



Facility Name & ID Number Lexington of LaGrange

# 0038083 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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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			25,338	25,338	8
9	SNF/PED					9
10	ICF	3,610	2,028		5,638	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,610	2,028	25,338	30,976	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.72%

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 7/31/92

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 120 and days of care provided 18,994

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 &amp; ID Number

Lexington of LaGrange

# 0038083

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
	<b>A. General Services</b>										
1	Dietary	412,987	18,890	1,103	432,980		432,980		432,980		1
2	Food Purchase		214,085		214,085		214,085	(22,008)	192,077		2
3	Housekeeping	277,585	28,741		306,326		306,326	157	306,483		3
4	Laundry	50,479	9,979		60,458		60,458		60,458		4
5	Heat and Other Utilities			208,846	208,846		208,846	4,574	213,420		5
6	Maintenance	43,015		177,908	220,923		220,923	30,519	251,442		6
7	Other (specify):* Alloc. Mgmt Co. Benef							6,024	6,024		7
8	<b>TOTAL General Services</b>	784,066	271,695	387,857	1,443,618		1,443,618	19,266	1,462,884		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			50,302	50,302		50,302		50,302		9
10	Nursing and Medical Records	3,781,685	400,031	118,330	4,300,046		4,300,046	26,335	4,326,381		10
10a	Therapy										10a
11	Activities	98,584	13,423	7,920	119,927		119,927		119,927		11
12	Social Services	147,515		3,106	150,621		150,621		150,621		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. Mgmt Co. Benef							3,323	3,323		15
16	<b>TOTAL Health Care and Programs</b>	4,027,784	413,454	179,658	4,620,896		4,620,896	29,658	4,650,554		16
	<b>C. General Administration</b>										
17	Administrative	148,698		1,201,218	1,349,916		1,349,916	(1,162,851)	187,065		17
18	Directors Fees										18
19	Professional Services			216,698	216,698		216,698	(912)	215,786		19
20	Dues, Fees, Subscriptions & Promotions			48,748	48,748		48,748	2,588	51,336		20
21	Clerical & General Office Expenses	204,665	18,473	74,996	298,134		298,134	389,857	687,991		21
22	Employee Benefits & Payroll Taxes			1,004,932	1,004,932		1,004,932	15,757	1,020,689		22
23	Inservice Training & Education			10,062	10,062		10,062	367	10,429		23
24	Travel and Seminar							798	798		24
25	Other Admin. Staff Transportation			6,626	6,626		6,626	7,665	14,291		25
26	Insurance-Prop.Liab.Malpractice			280,398	280,398		280,398	1,958	282,356		26
27	Other (specify):* Alloc. Mgmt Co. Benef							59,743	59,743		27
28	<b>TOTAL General Administration</b>	353,363	18,473	2,843,678	3,215,514		3,215,514	(685,030)	2,530,484		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,165,213	703,622	3,411,193	9,280,028		9,280,028	(636,106)	8,643,922		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 LaGrange

#0038083

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	
	<b>D. Ownership</b>											
30	Depreciation			125,873	125,873		125,873	291,130	417,003			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,393	1,393		1,393	341,517	342,910			32
33	Real Estate Taxes							326,313	326,313			33
34	Rent-Facility & Grounds			1,102,206	1,102,206		1,102,206	(1,099,562)	2,644			34
35	Rent-Equipment & Vehicles			97,691	97,691		97,691	1,547	99,238			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,327,163	1,327,163		1,327,163	(139,055)	1,188,108			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		760,953	2,428,761	3,189,714		3,189,714		3,189,714			39
40	Barber and Beauty Shops			19,111	19,111		19,111		19,111			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			138,450	138,450		138,450		138,450			42
43	Other (specify):* <b>Non-Allowable Co</b>	91,188		163,527	254,715		254,715	(254,715)				43
44	<b>TOTAL Special Cost Centers</b>	91,188	760,953	2,749,849	3,601,990		3,601,990	(254,715)	3,347,275			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,256,401	1,464,575	7,488,205	14,209,181		14,209,181	(1,029,876)	13,179,305			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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# 0038083

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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	(6,251)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,296)	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	(849)	30		9
10	Interest and Other Investment Income	1,109	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,187)	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	(1,700)	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	(24,866)	43		24
25	Fund Raising, Advertising and Promotional	(37,656)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,367)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(938)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (87,001)		\$	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)	(942,875)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (942,875)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (1,029,876)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

Lexington of LaGrange

ID# 0038083

Report Period Beginning: 1/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Reclass Repairs & Maintenance	\$ (15,650)	6	1
2	Labs-Part A	(29,812)	43	2
3	X-Rays-Part A	(42,000)	43	3
4	Diagnostics Managed Care	(11,670)	43	4
5	Trust Fees	(75)	43	5
6	Collections	(8,839)	19	6
7	Out of Period & Non-Allowable Legal	(5,270)	19	7
8	Marketing Salary	(91,188)	43	8
9	Nonallowable Finance Charge	(1,393)	24	9
10	Unrealized loss on FMV swap	212,522	43	10
11	Disallow Marketing Software	(7,228)	19	11
12	Misc Income	(210)	21	12
13	Disallowed Lobbying	(100)	20	13
14	Dues & Subscriptions Marketing	(25)	20	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>		(938)	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 LaGrange Limited Partnership	**	\$ 2,800	\$ 2,800	1
2	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	230,488	230,488	2
3	V	32 Interest Expense		Sambell of LaGrange Limited Partnership	**	329,582	329,582	3
4	V	32 Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	1,339	1,339	4
5	V	33 Property Taxes		Sambell of LaGrange Limited Partnership	**	322,206	322,206	5
6	V	34 Rental Expense	1,102,206	Sambell of LaGrange Limited Partnership	**		(1,102,206)	6
7	V	43 Trust Fees		Sambell of LaGrange Limited Partnership	**	75	75	7
8	V	43 Unrealized loss on FMV swap	212,522	Sambell of LaGrange Limited Partnership	**		(212,522)	8
9	V	43 State Replacement Tax		Sambell of LaGrange Limited Partnership	**	27	27	9
10	V	21 Miscellaneous	29	Sambell of LaGrange Limited Partnership	**		(29)	10
11	V							11
12	V			** The owners of Lexington Health Care Center of LaGrange, In				12
13	V			of Sambell of LaGrange Limited Partnership.				13
14	Total		\$ 1,314,757			\$ 886,517	\$ * (428,240)	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.	**	\$ 157	\$	157	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,067		4,067	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	168		168	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	339		339	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	41,653		41,653	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,341		4,341	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	175		175	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	6,024		6,024	22
23	V	10 Medical consultant		Royal Management Corp.	**	3,359		3,359	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	22,976		22,976	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,323		3,323	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	38,367		38,367	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	10,529		10,529	27
28	V	19 Professional fees		Royal Management Corp.	**	7,096		7,096	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,331		1,331	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	1,382		1,382	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	374,719		374,719	31
32	V	21 Bank charges		Royal Management Corp.	**	1,340		1,340	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	5,374		5,374	33
34	V	21 Postage		Royal Management Corp.	**	2,405		2,405	34
35	V	21 Telephone		Royal Management Corp.	**	6,258		6,258	35
36	V								36
37	V								37
38	V	**The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 535,383	\$ *	535,383	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.	**	\$ 367	\$	367	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	798		798	16	
17	V	25 Auto expense		Royal Management Corp.	**	7,665		7,665	17	
18	V	26 Insurance general		Royal Management Corp.	**	1,958		1,958	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	59,743		59,743	19	
20	V	30 Depreciation		Royal Management Corp.	**	61,491		61,491	20	
21	V	32 Interest		Royal Management Corp.	**	9,645		9,645	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	1,235		1,235	22	
23	V	33 Property taxes		Royal Management Corp.	**	4,107		4,107	23	
24	V	34 Rent expense		Royal Management Corp.	**	2,644		2,644	24	
25	V	35 Equipment rental		Royal Management Corp.	**	876		876	25	
26	V	17 Management fees	1,201,218	Royal Management Corp.	**			(1,201,218)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	671		671	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 LaGrange, Inc. own 100% of Royal Management Corp.								36
37	V								37	
38	V								38	
39	Total		\$ 1,201,218			\$ 151,200	\$ *	(1,050,018)	39	

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

Facility Name &amp; ID Number

Lexington of LaGrange

# 0038083

Report Period Beginning:

1/01/2015

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 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 Elmhurst, Inc.	Elmhurst	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	LaGrange	Real Estate	11
12					LaGrange Ltd. Ptsp.		Property	12
13					Royal Management	Lombard	Mgmt. Company	13
14					Corporation			14
15					Lexington Financial	Lombard	Finance Company	15
16					Services II, LLC			16
17					Heron Point	Lombard	Mgmt. Company	17
18					Management Corp			18
19					Samvest of Lombard	Lombard	Lessor	19
20					II, LLC			20
21					North Heron	Lombard	Finance Company	21
22					Investments, LLC			22
23					Lexington Home	Lombard	Home Health	23
24					Health Care, Inc.			24
25					Lexington Hospice	Lombard	Hospice	25
26					Services, LLC			26
27					Lexington Private	Lombard	Healthcare	27
28					Home Care			28
29					Merit Sleep	Lombard	Mgmt. Company	29
30					Management, LLC			30

Facility Name & ID Number

Lexington of LaGrange

# 0038083

Report Period Beginning:

1/01/2015

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

Facility Name & ID Number Lexington of LaGrange # 0038083 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	\$ 5,546	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,886	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,182	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,688	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	13,841	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 38,143		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 LaGrange

# 0038083

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	43,800	\$ 157	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,169	0	43,800	4,067	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	2,778	0	43,800	168	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	5,597	0	43,800	339	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	687,966	687,966	43,800	41,653	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	71,704	0	43,800	4,341	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	2,893	0	43,800	175	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	99,498	0	43,800	6,024	8
9	10	Medical consultant	Bed Days Available	723,430	10	55,482	0	43,800	3,359	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	379,485	379,485	43,800	22,976	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	54,884	0	43,800	3,323	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	633,695	633,695	43,800	38,367	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	173,912	0	43,800	10,529	13
14	19	Professional fees	Bed Days Available	723,430	10	117,198	0	43,800	7,096	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	21,979	0	43,800	1,331	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	22,821	0	43,800	1,382	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	6,189,117	6,189,117	43,800	374,719	17
18	21	Bank charges	Bed Days Available	723,430	10	22,129	0	43,800	1,340	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	88,755	0	43,800	5,374	19
20	21	Postage	Bed Days Available	723,430	10	39,720	0	43,800	2,405	20
21	21	Telephone	Bed Days Available	723,430	10	103,369	0	43,800	6,258	21
22										22
23										23
24										24
25	TOTALS					\$ 8,842,736	\$ 7,890,263		\$ 535,383	25

Facility Name & ID Number Lexington of LaGrange

# 0038083

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	\$ 43,800	\$ 367	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	13,182	43,800	798	2
3	25	Auto expense	Bed Days Available	723,430	10	126,592	43,800	7,665	3
4	26	Insurance general	Bed Days Available	723,430	10	32,340	43,800	1,958	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	986,762	43,800	59,743	5
6	30	Depreciation	Bed Days Available	723,430	10	1,015,630	43,800	61,491	6
7	32	Interest	Bed Days Available	723,430	10	159,306	43,800	9,645	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	20,406	43,800	1,235	8
9	33	Property taxes	Bed Days Available	723,430	10	67,835	43,800	4,107	9
10	34	Rent expense	Bed Days Available	723,430	10	43,669	43,800	2,644	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,465	43,800	876	11
12	35	Auto Lease	Bed Days Available	723,430	10	11,086	43,800	671	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	\$	\$ 151,200	25

Facility Name &amp; ID Number

Lexington of LaGrange

# 0038083

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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Lexington Financial						\$	\$		\$	1						
2	Sevices II, LLC	X		Mortgage	Varies	4/30/07	5,991,000	4,930,731	5/1/17	0.0650	329,582						
3											3						
4				Finance Charge - Insurance Policy							1,393						
5											5						
<b>Working Capital</b>																	
6	JP Morgan Chase		X	Line of Credit	Various	6/29/13	5,600,000		3/31/16	Libor +2.25%	6						
7											7						
8											8						
9	<b>TOTAL Facility Related</b>						\$ 11,591,000	\$ 4,930,731			\$ 330,975						
<b>B. Non-Facility Related*</b>																	
10											Amortization of Loan Cost	1,339	10				
11											Interest Income offset	1,109	11				
12											Non Allowable Finance Charge	(1,393)	12				
13											Allocated from Mgmt. Co.	10,880	13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 11,935	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 11,591,000	\$ 4,930,731			\$ 342,910	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**

		<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.			\$	<u>367,200</u>	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		\$	<u>363,484</u>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>(3,716)</u>	3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>374,400</u>	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>			\$	<u>16,392</u>	5														
		Allocated from Management Co.		<u>4,107</u>															
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 \$ <u>64,870</u> For <u>12</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<u>(64,870)</u>	6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>326,313</u>	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>244,173</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>331,522</u>	9																
	2012	<u>345,195</u>	10																
	2013	<u>355,813</u>	11																
	2014	<u>363,484</u>	12																
<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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of LaGrange, Inc. COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0038083  
 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>18-08-207-017-0000</u>	<u>Land &amp; Building</u>	\$ <u>202,701.80</u>	\$ <u>202,701.80</u>
2. <u>18-08-207-018-0000</u>	<u>Land &amp; Building</u>	\$ <u>160,781.82</u>	\$ <u>160,781.82</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
4. <u>05-01-202-021</u>	<u>Land &amp; Building</u>	\$ <u>290,524.44</u>	\$ <u>4,107.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>654,008.06</u></u>	\$ <u><u>367,590.62</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?                 YES                 N/A      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: 50,072 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>40,000</u>	<u>1991</u>	<u>\$ 500,000</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>10,781</u>	<u>2</u>
3	<b>TOTALS</b>	<b>40,000</b>		<b>\$ 510,781</b>	<b>3</b>

Facility Name & ID Number Lexington of LaGrange# 0038083

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	120		1992	1992	\$ 2,661,448	\$	35	\$ 76,041	\$ 76,041	\$ 1,786,969	4
5			1995	1995	79,363		10			79,363	5
6			2005	2005	2,321,014		21	110,524	110,524	1,160,504	6
7											7
8											8
	<b>Improvement Type**</b>										
9		Land Improvements	1992		1,152		20			1,152	9
10		Building Improvements	1992		2,714		31			2,714	10
11		Building Improvements	1993		2,901		35	83	83	1,907	11
12		Leasehold Improvements	1994		6,402		10			6,402	12
13		Leasehold Improvements - Corner Guards	1996		2,195		10			2,122	13
14		Wiring	1998		3,378		10			3,378	14
15		Resurface & Restripe Parking Lot	1998		3,753		10			3,753	15
16		Lobby Tile	1998		19,488		10			19,488	16
17		Resurface & Restripe Parking Lot	2000		1,997		10			1,997	17
18		Automatic Door	2000		1,300		10			1,300	18
19		Kitchen Rehab	2001		1,441		10			1,441	19
20		Infrared curtains for elevator	2001		3,000		10			3,000	20
21		Dining room, resident rooms, and corridors renovation	2002		150,083	7,505	20	7,505		98,186	21
22		Elevator upgrade	2002		5,398		10			5,398	22
23		Air conditioner compressor	2003		9,218		10			9,218	23
24		Sidewalk and fencing	2005		46,701	2,335	20	2,335		23,739	24
25		HVAC	2005		8,141	407	20	407		4,104	25
26		Wiring	2005		4,506	225	20	225		2,307	26
27		Lobby, lounge and reception renovations	2005		24,362	1,218	20	1,218		12,586	27
28		1st floor new dining room, floors, ceilings, wallcoverings, doors	2005		326,862		20	16,343	16,343	163,430	28
29		Wallcoverings	2005		10,822		5			10,822	29
30		Medical records room rehab	2006		19,739	987	20	987		8,883	30
31		Activity/PT Room Rehab	2006		1,158	58	20	58		522	31
32		Land scape enhancement	2006		8,726	582	15	582		5,432	32
33		Roof	2006		29,700	1,980	15	1,980		18,480	33
34		HVAC	2006		3,254	163	20	163		1,521	34
35		Plumbing and sprinkler system	2006		20,725	1,036	20	1,036		10,361	35
36		Laundry Combustion Air	2006		16,814	841	20	841		8,199	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 LaGrange# 0038083

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	Lobby/Lounge/Reception rehab	2006	\$ 14,033	\$ 1,403	10	\$ 1,403	\$	\$ 13,329	37
38	Cubicle curtains/drapery	2006	6,955		5			6,955	38
39	Cabinets/counters for 2nd FI library	2006	2,665	267	10	267		2,469	39
40	TCU rehab	2006	2,402	120	20	120		1,090	40
41	First floor remodel	2006	212,084		20	10,604	10,604	95,436	41
42	Kitchen rehab	2006	8,165	408	20	408		3,877	42
43	Bath fixtures-2nd floor	2006	2,076	208	10	208		2,045	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		1,585	44
45	Landscaping	2007	3,862	257	15	257		2,206	45
46	HVAC	2007	58,326	2,916	20	2,916		24,543	46
47	Common Areas Remodel	2007	2,059	206	10	206		1,768	47
48	First Floor Remodel	2007	6,517		20	326	326	2,851	48
49	Garage	2007	16,487	824	20	824		6,661	49
50	Land Improvements	2008	3,745	250	15	250		1,771	50
51	Parking lot-paving	2008	8,720	436	20	436		3,234	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		980	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV.	2008	447,153		27	16,260	16,260	127,370	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		23,287	55
56	Irrigation System	2009	16,740	1,116	15	1,116		6,975	56
57	Landscaping	2009	10,321	688	15	688		4,300	57
58	Parking lot repairs	2009	3,500	175	20	175		1,152	58
59	HVAC Chiller	2009	2,594	130	20	130		834	59
60	Patio Pergola	2009	6,760	338	20	338		2,310	60
61	Stamped Concrete	2009	16,658	833	20	833		5,276	61
62	Fence	2009	4,084	204	20	204		1,241	62
63	Patio Wall	2009	8,212	411	20	411		2,569	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		1,767	64
65									65
66	Brick Panel Replacement	2010	16,578	603	27	603		3,417	66
67	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	17,565	641	27	641		3,205	67
68	Landscaping Enhancements	2010	15,258	1,017	15	1,017		5,594	68
69	Drain tile,sewer concrete	2010	3,221	214	15	214		1,116	69
70	TOTAL (lines 4 thru 69)		\$ 6,882,020	\$ 35,411		\$ 265,592	\$ 230,181	\$ 3,819,892	70

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

Facility Name &amp; ID Number Lexington of LaGrange

# 0038083

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		\$ 6,882,020	\$ 35,411		\$ 265,592	\$ 230,181	\$ 3,819,892	1
2	Retaining wall	2010	15,736	1,049	15	1,049		5,245	2
3	Canopy Installation	2010	4,466	163	27	163		842	3
4	Dining Room HVAC	2010	4,169	152	27	152		836	4
5	Pantry carpentry, flooring, plumbing	2010	2,911	106	27	106		565	5
6	Director of Nursing office painting	2010	4,245	155	27	155		775	6
7	Remodel Library/Lounge-art, painting, flooring	2010	6,477	236	27	236		1,180	7
8	2nd floor doors	2010	3,046	111	27	111		638	8
9	Office changes-carpentry, painting, flooring	2011	2,487	90	27	90		413	9
10	Fence	2011	2,750	183	15	183		763	10
11	Mulch and stone	2011	2,662	177	15	177		738	11
12	Laundry Room-Tile, Painting	2011	7,311	266	27	266		1,153	12
13	Locker Room - Installation of 6 tier box lockers	2011	2,573	94	27	94		431	13
14	Place beds back into service - Carpentry, Flooring, Electrical, -Painting and Plumbing	2011	117,350	4,267	27	4,267		19,557	14
15									15
16									16
17									17
18	Electrical wiring for EMR	2012	13,699	498	27	498		1,536	18
19									19
20	Landscaping (Planting roses and day lilies Main Entrance)	2014	10,648	177	15	177		354	20
21	Install Automatic Doors (Front Entrance)	2014	6,859	83	15	83		166	21
22	Install LED Lights throughout facility	2014	22,200	67	27	67		134	22
23	R/M Reclass: Elevator door restrictor (Front Entrance)	2014	3,500		10	350	350	525	23
24									24
25	Install LED Lights throughout facility	2015	22,799	69	27	69		69	25
26	Electrical wiring throughout facility	2015	5,832	124	27	124		124	26
27	R/M Reclass: asphalt and concrete work in parking lot	2015	15,650		10	391	391	391	27
28									28
29	Reconcile to book depreciation			1,589			(1,589)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,159,390	\$ 45,067		\$ 274,400	\$ 229,333	\$ 3,856,324	34

\*\*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	Totals from Page 12B, Carried Forward		\$ 7,159,390	\$ 45,067		\$ 274,400	\$ 229,333	\$ 3,856,324	1
2									2
3	Building - management company	2002	149,189		40	4,922	4,922	61,758	3
4	HVAC, electrical, security system - management company	2003	1,310		30	350	350	1,001	4
5	Key card system - management company	2004	206		20	11	11	118	5
6	VAV TX controls - management company	2005	63		20	3	3	34	6
7	Interior Signs-management company	2006	46		20	3	3	28	7
8	Building - management company	2008	7,230		20	222	222	2,997	8
9	Building - management company	2009	1,349		20	28	28	474	9
10	Building - management company	2010	1,315		20	27	27	450	10
11	Building - management company	2011	929		20	48	48	194	11
12	Building - management company	2012	3,207		20	7	7	430	12
13	Building - management company	2013	2,424		20	196	196	400	13
14	Building - management company	2014	1,312		20	145	145	198	14
15	Building - management company	2015	231		20	16	16	14	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,328,201	\$ 45,067		\$ 280,378	\$ 235,311	\$ 3,924,420	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 545,175	\$ 74,680	\$ 74,987	\$ 307	5	\$ 376,017	71
72	Current Year Purchases	40,398	6,126	6,126		5-7	6,126	72
73	Fully Depreciated Assets	337,913				5	337,913	73
74	Allocated from Mgmt. Co.	304,571		53,883	53,883	5-7	214,648	74
75	TOTALS	\$ 1,228,057	\$ 80,806	\$ 134,996	\$ 54,190		\$ 934,704	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.			27,285		1,629	1,629	5	24,514	79
80	TOTALS			\$ 27,285	\$	\$ 1,629	\$ 1,629		\$ 24,514	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)	\$ 9,094,324	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,873	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 417,003	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 291,130	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,883,638	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				2,644			6
7	TOTAL				\$ 2,644			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: \$ 98,567 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	Allocated from Management Company			671	20
21	TOTAL		\$	\$ 671	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 LaGrange  
IDPH License ID Number: 0038083  
Fiscal Year End: 12/31/2015

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Copier	7,486
Mailing System	397
Printer	4,870
Medical Equipment	41,706
Oxygen Equipment	43,232
Management Company	876
<b>Total - Line 16</b>	<b><u>98,567</u></b>

Facility Name & ID Number Lexington of LaGrange # 0038083 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><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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	22,809	\$ 837,023	\$	22,809	\$ 837,023	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,492	180,126		4,492	180,126	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(3)	hrs		28,631	1,408,048		28,631	1,408,048	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				737,182		737,182	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Ambulance</u>	39(3)				3,564			3,564	12	
13	Other (specify): <u>See Sch. 16A</u>	39(2)					23,771		23,771	13	
14	<b>TOTAL</b>			\$	55,932	\$ 2,428,761	\$ 760,953	55,932	\$ 3,189,714	14	

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

Facility Name: Lexington of LaGrange  
IDPH License ID Number: 0038083  
Fiscal Year End: 12/31/2015

**Schedule 16A**

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

**Line 13 Other (specify)**

<u>Description</u>	<u>Amount</u>	<u>Line Ref.</u>
Oxygen	12,295	39(2)
DME	11,476	39(2)
<b>Total - Line 13</b>	<b><u>23,771</u></b>	

Facility Name & ID Number Lexington of LaGrange# 0038083Report 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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,660,408	\$ 2,698,212	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>360,318</u> )	2,197,697	2,197,697	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,129	83,129	6
7	Other Prepaid Expenses	5,471	5,471	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,946,705	\$ 4,984,509	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		510,781	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	1,132,021	4,666,753	15
16	Equipment, at Historical Cost	546,733	1,255,342	16
17	Accumulated Depreciation (book methods)	(867,164)	(4,883,638)	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>		22,198	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 818,642	\$ 4,239,936	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,765,347	\$ 9,224,445	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 747,126	\$ 747,126	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	476,809	476,809	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,312	32,312	31
32	Accrued Real Estate Taxes(Sch.IX-B)		374,400	32
33	Accrued Interest Payable		29,287	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	977,568	1,007,784	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,233,815	\$ 2,667,718	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,930,731	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>	\$	\$ 4,930,731	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,233,815	\$ 7,598,449	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,531,532	\$ 1,625,996	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,765,347	\$ 9,224,445	48

\*(See instructions.)

**Facility Name:** Lexington of LaGrange  
**IDPH License ID Number:** 0038083  
**Fiscal Year End:** 12/31/2015

**Schedule 17A**

**XV. Balance Sheet**

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

	<b>Description</b>	<b>Operating</b>	<b>After Consolidation</b>
00-13040-00	Sambel Rent Receivable	0	(279,795)
00-14530-00	PREPAID INSURANCE	2,765	2,765
00-22030-00	ACCRUED EXPENSES	27,196	27,196
00-22040-00	ACCRUED RESIDENT TAX	8,257	8,257
00-22060-00	ACCRUED ROYL / VESTA MGMT FEES	364,061	364,061
00-22120-00	ACCRUED RENT	279,795	279,795
00-22140-00	ACCRUED INSURANCE	8,314	8,314
00-22270-00	DUE TO PATIENT TRUST FUND	(10,074)	(10,074)
00-22330-00	ADVANCE - BIWEEKLY PART A PAYM	(72,169)	(72,169)
00-22360-00	UNCOLLECTIBLE PART A CO PVTS	(71,551)	(71,551)
00-23530-00	DUE TO - ROYAL OPERATIONS	7,689	7,689
00-23720-00	Due to Republic	663	663
00-23770-00	Due to Lake Zurich	(24,710)	(24,710)
00-23820-00	Due to Wheeling	172	172
00-23830-00	DUE/TO FROM VESTA	10,453	10,453
00-24345-00	Sambel Interest Rate Swap Liability	0	310,011
00-24400-00	PROFESSIONAL LIABILITIES CLAIMS	446,707	446,707
	<b>Total - Line 36</b>	<b>977,568</b>	<b>1,007,784</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,721,747	1
2	Restatements (describe):		2
3	Post closing adjustment	(322,908)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,398,839	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	645,693	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	(513,000)	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)	\$ 132,693	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)	\$ 3,531,532	24 *

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

Facility Name & ID Number Lexington of LaGrange# 0038083Report Period Beginning: 1/01/2015Ending: 12/31/2015

**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	\$ 13,939,057	1
2	Discounts and Allowances for all Levels	(9,839,491)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,099,566	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,595,563	6
7	Oxygen	61,026	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 8,656,589	8
<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	182	12
13	Barber and Beauty Care	21,236	13
14	Non-Patient Meals	6,251	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,139,704	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	427,333	19
20	Radiology and X-Ray	65,063	20
21	Other Medical Services	439,849	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,099,618	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	(1,109)	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ (1,109)	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	210	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 210	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,854,874	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,443,618	31
32	Health Care	4,620,896	32
33	General Administration	3,215,514	33
<b>B. Capital Expense</b>			
34	Ownership	1,327,163	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,463,540	35
36	Provider Participation Fee	138,450	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,209,181	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	645,693	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 645,693	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 592,610	44
45	Private Pay - Net Inpatient Revenue	640,296	45
46	Medicare - Net Inpatient Revenue	2,501,557	46
47	Other-(specify) <u>Managed Care</u>	365,103	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,099,566	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 LaGrange

# 0038083

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	1,831	2,044	\$ 131,788	\$ 64.48	1
2	Assistant Director of Nursing	31,365	35,009	1,017,161	29.05	2
3	Registered Nurses	25,922	28,242	863,891	30.59	3
4	Licensed Practical Nurses	25,970	28,404	753,713	26.54	4
5	CNAs & Orderlies	69,380	75,883	983,648	12.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,224	6,985	98,584	14.11	10
11	Social Service Workers	6,731	7,184	147,515	20.53	11
12	Dietician	3,251	3,473	84,560	24.35	12
13	Food Service Supervisor	1,895	2,024	42,981	21.24	13
14	Head Cook	1,949	2,082	33,707	16.19	14
15	Cook Helpers/Assistants	22,797	24,352	251,739	10.34	15
16	Dishwashers					16
17	Maintenance Workers	1,940	2,217	43,015	19.40	17
18	Housekeepers	23,036	25,266	277,585	10.99	18
19	Laundry	4,193	4,728	50,479	10.68	19
20	Administrator	1,709	2,117	148,698	70.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,825	12,166	204,665	16.82	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	1,725	1,926	31,484	16.35	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,307	2,307	91,188	39.53	33
34	TOTAL (lines 1 - 33)	241,950	266,409	\$ 5,256,401 *	\$ 19.73	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 50,302	9(3)	36
37	Medical Records Consultant	25 813	10(3)	37
38	Nurse Consultant	Monthly 5,027	10(3)	38
39	Pharmacist Consultant	Monthly 7,528	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly 4,738	11(3)	44
45	Social Service Consultant	25 3,106	12(3)	45
46	Other(specify) <u>Pulmonary</u>	Monthly 96,424	10(3)	46
47	<u>Medical Consultant</u>	Monthly 3,359	10(7)	47
48	<u>See Sch 20B</u>	Monthly 8,538	10(3)	48
49	TOTAL (lines 35 - 48)	50 \$ 179,835		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 Health Care Center of LaGrange, Inc.  
IDPH License ID Number: 0038083  
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	813	10(3)
Telemedicine Consulting	Monthly	7,725	10(3)
<b>Total - Line 48</b>	<b>0</b>	<b>8,538</b>	

**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	
Renee Mills	Administrator	0	\$ 148,698	Workers' Compensation Insurance	\$ 177,438	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	132,570	Advertising: Employee Recruitment	16,331	
				FICA Taxes	397,177	Health Care Worker Background Check		
				Employee Health Insurance	249,054	(Indicate # of checks performed <u>358</u> )	4,300	
				Employee Meals	15,757	Patient Background Checks	14,345	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	6,276	
				401K	19,431	Miscellaneous Dues & Subscriptions	5,216	
				Other Employee Benefits	17,230	IHCA	265	
				Uniform Expense	1,106	Less non-allowable dues	(100)	
				Tuition	10,926	Management Company Allocation	2,713	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 1,020,689	\$ 51,336		
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			\$ 756,945	N/A			Out-of-State Travel	\$
Management Fees-Vesta Mgmt.			444,273					
Management Fees (Eliminated in Column 7)							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,201,218				Seminar Expense	
							Management Company Allocation	798
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	\$ 798
Vendor/Payee	Type	Amount						
Assessment & Intelligent Systems	PPS Review Consulting	\$ 833						
Cassiday Schade	Legal	66,687						
Duane Morris	Legal	5,271						
Grabowski Law Center , LLC	Collections	8,839						
RSM US LLP	Accounting	45,432						
Personnel Planners	U/C Consulting	1,153						
Much Shelist	Legal	10,703						
Pension Administrators	401K Administration	1,043						
Law Offices of Serpico	Legal	870						
Scott & Kraus	Legal	310						
JP Morgan Chase Bank	Building Appraisal	3,400						
See Schedule 21C		72,157						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 216,698	TOTAL		\$		

\* Attach copy of IMRF notifications

\*\*See instructions.

**Facility Name:** Lexington of LaGrange  
**IDPH License ID Number:** 0038083  
**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
Amazon Marketplace	Computer Services	77
Availity	Computer Services	211
Avatier	Computer Services	330
Bank of America (P KNIGHT)	Computer Services	130
Business Software Inc.	Computer Services	876
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	4,337
Genesis Technology	Computer Services	140
Greenshades Software	Computer Services	71
HealthMedx	Computer Services	2,101
HealthMEDX Software	Computer Services	9,330
Home Depot	Computer Services	1
Infor(US) Inc.	Computer Services	5,881
Inpriva Inc.	Computer Services	99
MHC Software	Computer Services	525
Microsoft Licensing	Computer Services	9,297
National Datacare	Computer Services	1,363
OnShift	Computer Services	3,617
Provinet	Computer Services	356
Relias	Computer Services	6,465
RSM US LLP (McGladrey)	Computer Services	3,725
Salesforce.com	Computer Services	7,228
Softchoice Corporation	Computer Services	3,643

Symbria	Computer Services	2,400
Tableau	Computer Services	407
Trisys	Computer Services	96
	<b>Total (agree to Schedule V, line 19, column 3)</b>	<b>72,157</b>
	Schedule V, line 19 column 3	<b>216,698</b>
	Less:	
	Collection Fees	(8,839)
	Salesforce.com	(7,228)
	Out of Period Legal	(333)
	Non-allowable Legal	(4,937)
	<b>Total Disallowance</b>	<b>(21,337)</b>
	Legal allocated from Real Estate	
	Secretary of State	2,800
	Samvest of Lombard	
	Accounting	68
	Filing Fees	5
		<b>73</b>
Allocated from Mgmt Co.		
Much Shelist	Legal	22
McGladrey LLP	Accounting	795
Frost, Ruttenger & Rothblatt, P.C	Accounting	298
Gilson Labus & Silverman	Accounting	1,636
Illinois Secretary of State	Filing Fees	28
LaSalle Network	Recruiting/Finance	1,885
Pension Administrators, Inc.	401K Administration	261
Gene Whitehorn	Medicaid Reimb Specialist	957
M. Werner Consulting	Financial Consultant	1,132
Personnel Planners	Unemployment Consultant	7
Computer Services (Adding 2 for rounding)	Computer Consulting	10,531
		<b>17,552</b>
	<b>Total (agree to Schedule V, line 19, column 8)</b>	<b>215,786</b>

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>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Lexington of LaGrange# 0038083

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 - \$165
- (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? 5-7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,841 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. \$ 138,450  
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. \$ 15,757 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,251
- (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.