

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

0035188 Report Period Beginning: 1/1/2017 Ending: 12/31/17

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	<u>166</u>	Skilled (SNF)	<u>166</u>	<u>60,590</u>	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	<u>166</u>	TOTALS	<u>166</u>	<u>60,590</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			<u>10,649</u>	<u>10,649</u>	8
9	SNF/PED					9
10	ICF	<u>25,989</u>	<u>7,888</u>	<u>1,333</u>	<u>35,210</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,989</u>	<u>7,888</u>	<u>11,982</u>	<u>45,859</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.69%

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

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

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

YES NO

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

Date started 05/01/89

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

YES Date New Construction NO

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

YES NO If YES, enter number of beds certified 166 and days of care provided 8,110

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Lexington Health Care Center of Bloomingda # 0035188 Report Period Beginning: 1/1/2017 Ending: 12/31/17

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	417,000	31,615	3,815	452,430		452,430	-	452,430		1
2	Food Purchase		298,719		298,719		298,719	(401)	298,318		2
3	Housekeeping	310,955	33,392	53,579	397,926		397,926	246	398,172		3
4	Laundry	-	16,306	-	16,306	-	16,306	-	16,306		4
5	Heat and Other Utilities			217,166	217,166		217,166	7,065	224,231		5
6	Maintenance	33,346	-	234,066	267,412		267,412	96,381	363,793		6
7	Other (specify):* Mgmt. Co. Alloc. Ben	-	-	-	-		-	12,850	12,850		7
8	TOTAL General Services	761,301	380,032	508,626	1,649,959	-	1,649,959	116,141	1,766,100		8
	B. Health Care and Programs										
9	Medical Director	-	-	27,875	27,875		27,875	-	27,875		9
10	Nursing and Medical Records	4,037,718	288,329	657,837	4,983,884		4,983,884	20,988	5,004,872		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	175,550	15,019	6,034	196,603		196,603	-	196,603		11
12	Social Services	153,414	-	4,065	157,479		157,479	-	157,479		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):* Mgmt. Co. Alloc. Ben	-	-	-	-		-	2,789	2,789		15
16	TOTAL Health Care and Programs	4,366,682	303,348	695,811	5,365,841	-	5,365,841	23,777	5,389,618		16
	C. General Administration										
17	Administrative	157,362	-	1,513,082	1,670,444		1,670,444	(1,463,332)	207,112		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			209,563	209,563		209,563	10,740	220,303		19
20	Dues, Fees, Subscriptions & Promotions			40,582	40,582		40,582	6,814	47,396		20
21	Clerical & General Office Expenses	190,245	31,256	38,620	260,121		260,121	674,829	934,950		21
22	Employee Benefits & Payroll Taxes			798,766	798,766		798,766	-	798,766		22
23	Inservice Training & Education			7,958	7,958		7,958	423	8,381		23
24	Travel and Seminar			111	111		111	742	853		24
25	Other Admin. Staff Transportation		-	1,473	1,473		1,473	11,822	13,295		25
26	Insurance-Prop.Liab.Malpractice			620,870	620,870		620,870	7,484	628,354		26
27	Other (specify):* Mgmt. Co. Alloc. Ben	-	-	-	-		-	92,796	92,796		27
28	TOTAL General Administration	347,607	31,256	3,231,025	3,609,888	-	3,609,888	(657,682)	2,952,206		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,475,590	714,636	4,435,462	10,625,688	-	10,625,688	(517,764)	10,107,924		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			125,122	125,122		125,122	300,963	426,085		30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-		31
32	Interest			18,407	18,407		18,407	286,435	304,842		32
33	Real Estate Taxes			-	-		-	151,077	151,077		33
34	Rent-Facility & Grounds			1,237,820	1,237,820		1,237,820	(1,229,643)	8,177		34
35	Rent-Equipment & Vehicles			48,250	48,250		48,250	1,720	49,970		35
36	Other (specify):*			-	-		-	-	-		36
37	TOTAL Ownership			1,429,599	1,429,599	-	1,429,599	(489,448)	940,151		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation	-	-	-	-		-	-	-		38
39	Ancillary Service Centers	-	277,327	1,412,339	1,689,666		1,689,666	-	1,689,666		39
40	Barber and Beauty Shops	-	-	14,261	14,261		14,261	-	14,261		40
41	Coffee and Gift Shops	-	-	1,747	1,747		1,747	(1,719)	28		41
42	Provider Participation Fee			319,476	319,476		319,476	-	319,476		42
43	Other (specify):* Non-Allowable Cos	92,630	-	424,998	517,628		517,628	(517,628)	-		43
44	TOTAL Special Cost Centers	92,630	277,327	2,172,821	2,542,778	-	2,542,778	(519,347)	2,023,431		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,568,220	991,963	8,037,882	14,598,065	-	14,598,065	(1,526,559)	13,071,506		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(401)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,644)	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	41,441	30		9
10	Interest and Other Investment Income	(2,785)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10,033)	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	(2,000)	43		18
19	Entertainment				19
20	Contributions	(2,600)	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	(343,366)	43		24
25	Fund Raising, Advertising and Promotional	(15,588)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,176)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	31,261	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (320,891)		\$	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)	(1,205,668)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,205,668)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,526,559)		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 Health Care Center of Bloomingdale, Inc.

ID# 0035188

Report Period Beginning: 1/1/2017

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Radiology	\$ (15,574)	43	1
2	Laboratory	(19,017)	43	2
3	Trust Fees	(50)	43	3
4	Non-Allowable Marketing Salaries	(92,630)	43	4
5	Cap R/M to Leasehold	(6,800)	6	5
6	Unrealized loss on FMV swap	212,051	43	6
7	Disallowed Lobbying	(3,753)	20	7
8	Gift Shop Income	(1,719)	41	8
9	Non-allowable legal expense	(41,247)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	31,261		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	Professional Fees	\$	Sambell of Bloomingdale Limited Partnership	**	\$ 199	\$ 199	1
2	V	Depreciation Expense		Sambell of Bloomingdale Limited Partnership	**	207,043	207,043	2
3	V	Amortization of Mortgage Cost		Sambell of Bloomingdale Limited Partnership	**	2,171	2,171	3
4	V	Interest	69,678	Sambell of Bloomingdale Limited Partnership	**	340,193	270,515	4
5	V	Property Tax		Sambell of Bloomingdale Limited Partnership	**	145,620	145,620	5
6	V	Rent	1,233,620	Sambell of Bloomingdale Limited Partnership	**		(1,233,620)	6
7	V	Trust Fees		Sambell of Bloomingdale Limited Partnership	**	50	50	7
8	V	Unrealized loss on FMV of Swap	212,051	Sambell of Bloomingdale Limited Partnership	**		(212,051)	8
9	V							9
10	V							10
11	V			** The owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Sambell of Bloomingdale Limited Partnership				11
12	V							12
13	V							13
14	Total		\$ 1,515,349			\$ 695,276	\$ * (820,073)	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.	**	\$ 246	\$	246	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,310		6,310	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	263		263	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	492		492	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	96,712		96,712	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	6,209		6,209	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	260		260	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	12,850		12,850	22	
23	V	10 Medical consultant		Royal Management Corp.	**	0			23	
24	V	10 Management allocation - salaries		Royal Management Corp.	**	20,988		20,988	24	
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	2,789		2,789	25	
26	V	17 Management allocation - salaries		Royal Management Corp.	**	49,750		49,750	26	
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	29,733		29,733	27	
28	V	19 Professional fees		Royal Management Corp.	**	22,055		22,055	28	
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,209		1,209	29	
30	V	20 Advertising - help wanted		Royal Management Corp.	**	9,358		9,358	30	
31	V	21 Management allocation - salaries		Royal Management Corp.	**	648,639		648,639	31	
32	V	21 Bank charges		Royal Management Corp.	**	2,620		2,620	32	
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,587		10,587	33	
34	V	21 Postage		Royal Management Corp.	**	3,134		3,134	34	
35	V	21 Telephone		Royal Management Corp.	**	9,849		9,849	35	
36	V								36	
37	V	** The owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.								37
38	V								38	
39	Total		\$			\$ 934,053	\$ *	934,053	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 <u>Inservice Training</u>	\$	<u>Royal Management Corp.</u>	**	\$ 423	\$	423	15	
16	V	24 <u>Travel & seminar</u>		<u>Royal Management Corp.</u>	**	742		742	16	
17	V	25 <u>Auto expense</u>		<u>Royal Management Corp.</u>	**	11,822		11,822	17	
18	V	26 <u>Insurance general</u>		<u>Royal Management Corp.</u>	**	7,484		7,484	18	
19	V	27 <u>Management allocation - employee benefits</u>		<u>Royal Management Corp.</u>	**	92,796		92,796	19	
20	V	30 <u>Depreciation</u>		<u>Royal Management Corp.</u>	**	52,479		52,479	20	
21	V	32 <u>Interest</u>		<u>Royal Management Corp.</u>	**	14,616		14,616	21	
22	V	32 <u>Amortization of mortgage costs</u>		<u>Royal Management Corp.</u>	**	1,918		1,918	22	
23	V	33 <u>Property taxes</u>		<u>Royal Management Corp.</u>	**	5,457		5,457	23	
24	V	34 <u>Rent expense</u>		<u>Royal Management Corp.</u>	**	3,977		3,977	24	
25	V	35 <u>Equipment rental</u>		<u>Royal Management Corp.</u>	**	1,215		1,215	25	
26	V	17 <u>Management fees</u>	1,513,082	<u>Royal Management Corp.</u>	**			(1,513,082)	26	
27	V	35 <u>Auto Lease</u>		<u>Royal Management Corp.</u>	**	505		505	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V	** The owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.								36
37	V								37	
38	V								38	
39	Total		\$ 1,513,082			\$ 193,434	\$ *	(1,319,648)	39	

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

Facility Name & ID Number

Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning:

1/1/2017

Ending:

12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning:

1/1/2017

Ending:

12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Lexington Health Care Center of Bloomingd # 0035188 Report Period Beginning: 1/1/2017 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 7,816	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,429	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,239	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	10,153	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	13,386	L17, C7	5
6	Phil Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,097	L17, C7	6
7	Jeremy Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,628	L17, C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 49,750		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 Health Care Center of Bloomingdale, Inc. # 0035188 Report Period Beginning: 1/1/2017 Ending: 12/31/17

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	722,335	10	\$ 2,937	\$	60,590	\$ 246	1
2	5	Utilities - gas & electric	722,335	10	75,222		60,590	6,310	2
3	5	Utilities - water & sewer	722,335	10	3,135		60,590	263	3
4	5	Utilities - maintenance office	722,335	10	5,869		60,590	492	4
5	6	Management allocation - salaries	722,335	10	1,152,969	1,152,969	60,590	96,712	5
6	6	Repairs & maintenance	722,335	10	74,022		60,590	6,209	6
7	6	Scavenger & exterminating	722,335	10	3,102		60,590	260	7
8	7	Management allocation - employees	722,335	10	153,196		60,590	12,850	8
9	10	Medical consultant	722,335	10	0		60,590	0	9
10	10	Management allocation - salaries	722,335	10	250,218	250,218	60,590	20,988	10
11	15	Management allocation - employees	722,335	10	33,247		60,590	2,789	11
12	17	Management allocation - salaries	722,335	10	593,100	593,100	60,590	49,750	12
13	19	Computer consultant & supplies	722,335	10	354,473		60,590	29,733	13
14	19	Professional fees	722,335	10	262,937		60,590	22,055	14
15	20	Dues & subscriptions	722,335	10	14,411		60,590	1,209	15
16	20	Advertising - help wanted	722,335	10	111,560		60,590	9,358	16
17	21	Management allocation - salaries	722,335	10	7,732,875	7,732,875	60,590	648,639	17
18	21	Bank charges	722,335	10	31,229		60,590	2,620	18
19	21	Office supplies & printing	722,335	10	126,211		60,590	10,587	19
20	21	Postage	722,335	10	37,365		60,590	3,134	20
21	21	Telephone	722,335	10	117,421		60,590	9,849	21
22									22
23									23
24									24
25	TOTALS				\$ 11,135,499	\$ 9,729,162		\$ 934,053	25

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc. # 0035188 Report Period Beginning: 1/1/2017 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Royal Management Corp.
 Street Address 665 W. North Avenue, Suite 500
 City / State / Zip Code Lombard, IL 60148
 Phone Number (630) 458-4700
 Fax Number (630) 458-4796

1	2	3	4	5	6	7	8	9	
Schedule V 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	722,335	10	\$ 5,038	\$ 60,590	\$ 423	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	8,850	60,590	742	2
3	25	Auto expense	Bed Days Available	722,335	10	140,934	60,590	11,822	3
4	26	Insurance general	Bed Days Available	722,335	10	89,225	60,590	7,484	4
5	27	Management allocation - employees	Bed Days Available	722,335	10	1,106,283	60,590	92,796	5
6	30	Depreciation	Bed Days Available	722,335	10	625,643	60,590	52,479	6
7	32	Interest	Bed Days Available	722,335	10	174,244	60,590	14,616	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	22,869	60,590	1,918	8
9	33	Property taxes	Bed Days Available	722,335	10	65,056	60,590	5,457	9
10	34	Rent expense	Bed Days Available	722,335	10	47,418	60,590	3,977	10
11	35	Equipment rental	Bed Days Available	722,335	10	14,486	60,590	1,215	11
12	35	Auto Lease	Bed Days Available	722,335	10	6,017	60,590	505	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					\$ 2,306,063	\$	\$ 193,434	25

Facility Name & ID Number Lexington Health Care Center of Bloomington # 0035188 Report Period Beginning: 1/1/2017 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lexington Financial					\$		\$		\$	1									
2	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,375,000	4,863,462	1/1/2033	Variable	340,193	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Bank of America		X	Working Capital	None	9/30/2013	300,000	300,000	1/31/2018	Prime/Libor	18,407	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 6,675,000	\$ 5,163,462			\$ 358,600	9								
B. Non-Facility Related*																				
10										Amortization of mortgage cost	2,171	10								
11										Interest Income	(72,463)	11								
12										Allocated from Mgmt Co.	16,534	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (53,758)	14								
15	TOTALS (line 9+line14)						\$ 6,675,000	\$ 5,163,462			\$ 304,842	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 2016 report.			\$	172,800	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.)	2016		\$	157,740	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(15,060)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	160,680	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
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.)		Alloc Fr. Mgmt Co.	\$	5,457	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	151,077	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	163,116	8	FOR BHF USE ONLY	
	2013	169,987	9	13	FROM R. E. TAX STATEMENT FOR 2016 \$
	2014	172,357	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2015	156,302	11	15	LESS REFUND FROM LINE 6 \$
	2016	157,740	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
See attached real estate accrual sheet					

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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0035188

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 2016 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 2016.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>02-15-401-003</u>	<u>Land & Building</u>	\$ <u>157,740.00</u>	\$ <u>157,740.00</u>
2.	<u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>257,787.52</u>	\$ <u>5,457.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>415,527.52</u></u>	\$ <u><u>163,197.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.**

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning:

1/1/2017

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>17,583</u>	<u>2</u>
3	TOTALS	43,000		\$ 420,131	3

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning:

1/1/2017

Ending:

12/31/17

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82	1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 2,442,171	4
5	9	1992	1992	178,974		35	5,114	5,114	132,957	5
6	75	1994	1994	2,022,894		35	57,797	57,797	1,358,228	6
7										7
8										8
	Improvement Type**									
9	Capitalized repairs	1989		9,080		10			9,080	9
10	Building Improvements	1990		3,674		10			3,674	10
11	Building Improvements	1991		2,586		10			2,586	11
12	Building Improvements	1992		3,154		10			2,997	12
13	Building Improvements	1993		1,582		10			1,503	13
14	Building Improvements	1994		15,734		10			15,734	14
15	Land Improvements	1994		1,381		10			1,381	15
16	Land Improvements	1995		1,074		15			1,068	16
17	Building Improvements	1995		1,288		35	37	37	847	17
18	Building Improvements	1995		9,433	270	35	270		6,075	18
19	Building Improvements	1995		43,839	1,252	35	1,252		28,171	19
20	Concrete flooring, fire doors, tile, sprinkler heads, and basement renovation	1996		8,706		15			3,606	21
22	Land improvements	1996		7,858		15			7,858	22
23										23
24	Resident room heaters	1997		3,563	102	35	102		2,140	24
25	Automatic doors	1997		12,950	370	35	370		7,431	25
26	Basement renovation	1997		59,358		10			59,358	26
27	Land Improvement - outdoor flagpoles	1997		1,574		15			1,574	27
28	1st Floor Remodel (Nurses Station/Lounge)	1998		76,487		10			76,487	28
29	Wiring for MDS	1998		4,506		10			4,506	29
30	Flag Pole	1998		787		10			787	30
31	Resurface/Stripe Parking Lot	1998		9,777		10			9,777	31
32	Kitchen tile/paint	1999		718		10			718	32
33	1st Floor Remodel	1999		3,296		10			3,296	33
34	Roof repairs	2000		5,748		15			5,748	34
35	Sump pump	2000		2,534		10			2,534	35
36	Sump pump basin repair	2000		6,307		10			6,307	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning:

1/1/2017

Ending:

12/31/17

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic door closers	2000	\$ 1,300	\$	15	\$	\$	\$ 1,300	37
38	Infrared curtains for elevator doors	2001	3,000		10			3,000	38
39	Ejector pump	2002	3,050		5			3,050	39
40	Lift station pump	2002	3,359		5			3,359	40
41	New asphalt parking lot	2003	16,450		10			16,450	41
42	Roof repairs	2003	2,900		10			2,900	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		2,885	43
44	Kitchen remodel	2003	7,188	359	20	359		5,178	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		44,638	45
46	Floor tile	2003	16,305	815	20	815		12,227	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		53,360	47
48	Rehab-floor tile	2003	8,117	406	20	406		5,717	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		30,068	49
50	Foundation repair	2003	4,800	240	20	240		3,460	50
51	Parking lot	2004	24,550		10			24,550	51
52	Kitchen walk-in cooler floor	2004	7,161		10			7,161	52
53	Old Towne rehab	2004	13,967	698	20	698		9,250	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		136,681	54
55	Create first floor therapy room	2004	185	9	20	9		99	55
56	Transitional unit	2005	213	11	20	11		120	56
57	Landscaping	2005	8,814	441	20	441		5,365	57
58	Roof repairs	2005	3,250	163	20	163		1,982	58
59	HVAC upgrade	2005	7,048	352	20	352		4,343	59
60	Kitchen repair	2005	1,631	82	20	82		1,023	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		11,940	61
62	Window treatments	2005	3,606		5			3,606	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		4,655	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		25,285	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		21,889	65
66	Basement renovation	2005	14,176	709	20	709		8,507	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,126,921	\$ 31,085		\$ 179,225	\$ 148,140	\$ 4,652,647	70

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

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning:

1/1/2017

Ending:

12/31/17

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		\$ 6,126,921	\$ 31,085		\$ 179,225	\$ 148,140	\$ 4,652,647	1
2	Landscaping Enhancement	2006	7084	472	15	472		5,350	2
3	Install Kitchen Sink	2006	2915	146	20	146		1,715	3
4	Common area rehab	2006	2382	119	20	119		1,389	4
5	Paint Building Exterior	2006	19500		5			19,500	5
6	Patio	2006	53305	3,554	15	3,554		39,389	6
7	Retaining Wall	2007	2950	197	15	197		2,101	7
8	Roof Repair	2007	17050	853	20	853		9,169	8
9	Air Conditioning units	2007	4338	217	20	217		2,369	9
10	Paver walk and stairway	2007	10500	525	20	525		5,600	10
11	Fire exit stairways	2007	9379	469	20	469		4,768	11
12	Landscaping	2008	35147	2,343	15	2,343		21,282	12
13	Parking Lot - Seal & Striping	2008	6460	323	20	323		3,069	13
14	Roof	2008	15300	765	20	765		7,395	14
15	HVAC - Spot Coolers	2008	5589	140	40	140		1,260	15
16	Electrical - Storage Room	2008	4768	238	20	238		2,241	16
17	Electrical - Fire Alarm Panel	2008	118395	5,920	20	5,920		53,773	17
18	1st floor remodel-Carpentry,Flooring,Electrical,Parking fixtures	2008	557202		27	20,262	20,262	195,866	18
19	Lawn Irrigation	2009	14435	962	15	962		8,017	19
20	Landscaping	2009	12950	863	15	863		7,048	20
21	Roof	2009	49330	2,467	20	2,467		20,147	21
22	Front Entrance	2009	19392	485	40	485		3,961	22
23	HVAC-Window unit	2009	41315	4,131	10	4,131		36,147	23
24	HVAC Quick connectors	2009	7058	706	10	706		6,177	24
25	Lift pump	2009	14783	1,478	10	1,478		12,070	25
26	Fire alarm panel	2009	93279	4,664	20	4,664		37,701	26
27	Pantry Cabinets	2009	3523	352	10	352		2,875	27
28	Therapy Room counter tops-carpentry	2009	2500	250	10	250		2,188	28
29	Patio Pergola	2009	7930	397	20	397		3,308	29
30	Patio Stamped Concrete	2009	13901	927	15	927		7,802	30
31	Lobby 1st floor remodel-Carpentry,doors frames,electrical	2009	52018		27	1,892	1,892	15,136	31
32	painting,wallpaper								32
33	OT Remodel-carpentry,electrical	2010	791224		27	62,223	62,223	445,932	33
34	TOTAL (lines 1 thru 33)		\$ 8,122,823	\$ 65,048		\$ 297,565	\$ 232,517	\$ 5,637,392	34

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

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning:

1/1/2017

Ending:

12/31/17

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		\$ 8,122,823	\$ 65,048		\$ 297,565	\$ 232,517	\$ 5,637,392	1
2									2
3	Lawn irrigation system	2010	5,503	367	15	367		2,752	3
4	Roof work	2010	15,268	557	27	557		4,177	4
5	HVAC Chiller	2010	84,004	3,064	27	3,064		21,959	5
6	Pantry-shelves	2010	23,805	868	27	868		6,438	6
7	Wanderguard	2010	3,747	137	27	137		993	7
8	Concrete work	2010	7,080	258	27	258		1,849	8
9	Automatic Doors	2010	4,903	490	10	490		3,675	9
10	Physician office carpentry and electrical update	2010	4,677	171	27	171		1,211	10
11	Library/Lounge-art, painting	2010	13,763	502	27	502		3,640	11
12	Pergola and patio wall	2010	21,186	57	27		(57)	21,186	12
13	Office carpentry and electrical changes	2010	5,744	209	27	209		1,498	13
14	Payroll office-painting, carpentry	2011	18,505	673	27	673		4,150	14
15	Mulch stone and perennials	2011	4,364	291	15	291		1,794	15
16	Admissions office-painting, carpentry	2011	2,868	104	27	104		641	16
17	Parking lot lights	2011	6,070	221	27	221		1,363	17
18	Roof work	2011	93,530	3,401	27	3,401		20,689	18
19	Front entrance-awning, doors	2011	11,869	432	27	432		2,951	19
20	Duct extension	2011	3,476	126	27	126		872	20
21	HVAC unit	2011	23,400	851	27	851		5,248	21
22	Fluid pump	2011	8,400	305	27	305		2,085	22
23	Plumbing valves	2011	9,257	337	27	337		2,050	23
24	Laundry room-painting, electrical, tile	2011	8,386	305	27	305		1,906	24
25	Elevator-electrical work	2011	60,523	2,201	27	2,201		13,573	25
26	VCT Floor OT-painting, electrical, carpentry	2011	49,344	1,794	27	1,794		10,914	26
27									27
28	Front entrance door	2012	5,387	196	27	196		1,045	28
29	Sprinklers building	2012	6,500	236	27	236		1,219	29
30	Washing machine slab	2012	3,500	127	27	127		709	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,627,881	\$ 83,328		\$ 315,788	\$ 232,460	\$ 5,777,979	34

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

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning:

1/1/2017

Ending:

12/31/17

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,627,881	\$ 83,328		\$ 315,788	\$ 232,460	\$ 5,777,979	1
2	Generator Exhaust Pipe - Rooftop	2013	9,715	177	27	353	176	1,589	2
3	EMR Wiring - Entire Facility	2013	14,022	42	27	510	468	2,082	3
4									4
5	A/C GAS UNIT - HVAC mechanical room	2014	30,091	1,094	27	1,094		2,736	5
6	R/M - Remodel and relocating kitchen sink	2014	5,205		10	521	521	1,822	6
7	replaced pipes concrete and tile								7
8									8
9									9
10	Furnace in Shower Room	2015	11,971	435	27	435		1,015	10
11	EMR Wiring - Entire Facility	2015	6,233	227	27	227		473	11
12	R&M - Asphalt work in the parking lot	2015	5,800		20	290	290	725	12
13	R&M - PTAC, Heat Pump, Cooling, Heating and	2015	20,633		27	764	764	1,910	13
14	Control systems replacement in mechanical								14
15	room								15
16									16
17	Injections to raise sinking concrete slab for 6 patient rooms &	2016	29,077	1,057	27	1,057		1,057	17
18	Chair Rail Installations in 1st Floor Rooms								18
19	Furnish/Install Cabinets in Lower Level Activity Room	2016	3,560	712	5	712		949	19
20	Furnish & Install 5 Rods/Valances for 8 Windows	2016	3,945	564	7	564		987	20
21	- Common Areas / Hallways								21
22	R&M: Replace Sanitary Line in Kitchen	2016	6,250		20	313	313	469	22
23	- Furnish & Install Cast Iron Piping, Lime Stone, Concrete & Ti								23
24	R&M: Heat Pump - HVAC Mechanical Room	2016	6,190		10	619	619	929	24
25	R&M: Remove 10 Trees & Install 4 New Trees - Outside NH	2016	9,511		20	476	476	714	25
26									26
27	R&M: 4" pipe furnished and installed plumbing work in Kitchen	2017	3,800		27	70	70	70	27
28	R&M: Remove asphalt; add concrete & sewer rebuild in parking l	2017	3,000		27	75	75	75	28
29									29
30									30
31	Reconcile to book depreciation			663			(663)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,796,884	\$ 88,299		\$ 323,867	\$ 235,568	\$ 5,795,580	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 12D, Carried Forward		\$ 8,796,884	\$ 88,299		\$ 323,867	\$ 235,568	\$ 5,795,580	1
2	Building - management company	2002	243,320		40	5,464	5,464	113,507	2
3	HVAC, electrical, security system - management company	2003	2,137		30	521	521	1,762	3
4	Key card system - management company	2004	336		20	17	17	225	4
5	VAV TX controls - management company	2005	102		20	5	5	66	5
6	Interior Signs - management company	2006	74		20	5	5	55	6
7	Building improvements - management company	2008	11,025		20	130	130	4,706	7
8	Building improvements - management company	2009	2,167		20	40	40	1,000	8
9	Building improvements - management company	2010	2,115		20	39	39	907	9
10	Building improvements - management company	2011	1,515		20	70	70	458	10
11	Building improvements - management company	2012	5,121		20	10	10	1,064	11
12	Building improvements - management company	2013	3,953		20	284	284	1,228	12
13	Building improvements - management company	2014	2,139		20	211	211	751	13
14	Building improvements - management company	2015	376		20	45	45	115	14
15	Building improvements - management company	2016	6,207		20	454	454	639	15
16	Building improvements - management company	2017	4,036		20	50	50	76	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,081,507	\$ 88,299		\$ 331,212	\$ 242,913	\$ 5,922,139	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	\$ 377,393	\$ 36,216	\$ 49,132	\$ 12,916	5-10	\$ 319,515	71
72	Current Year Purchases	18,210	607	607	0	10	607	72
73	Fully Depreciated Assets	687,322				5-7	687,322	73
74	Allocated from Mgmt. Co.	494,795		43,267	43,267	5-7	445,004	74
75	TOTALS	\$ 1,577,720	\$ 36,823	\$ 93,007	\$ 56,184		\$ 1,452,448	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.			44,508		1,866	1,866	5	41,415	79
80	TOTALS			\$ 44,508	\$	\$ 1,866	\$ 1,866		\$ 41,415	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,123,866	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,122	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 426,085	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 300,963	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,416,002	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Parking Space Lease				4,200			5
6	Allocated from Mgmt. Co.				3,977			6
7	TOTAL				\$ 8,177			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 49,465 Description: Copier-\$7,962, Postage machine - \$313, Med Eq.-\$13,522, Oxy Eq.-\$26,454, Mgmt. Co.-\$1,215

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Mgmt. Co.			505	20
21	TOTAL		\$	\$ 505	21

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

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

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc. # 0035188 Report Period Beginning: 1/1/2017 Ending: 12/31/17

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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	9,869	\$ 551,625	\$	9,869	\$ 551,625	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,728	215,372		4,728	215,372	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		13,929	644,862		13,929	644,862	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				255,726		255,726	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Schedule 16A</u>	39(2)					21,601		21,601	12
13	Other (specify): <u>Ambulance</u>	39(3)				480			480	13
14	TOTAL			\$	28,526	\$ 1,412,339	\$ 277,327	28,526	\$ 1,689,666	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 Bloomingdale, Inc.
IDPH License ID Number: 0035188
Fiscal Year End: 12/31/17

Schedule 16A

XIV. Special Services (Direct Cost)

Line 12 Other (specify)

Description	Amount
Oxygen	5,300
DME	10,367
Rehab Supplies	5,934
Total - Line 12	<u>21,601</u>

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning: 1/1/2017

Ending: 12/31/17

12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,306,292	\$ 1,398,688	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>695,353</u>)	1,569,161	1,569,161	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,209	73,209	6
7	Other Prepaid Expenses	31,588	31,588	7
8	Accounts Receivable (owners or related parties)		1,138,746	8
9	Other(specify): <u>Interest Receivable</u>	50,893	50,893	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,031,143	\$ 4,262,285	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,261	64,261	12
13	Land		420,131	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	2,080,395	3,898,776	15
16	Equipment, at Historical Cost	586,632	1,622,228	16
17	Accumulated Depreciation (book methods)	(1,639,846)	(7,416,002)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Insurance Recovery</u>)	593,022	593,022	22
23	Other(specify): <u>Mortgage Cost, net</u>		37,402	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,684,464	\$ 4,402,549	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,715,607	\$ 8,664,834	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 580,095	\$ 580,095	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	345,948	345,948	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,524	10,524	31
32	Accrued Real Estate Taxes(Sch.IX-B)		160,680	32
33	Accrued Interest Payable		35,579	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	3,325,632	704,497	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,562,199	\$ 2,137,323	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,863,462	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Professional Liabilities Claims</u>	878,461	878,461	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 878,461	\$ 5,741,923	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,440,660	\$ 7,879,246	46
47	TOTAL EQUITY(page 18, line 24)	\$ (725,053)	\$ 785,588	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,715,607	\$ 8,664,834	48

*(See instructions.)

Facility Name: Lexington Health Care Center of Bloomingdale, Inc.
IDPH License ID Number: 0035188
Fiscal Year End: 12/31/17

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

	<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
00-10140-00	Cash Patient Trust	58,492	58,492
00-12020-00	PA Audit Settlement	274,326	274,326
00-13040-00	Sambell Rent Receivable	-	(2,732,259)
00-13250-00	Due to/from Rehab Care Therapy	(2,073)	(2,073)
00-13700-00	Due From LLC 1	-	1,276
00-13714-00	Due from/to LHCC Bloomingdale	-	25,740
00-14530-00	Prepaid Insurance	30,294	30,294
00-21030-00	Cobra	4,171	4,171
00-21040-00	Withholding - Dental Insurance	255	255
00-21050-00	Withholding - EP/CI/WL	736	736
00-21060-00	Withholding - short term disability	-	-
00-21065-00	Life insurance withholding	-	-
00-21085-00	Vision Withholding	(329)	(329)
00-21100-00	401K Withholding	9,796	9,796
00-22030-00	Accrued Expenses	91,086	91,086
00-22040-00	Accrued Resident Tax	37,792	37,792
00-22060-00	Accrued Royal / Vesta Mgmt Fees	25,561	25,561
00-22120-00	Accrued Rent	2,732,259	2,732,259
00-22140-00	Accrued Insurance	75,108	75,108
00-22270-00	Due To Patient Trust Fund	(57,803)	(57,803)
00-22330-00	Advance - Biweekly Part A Paym	(22,160)	(22,160)
00-22360-00	Uncollectible Part A Co Pvts	(19,831)	(19,831)
00-23530-00	Due To - Royal Operations	36,984	36,984
00-23720-00	Due To Republic	8,981	8,981
00-23750-00	Due To LHCC Elmhurst	317	317
00-23760-00	Due To LHCC LaGrange	17,605	17,605
00-23780-00	Due To LHCC Lombard	366	366
00-23800-00	Due To Schaumburg	23,699	23,699
00-24345-00	Sambell Interest Rate Swap Liability	-	84,108
	Total - Line 36	3,325,632	704,497
		-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 557,355	1
2	Restatements (describe):		2
3	Post Closing Adjustment	15,438	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 572,793	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,297,846)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,297,846)	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)	\$ (725,053)	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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,977,528	1
2	Discounts and Allowances for all Levels	(8,167,800)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,809,728	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,631,410	6
7	Oxygen	35,325	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,666,735	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,719	12
13	Barber and Beauty Care	16,259	13
14	Non-Patient Meals	401	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	446,547	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	152,317	19
20	Radiology and X-Ray	23,761	20
21	Other Medical Services	179,967	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 820,971	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,785	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,785	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)	\$ 13,300,219	30

1		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,649,959	31
32	Health Care	5,365,841	32
33	General Administration	3,609,888	33
B. Capital Expense			
34	Ownership	1,429,599	34
C. Ancillary Expense			
35	Special Cost Centers	2,223,302	35
36	Provider Participation Fee	319,476	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,598,065	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,297,846)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,297,846)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,492,925	44
45	Private Pay - Net Inpatient Revenue	1,775,770	45
46	Medicare - Net Inpatient Revenue	1,010,260	46
47	Other-(specify) Managed Care	1,530,773	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,809,728	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 Health Care Center of Bloomingdale, Inc.

0035188

Report Period Beginning: 1/1/2017

Ending: 12/31/17

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	1,654	2,116	\$ 130,791	\$ 61.82	1
2	Assistant Director of Nursing	1,696	2,106	85,336	40.53	2
3	Registered Nurses	29,468	39,403	1,284,377	32.60	3
4	Licensed Practical Nurses	18,239	24,054	633,603	26.34	4
5	CNAs & Orderlies	62,939	78,851	1,277,818	16.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,423	1,744	36,576	20.97	9
10	Activity Assistants	7,831	9,616	138,974	14.45	10
11	Social Service Workers	5,524	6,732	153,414	22.79	11
12	Dietician			27,688		12
13	Food Service Supervisor	1,760	2,067	47,225	22.85	13
14	Head Cook	1,753	2,107	38,919	18.47	14
15	Cook Helpers/Assistants	21,616	25,473	303,169	11.90	15
16	Dishwashers					16
17	Maintenance Workers	1,314	1,779	33,346	18.74	17
18	Housekeepers	21,569	26,751	310,955	11.62	18
19	Laundry					19
20	Administrator	1,792	2,289	157,362	68.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,419	11,039	190,245	17.23	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					31
32	Other Health C: <u>See Sch 20A</u>	18,523	23,154	625,793	27.03	32
33	Other(specify) <u>Marketing</u>	1,764	2,017	92,630	45.93	33
34	TOTAL (lines 1 - 33)	207,286	261,298	\$ 5,568,220 *	\$ 21.31	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 27,875	9(3)	36
37	Medical Records Consultant	Monthly 748	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 14,241	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 2,369	11(3)	44
45	Social Service Consultant	Monthly 4,065	12(3)	45
46	Other(specify) <u>Pulmonary</u>	Monthly 18,365	10(3)	46
47				47
48	<u>See Sch 20B</u>	Monthly 10,435	10(3)	48
49	TOTAL (lines 35 - 48)	\$ 78,098		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$		50	
51	Licensed Practical Nurses			51	
52	Certified Nurse Assistants/Aides	22,617	614,048	10(3)	52
53	TOTAL (lines 50 - 52)	22,617	\$ 614,048		53

Facility Name: Lexington Health Care Center of Bloomingdale, Inc.
IDPH License ID Number: 0035188
Fiscal Year End: 12/31/17

Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Staffing Coordinator	2,507	3,002	52,372	\$ 17.44
Unit Secretary	5,765	7,135	171,930	24.10
Accounts Coordinator	1,562	2,004	34,093	17.02
Admissions	1,661	1,941	54,990	28.33
MDS	3,196	4,085	146,485	35.86
Clinical Coordinator	2,096	2,688	99,487	37.02
Transitional Care Nurse	224	267	8,716	32.71
Wound Care Coordinator	1,511	2,033	57,721	28.39
Total - Line 32 Other Health Care (specify):	18,523	23,154	625,793	\$ 27.03

Facility Name: Lexington Health Care Center of Bloomingdale, Inc.
IDPH License ID Number: 0035188
Fiscal Year End: 12/31/17

Schedule 20B

XVIII. SUPPORT SCHEDULES

B. Consultant Services

Description	# of Hrs. Paid and Accrued	Total Consultant Cost	Ref.
Post Acute Consulting	Monthly	1,335	10(3)
Telemedicine	Monthly	9,100	10(3)
Total - Line 48	Monthly	10,435	

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		
Anshu Raina	Administrator	0	157,362	Workers' Compensation Insurance	\$	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	23,211	Advertising: Employee Recruitment	6,741		
				FICA Taxes	418,594	Health Care Worker Background Check			
				Employee Health Insurance	299,472	(Indicate # of checks performed <u>177</u>)	2,130		
				Employee Meals		Patient Background Checks	604 7,246		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	3,720		
				401(k) Contributions	31,119	Miscellaneous Dues & Subscriptions	7,750		
				Other Employee Benefits	24,866	IHCA	11,005		
				Uniform Allowance	949	Less: Non-Allowable Dues	(3,753)		
				Tuition	555	Management Company Allocation	10,567		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 157,362	TOTAL (agree to Schedule V, line 22, col.8)		\$ 798,766	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 47,396
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-Royal Operating			\$ 1,116,497	N/A		\$	Out-of-State Travel	\$	
Management Fees-Vesta Mgmt.			396,585						
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,513,082				Seminar Expense	111	
C. Professional Services									
Vendor/Payee	Type		Amount						
RSM US LLP	Accounting		\$ 35,590						
Much Shelist	Legal		6,691						
Serpico, Petrosino, Dipiero & O'shea	Legal		8,127						
Vannessa Wells	Legal		500						
Hughes Socol Piers Resnick & Dym	Legal		369						
Suzanne Wolber	Legal		500						
Dunane Morris	Legal		3,236						
McGuire Woods	Legal		4,287						
Pension Administrators	401K Administration		1,827						
Attadale Partners	Operations Consulting		(83)						
Personal Planners	U/C Consulting		1,215						
See Sch 21C	See Sch 21C		147,304						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 209,563	TOTAL		\$	Management Company Allocation	742	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 853	

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Lexington Health Care Center of Bloomingdale, Inc.
 IDPH License ID Number: 0035188
 Fiscal Year End: 12/31/17

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Lexington Financial Services	Financial	20,853
Royal Management	Consulting	65
Much Shelist	Collections	41,178
Lawson	Computer services	6,212
Replacement Local Servers	Computer services	2,012
Softchoice	Computer services	9,291
Ability Network	Computer services	271
Information Control	Computer services	(63)
Symbria	Computer services	200
EHDS	Computer services	2,567
Relias	Computer services	1,565
Salesforce.com	Computer services	(4,594)
Onshift	Computer services	6,891
Royal Management	Computer services	47,303
MHC Software	Computer services	165
Onshift	Computer services	(6,966)
National Data Care	Computer services	2,171
ICIM Software	Computer services	(789)
Carewatch	Computer services	(2,567)
BSI	Computer services	469
Microsoft	Computer services	9,553
HealthMedX	Computer services	7,044
GP Software	Computer services	4,472
		147,304

Total (agree to Schedule V, line 19, column 3) 209,562.63

Allocated from Real Estate Entity	Professional Services	199
Less: Non-Allowable Legal Fees		(41,247)

Allocated from Mgmt. Co.

Much Shelist Legal	1,400
Hinshaw & Culbertson LLP Legal	193
Duane Morris Legal	1,652
Serpico, Petrosino Legal	10
Golan and Christie Legal	17
RSM Accounting	1,146
Friedman & Huey Accounting	613
IL Secretary of State Filing Fees	40
Gilson Labus & Silverman LLC Accounting	544
Marcum LLP Accounting	268
LaSalle Network Recruiting / Finance	963
Pension Administrators, Inc. 401K Administration	(99)
Gene Whitehorn Medicaid Reimb Specialist	1,564
M Werner Consulting Financial Consulting	802
Eisen Alliance LLC Workplace Consultant	250
Barry Lazarus Health Care Consultant	214
Mark Rodeghier Survey Preparation Consultant	553
Pathway Health Services Operational & Financial Consulti	1,922
IMEC Operational & Financial Consulti	4,672
Forest Performance Performance Consulting	1,430
Reputation.com Performance Consulting	857
Devree Molnar Strategy/Operations Consulting	120
Steven Wood Strategy/Operations Consulting	247
Susan Parker Social Service Consultant	14
Focus Pointe Global Strategic Planning	984
CLIN-SCIENCE RESEARCH General Business Consulting	324
Provinet Solutions Technical Consulting	12
ANDRZJ STANKIEWIC General Business Consulting	77
DLC Financial Planning & Analysis	1,141
Computer Services Computer Consulting	29,733
	51,663

Allocated from SV of Lombard II

Friedman & Huey Accounting	112
Illinois Secretary of State Filing Fees	13
	124

Total (agree to Schedule V, line 19, column 8) 220,303

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 - \$11,005
- (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? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,639 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. \$ 319,476
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 401
- (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? N/A Adequate records have been maintain
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees