landscaping Enhancement-Patio	2006	2,340	156	15	156		1,469	47
48	PT Therapy Room	2006	570	14	40	14		126	48
49									49
50									50
51									51
52	Transitional Unit	2007	1,864	93	20	93		814	52
53	Employee Lunch Room	2007	2,827	141	20	141		1,199	53
54	PT Room Rehab	2007	58,628	2,941	20	2,941		24,313	54
55	Landscaping-brick pavers	2008	43,813	2,921	15	2,921		21,177	55
56	Parking Lot	2008	31,700	1,585	20	1,585		12,020	56
57	Roof Repairs	2008	4,200	280	15	280		2,147	57
58	HVAC-New Chillers	2008	118,557	5,928	20	5,928		43,472	58
59	Emergency A/C	2008	5,706	285	20	285		2,090	59
60	Building Addition	2008			27				60
61	Kitchen Upgrade	2008	7,214		27	262	262	1,878	61
62	2nd Floor Remodel-painting, flooring, electrical	2008	561,274		27	20,410	20,410	146,272	62
63	Foundation Stabilization	2008	66,195		27	2,407	2,407	17,250	63
64	Irrigation System	2009	15,485	1,032	15	1,032		6,536	64
65	Landscaping Enhancements	2009	26,798	1,787	15	1,787		11,466	65
66	Patio Fence	2009	9,319	466	20	466		3,068	66
67	Chiller	2009	82,310	4,115	20	4,115		27,777	67
68	Plumbing	2009	4,280	214	20	214		1,284	68
69	2nd floor remodel-MDS office,HR office,Nursing call system	2009	6,853	250	27	250		1,510	69
70	TOTAL (lines 4 thru 69)		\$ 5,649,111	\$ 31,155		\$ 171,679	\$ 140,524	\$ 3,563,346	70

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

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

1/01/2015

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	Totals from Page 12A, Carried Forward		\$ 5,649,111	\$ 31,155		\$ 171,679	\$ 140,524	\$ 3,563,346	1
2	Patio Pergola	2009	12,814	641	20	641		4,060	2
3	Tub Room carpentry, flooring, electrical	2009	5,828	212	27	212		1,272	3
4	2nd Floor remodel-Carpentry, doors, flooring, electrical	2009	455,801		7	16,575	16,575	111,881	4
5	painting, sprinkler system								5
6	Landscaping	2010	3,314	221	15	221		1,160	6
7	Physician office remodel-carpentry, tiling	2010	6,450	235	27	235		1,195	7
8	Front Entrance-door and drain tile	2010	4,418	216	27	216		1,127	8
9	Nurse pull cord station	2010	3,256	118	27	118		590	9
10	Remodel Pantry-shelves	2010	7,146	260	27	260		1,300	10
11	Director of Nursing office painting	2010	5,539	201	27	201		1,005	11
12	Cooridor remodel-flag pole, tiling	2010	13,777	550	27	550		2,814	12
13	Library/Lounge remodel-art, carpentry, electrical	2010	11,870	432	27	432		2,160	13
14	Steel frame remodel	2010	6,740	245	27	245		1,348	14
15	2nd Floor remodel-Carpentry, doors, flooring, electrical	2010	17,168	624	27	624		3,744	15
16	Tub Room carpentry, plumbing	2010	11,731	427	27	427		2,491	16
17	Pergola	2010	8,180	1,091	5	1,091		8,180	17
18	Stamped concrete	2010	17,260	628	27	628		3,349	18
19	Landscaping	2011	4,443	296	15	296		1,283	19
20	Offices-doors, locks, keys	2011	66,131	2,405	27	2,405		11,023	20
21	Seal and stripe parking lot	2011	3,500	127	27	127		540	21
22	Laundry room-electrical, painting	2011	6,412	233	27	233		1,049	22
23	Floor install	2011	10,158	369	27	369		1,784	23
24	2nd floor doors	2011	9,654	351	27	351		1,726	24
25									25
26	Front entrance door	2012	3,733	136	27	136		442	26
27	Shower-Electrical	2012	4,982	181	27	181		573	27
28	Fire Dampers	2012	7,392	269	27	269		829	28
29	Low voltage wiring	2012	5,186	189	27	189		693	29
30	EMR Wiring	2012	14,543	529	27	529		1,631	30
31	1st floor doors	2012	8,476	308	27	308		1,052	31
32	Back patio fence	2012	3,536	129	27	129		494	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,388,549	\$ 42,778		\$ 199,877	\$ 157,099	\$ 3,734,141	34

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

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

1/01/2015

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	Totals from Page 12B, Carried Forward		\$ 6,388,549	\$ 42,778		\$ 199,877	\$ 157,099	\$ 3,734,141
2	1st Fl. Rm. Reconfigure. - labor, electrical, drywall, plumbing	2013	39,603	1,440	27	1,440		4,200
3								
4	MDS Office Millwork & Electrical	2014	15,401	560	27	560		793
5	Automate Front Doors (Front Entrance)	2014	9,593	349	27	349		436
6	Install LED Lights throughout facility	2014	44,958	1,635	27	1,635		1,635
7	Wiring -Fiber connection throughout facility	2014	5,597	204	27	204		272
8								
9								
10	Parking Lot - Replace Aprons and Curbs	2015	27,000	750	15	750		750
11	EMR Wiring - Entire Facility	2015	5,087	123	27	123		123
12								
13	R&M Reclas: Parking Lot - crack sealing, coating, and striping	2015	3,800		20	95	95	95
14	R&M Reclas: Landscaping on left and ride side of driveway	2015	8,676		15	289	289	289
15	and side of building							
16								
17	Building - management company	2002	205,305		40	5,947	5,947	84,989
18	HVAC, electrical, security system - management company	2003	1,803		30	423	423	1,377
19	Key card system - management company	2004	283		20	14	14	162
20	VAV TX controls - management company	2005	86		20	4	4	47
21	Interior Signs - management company	2006	63		20	4	4	38
22	Building improvements - management company	2008	9,948		20	268	268	4,123
23	Building improvements - management company	2009	1,857		20	33	33	652
24	Building improvements - management company	2010	1,810		20	33	33	619
25	Building improvements - management company	2011	1,278		20	58	58	267
26	Building improvements - management company	2012	4,413		20	8	8	591
27	Building improvements - management company	2013	3,335		20	237	237	550
28	Building improvements - management company	2014	1,805		20	176	176	272
29	Building improvements - management company		317			19	19	19
30								
31	Reconcile to book depreciation			727			(727)	
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 6,780,567	\$ 48,566		\$ 212,546	\$ 163,980	\$ 3,836,439

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

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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	\$ 885,680	\$ 111,423	\$ 134,460	\$ 23,037	5	\$ 701,522	71
72	Current Year Purchases	45,435	6,226	6,226		5	6,226	72
73	Fully Depreciated Assets	552,671				5	552,671	73
74	Allocated from Mgmt. Co.	419,134		65,109	65,109	5-7	295,387	74
75	TOTALS	\$ 1,902,920	\$ 117,649	\$ 205,795	\$ 88,146		\$ 1,555,806	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.			37,548		1,969	1,969	5	33,735	79
80	TOTALS			\$ 37,548	\$	\$ 1,969	\$ 1,969		\$ 33,735	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)	\$ 10,013,541	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,215	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 420,310	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 254,095	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,425,980	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	<u>Allocated from Management Company</u>				<u>3,195</u>			6
7	TOTAL				\$ 3,195			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: \$ 105,814 Description: See Schedule 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	<u>Allocated from Management Company</u>			<u>811</u>	20
21	TOTAL		\$	\$ 811	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: Lexington of Elmhurst
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2015

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	7,835
Printer	4,659
Postage	504
Medical Equip	61,218
Oxygen	30,540
Management Co.	1,058
Total - Line 16	<u>105,814</u>

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/01/2015 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	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	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	15,616	\$ 683,443	\$	15,616	\$ 683,443	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		5,190	263,468		5,190	263,468	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		26,427	1,170,287	13,242	26,427	1,183,529	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 prescripts				715,841		715,841	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39(3)				2,226			2,226	12
13	Other (specify): <u>See Sch. 16A</u>	39(2 & 3)					9,349		9,349	13
14	TOTAL			\$	47,233	\$ 2,119,424	\$ 738,432	47,233	\$ 2,857,856	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 Health Care Center of Elmhurst, Inc.
 IDPH License ID Number: 0037317
 Fiscal Year End: 12/31/2015

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	To (Col.
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost			
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist		hrs	\$				\$		\$			\$
2	Licensed Speech and Language Development Therapist		hrs										
3	Licensed Recreational Therapist		hrs										
4	Licensed Physical Therapist		hrs										
5	Physician Care		visits										
6	Dental Care		visits										
7	Work Related Program		hrs										
8	Habilitation		hrs										
9	Pharmacy		# of prescripts										
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										
11	Academic Education		hrs										
12	Other (specify):												
13	Other (specify): <u>Oxygen</u>	39(2)								6,285			
13A	Other (specify): <u>DME</u>	39(2)								3,064			
14	TOTAL			\$				\$		\$ 9,349			\$

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.

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tal Cost 3 + 5 + 6)	
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6,285	12
3,064	13
9,349	14

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 1/01/2015Ending: 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,205,680	\$ 2,236,125	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>229,317</u>)	2,467,980	2,467,980	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(3,721)	(3,721)	6
7	Other Prepaid Expenses	5,581	5,581	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>PA Interest Receivable</u>	3,954	3,954	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,679,474	\$ 4,709,919	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,319	6,319	12
13	Land		1,292,506	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	1,158,096	2,669,981	15
16	Equipment, at Historical Cost	718,944	1,940,468	16
17	Accumulated Depreciation (book methods)	(947,688)	(5,425,980)	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 Net Cost</u>		56,458	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 935,671	\$ 4,650,338	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,615,145	\$ 9,360,257	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 635,563	\$ 635,563	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,528	52,528	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	450,787	450,787	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,794	10,794	31
32	Accrued Real Estate Taxes(Sch.IX-B)		79,200	32
33	Accrued Interest Payable		22,282	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	1,194,770	1,467,196	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,344,442	\$ 2,718,350	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,821,854	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)	\$	\$ 3,821,854	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,344,442	\$ 6,540,204	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,270,703	\$ 2,820,053	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,615,145	\$ 9,360,257	48

*(See instructions.)

Facility Name: Lexington of Elmhurst
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2015

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
00-12020-00 LHCC PA AUDIT SETTLEMENT		(5,373)
00-13330-00 LHCC DUE TO/FROM REPUBLIC CONSTRUCTION	1,321	1,321
00-13370-00 LHCC DUE FROM LOMARD SQUARE- AR		
00-14530-00 LHCC PREPAID INSURANCE	6,763	6,763
00-21030-00 COBRA	(14,439)	(14,439)
00-22030-00 LHCC ACCRUED EXPENSES	92,779	92,779
00-22040-00 LHCC ACCRUED RESIDENT TAX	22,944	22,944
00-22060-00 LHCC ACCRUED ROYL / VESTA MGMT FEES	353,129	353,129
00-22120-00 LHCC ACCRUED RENT	5,373	5,373
00-22140-00 LHCC ACCRUED INSURANCE	11,514	11,514
00-22270-00 LHCC DUE TO PATIENT TRUST FUND	(53,505)	(53,505)
00-22330-00 LHCC ADVANCE - BIWEEKLY PART A PAYM	(73,233)	(73,233)
00-22360-00 LHCC UNCOLLECTIBLE PART A CO PVTS	(43,776)	(43,776)
00-23530-00 LHCC DUE TO - ROYAL OPERATIONS	11,941	11,941
00-23740-00 LHCC Due to Chicago Ridge	13,800	13,800
00-23760-00 LHCC Due to LaGrange	4,250	4,250
00-23830-00 LHCC Due/to from Vesta Management	11,437	11,437
00-23870-00 LHCC DUE TO/FROM LEXINGTON FINANCIAL SERVICES	45	45
00-24345-00 LHCC Sambel Interest Rate Swap Liability	-	277,799
00-24400-00 LHCC PROFESSIONAL LIABILITIES CLAIMS	844,427	844,427
Total - Line 36	1,194,770	1,467,196

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,146,179	1
2	Restatements (describe):		2
3	Post closing adjustment	(268,434)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,877,745	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	7,958	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	(615,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (607,042)	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)	\$ 3,270,703	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		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 15,089,643		1
2	Discounts and Allowances for all Levels	(9,777,438)		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,312,205		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy	7,214,035		6
7	Oxygen	40,624		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,254,659		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	117		12
13	Barber and Beauty Care	21,982		13
14	Non-Patient Meals	3,729		14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs	1,097,438		17
18	Sale of Supplies to Non-Patients			18
19	Laboratory	290,785		19
20	Radiology and X-Ray	63,174		20
21	Other Medical Services	434,469		21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,911,694		23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***	4,080		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,080		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)	\$ 14,482,638		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,588,802		31
32	Health Care	4,925,190		32
33	General Administration	3,301,416		33
B. Capital Expense				
34	Ownership	1,286,195		34
C. Ancillary Expense				
35	Special Cost Centers	3,167,353		35
36	Provider Participation Fee	205,724		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,474,680		40
41	Income before Income Taxes (line 30 minus line 40)**	7,958		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 7,958		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,608,926	44
45	Private Pay - Net Inpatient Revenue	1,886,531	45
46	Medicare - Net Inpatient Revenue	1,671,092	46
47	Other-(specify) <u>Managed Care</u>	145,656	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,312,205	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

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

1/01/2015

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	697	\$ 58,958	\$ 55.62	1
2	Assistant Director of Nursing	31,449	1,037,150	27.50	2
3	Registered Nurses	22,774	971,007	32.00	3
4	Licensed Practical Nurses	20,101	673,995	26.32	4
5	CNAs & Orderlies	69,465	1,124,899	13.12	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	7,075	115,223	12.97	10
11	Social Service Workers	6,970	156,741	19.92	11
12	Dietician	2,423	59,329	21.38	12
13	Food Service Supervisor	1,610	43,695	22.33	13
14	Head Cook	1,774	31,029	14.93	14
15	Cook Helpers/Assistants	31,907	392,920	10.32	15
16	Dishwashers				16
17	Maintenance Workers	1,837	46,891	20.80	17
18	Housekeepers	22,448	271,608	10.28	18
19	Laundry	4,064	44,759	9.59	19
20	Administrator	2,141	183,133	61.64	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	8,303	138,622	13.37	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	1,928	36,648	16.42	31
32	Other Health Care(specify)				32
33	Other(specify) <u>Marketing</u>	2,844	107,230	36.55	33
34	TOTAL (lines 1 - 33)	239,810	\$ 5,493,837 *	\$ 18.69	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	Monthly \$ 456	1(3)	35
36	Medical Director	Monthly 69,500	9(3)	36
37	Medical Records Consultant	Monthly 813	10(3)	37
38	Nurse Consultant	Monthly 4,877	10(3)	38
39	Pharmacist Consultant	Monthly 9,034	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly 2,386	11(3)	44
45	Social Service Consultant	Monthly 5,349	12(3)	45
46	Other(specify) <u>Pulmonary Consultant</u>	Monthly 84,459	10(3)	46
47	<u>Medical Consultant</u>	Monthly 4,059	10(7)	47
48	<u>See Sch 20B</u>	5,063	10(3)	48
49	TOTAL (lines 35 - 48)	\$ 185,996		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	453 \$ 23,297	10(3)	50
51	Licensed Practical Nurses	1,859 85,188	10(3)	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	2,312 \$ 108,485		53

Facility Name: Lexington Health Care Center of Elmhurst, Inc.
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2015

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	1,563	10(3)
Telemedicine Consultant	Monthly	3,500	10(3)
Total - Consulting Services	-	5,063	-

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sandra Cubas	Administrator	0	\$ 18,062	Workers' Compensation Insurance	\$ 174,434	IDPH License Fee	\$	
Karen Glaza	Administrator	0	98,842	Unemployment Compensation Insurance	74,240	Advertising: Employee Recruitment	57,718	
Tremaine Brown	Administrator	0	66,229	FICA Taxes	402,579	Health Care Worker Background Check		
				Employee Health Insurance	265,795	(Indicate # of checks performed <u>1370</u>)	16,445	
				Employee Meals	15,503	Patient Background Checks	507 6,085	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	8,839	
				401K	17,375	Miscellaneous Subscriptions & Dues	5,646	
				Other Employee Benefits	26,363	Less: Dues & Subscriptions marketing	(602)	
				Uniform Allowance	6,230	Less: Chamber of commerce dues	(324)	
				Tuition	4,376	Allocated from Home Office	3,278	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 183,133					
(List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)	\$ 986,895	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 97,085	
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			\$ 857,611	N/A		\$	Out-of-State Travel	\$
Management Fees-Vesta Mgmt.			434,187					
Management Fees (Eliminated in Column 7)							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,291,798					
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount			\$		
Cassiday Schade , LLP	Legal		\$ 118,692				Seminar Expense	165
JP Morgan Chase Bank NA	Building Appraisal Fee		3,400				Allocated from Home Office	964
RSM US LLP	Accounting		46,089					
Much Shelist	Legal		4,922				Entertainment Expense	()
Biometric Impressions	Background Check for Legal		115				(agree to Sch. V, line 24, col. 8)	
Pension Administrators	401K Administration		827				TOTAL	\$ 1,129
Personnel Planners	U/C Consulting		1,255					
Polsinelli Shughart	Legal		11,047					
Secretary of State	Filing Fees		132					
Illinois Department of Public Health	Non Allowable Fines		1,430					
Grabowski Law	Collections		11,214					
See Schedule 21C	Various		83,154					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 282,278					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Lexington of Elmhurst
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2015

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Serpico	Legal	1,920
Duane Morris	Legal	5,726
Scott & Kraus	Legal	246
Ability Network	Computer Services	3,018
Allscripts	Computer Services	223
Amazon Marketplace	Computer Services	77
Availity	Computer Services	198
Avatier	Computer Services	328
Business Software Inc.	Computer Services	917
Centino	Computer Services	110
Citrix	Computer Services	534
Corepoint	Computer Services	1,511
DocuSign Inc.	Computer Services	829
E-Health Data Solutions	Computer Services	3,450
Genesis Technologies	Computer Services	4,002
Genesis Technology	Computer Services	434
HEALTH MEDX	Computer Services	9,544
HealthMedx	Computer Services	1,888
Home Depot	Computer Services	1
HP commercial repair	Computer Services	130
Infor(US) Inc.	Computer Services	5,847
Information Controls	Computer Services	1,880
Inpriva Inc.	Computer Services	99
MHC Software	Computer Services	573
Microsoft Licensing	Computer Services	7,897
National Datacare	Computer Services	1,251

OnShift	Computer Services	3,953
Provinet	Computer Services	377
Relias	Computer Services	6,440
RSM US LLP	Computer Services	3,900
Salesforce.com	Computer Services	7,208
Soft choice Corporation	Computer Services	71
Softchoice Corporation	Computer Services	4,182
Symbria	Computer Services	2,400
Tableau	Computer Services	407
Trisys	Computer Services	96
Tympani	Computer Services	656
Assessment & Intelligence Systems	PPS Review	833
		<u>83,154</u>
	Total (agree to Schedule V, line 19, column 3)	<u><u>282,278</u></u>

Less:

Non-Allowable Legal Fees	(16,832)
Non-Allowable Fines/Penalty	(1,430)
Non-Allowable Marketing Software	(7,208)

Allocated from Real Estate Company	Professional Services	2,800
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Samvest of Lombard

Gilson Labus & Silverman	Accounting	83
Illinois Secretary of State	Filing Fees	6

Allocated from Mgmt Co.

Much Shelist	Legal	27
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	-
Duane Morris	Legal	-
McGladrey LLP	Accounting	961
Frost, Ruttenberg & Rothblatt, P.C	Accounting	360
Gilson Labus & Silverman	Accounting	1,977
Illinois Secretary of State	Filing Fees	34
LaSalle Network	Recruiting/Finance	2,278
Pension Administrators, Inc.	401K Administration	315
Gene Whitehorn	Medicaid Reimb Specialist	1,156
M. Werner Consulting	Financial Consultant	1,367

Personnel Planners
Healthcents
Computer Services

Unemployment Consultant	8
Managed Care Consultants	-
Computer Consulting	12,723
Total (agree to Schedule V, line 19, column 8)	<u><u>280,905</u></u>

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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Lexington of Elmhurst# 0037317

Report Period Beginning:

1/01/2015

Ending:

12/31/2015**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 - \$1,530
- (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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,318 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. \$ 205,724
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. \$ 15,503 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,729
- (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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? 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.