

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

0037317 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF			13,695	13,695	8
9	SNF/PED					9
10	ICF	7,999	10,957	709	19,665	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,999	10,957	14,404	33,360	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.03%

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 11/12/91

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 142 and days of care provided 9,025

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: 12/31/2017 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 Elmhurst, I # 0037317 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	549,440	27,092	738	577,270		577,270	-	577,270		1
2	Food Purchase		253,599		253,599		253,599	(2,434)	251,165		2
3	Housekeeping	325,342	26,263	-	351,605		351,605	215	351,820		3
4	Laundry	-	12,709	-	12,709	-	12,709	-	12,709		4
5	Heat and Other Utilities			194,354	194,354		194,354	6,171	200,525		5
6	Maintenance	47,828	-	150,030	197,858		197,858	90,128	287,986		6
7	Other (specify):* Mgmt Co. Alloc. Bene	-	-	-	-		-	11,225	11,225		7
8	TOTAL General Services	922,610	319,663	345,122	1,587,395	-	1,587,395	105,305	1,692,700		8
	B. Health Care and Programs										
9	Medical Director	-	-	80,900	80,900		80,900	-	80,900		9
10	Nursing and Medical Records	3,978,241	308,871	140,123	4,427,235		4,427,235	18,333	4,445,568		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	125,441	14,194	8,021	147,656		147,656	-	147,656		11
12	Social Services	142,237	-	3,219	145,456		145,456	-	145,456		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):* Mgmt Co. Alloc. Bene	-	-	-	-		-	2,436	2,436		15
16	TOTAL Health Care and Programs	4,245,919	323,065	232,263	4,801,247	-	4,801,247	20,769	4,822,016		16
	C. General Administration										
17	Administrative	143,511	-	1,084,168	1,227,679		1,227,679	(1,040,712)	186,967		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			179,866	179,866		179,866	(3,658)	176,208		19
20	Dues, Fees, Subscriptions & Promotions			43,795	43,795		43,795	5,774	49,569		20
21	Clerical & General Office Expenses	163,740	20,502	36,766	221,008		221,008	589,459	810,467		21
22	Employee Benefits & Payroll Taxes			885,005	885,005		885,005	-	885,005		22
23	Inservice Training & Education			10,140	10,140		10,140	369	10,509		23
24	Travel and Seminar			111	111		111	648	759		24
25	Other Admin. Staff Transportation		-	5,037	5,037		5,037	10,326	15,363		25
26	Insurance-Prop.Liab.Malpractice			525,797	525,797		525,797	6,537	532,334		26
27	Other (specify):* Mgmt Co. Alloc. Bene	-	-	-	-		-	81,057	81,057		27
28	TOTAL General Administration	307,251	20,502	2,770,685	3,098,438	-	3,098,438	(350,200)	2,748,238		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,475,780	663,230	3,348,070	9,487,080	-	9,487,080	(224,126)	9,262,954		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			104,192	104,192		104,192	203,446	307,638			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			465	465		465	202,392	202,857			32
33	Real Estate Taxes			-	-		-	84,447	84,447			33
34	Rent-Facility & Grounds			1,015,680	1,015,680		1,015,680	(1,012,206)	3,474			34
35	Rent-Equipment & Vehicles			81,226	81,226		81,226	1,502	82,728			35
36	Other (specify):*			-	-		-	-	-			36
37	TOTAL Ownership			1,201,563	1,201,563	-	1,201,563	(520,419)	681,144			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	477,802	1,352,596	1,830,398		1,830,398	-	1,830,398			39
40	Barber and Beauty Shops	-	-	7,921	7,921		7,921	(7,921)	-			40
41	Coffee and Gift Shops	-	-	1,555	1,555		1,555	(108)	1,447			41
42	Provider Participation Fee			228,689	228,689		228,689	-	228,689			42
43	Other (specify):* Non-Allowable Cos	107,701	-	414,673	522,374		522,374	(522,374)	-			43
44	TOTAL Special Cost Centers	107,701	477,802	2,005,434	2,590,937	-	2,590,937	(530,403)	2,060,534			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,583,481	1,141,032	6,555,067	13,279,580	-	13,279,580	(1,274,948)	12,004,632			45

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

Lexington Health Care Center of Elmhurst, Inc.

ID# 0037317

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (31,648)	43	1
2	X-Rays-Part A	(34,053)	43	2
3	Diagnostics Managed Care	(9,445)	43	3
4	Trust Fees	(50)	43	4
5	Unrealized (gain)/Loss on FMV of swap	80,337	43	5
6	Collection Fees	(51,120)	19	6
7	Out of Period Legal Fees	(2,569)	19	7
8	Marketing Salary	(107,701)	43	8
9	Gift Shop Income	(108)	41	9
10	Non-Allowable IHCA & AHCA Dues	(3,456)	20	10
11	(Gain)/loss on sale on Disposal of assets	(50,784)	43	11
12	Offset marketing	4,594	19	12
13	Offset barber & beauty	(7,921)	40	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(213,924)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Fees	\$	Sambell of Elmhurst II Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation		Sambell of Elmhurst II Limited Partnership	**	155,771	155,771	2
3	V	32 Interest expense	39,351	Sambell of Elmhurst II Limited Partnership	**	210,183	170,832	3
4	V	32 Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	20,588	20,588	4
5	V	33 Property taxes		Sambell of Elmhurst II Limited Partnership	**	79,680	79,680	5
6	V	34 Rental expense	1,015,680	Sambell of Elmhurst II Limited Partnership	**		(1,015,680)	6
7	V	43 Unrealized loss on FMV swap	80,337	Sambell of Elmhurst II Limited Partnership	**		(80,337)	7
8	V	43 Trust fees		Sambell of Elmhurst II Limited Partnership	**	50	50	8
9	V	43 (Gain)/Loss on Sale of Disposal of Assets				50,784	50,784	9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				12
13	V			of Sambell of Elmhurst II Limited Partnership				13
14	Total		\$ 1,135,368			\$ 517,256	\$ * (618,112)	14

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.	**	\$ 215	\$	215	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	5,511		5,511	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	230		230	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	430		430	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	84,477		84,477	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,424		5,424	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	227		227	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	11,225		11,225	22
23	V	10 Medical consultant		Royal Management Corp.	**	0			23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	18,333		18,333	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	2,436		2,436	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	43,456		43,456	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	25,972		25,972	27
28	V	19 Professional fees		Royal Management Corp.	**	19,265		19,265	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,056		1,056	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	8,174		8,174	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	566,583		566,583	31
32	V	21 Bank charges		Royal Management Corp.	**	2,288		2,288	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	9,247		9,247	33
34	V	21 Postage		Royal Management Corp.	**	2,738		2,738	34
35	V	21 Telephone		Royal Management Corp.	**	8,603		8,603	35
36	V								36
37	V								37
38	V	** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 815,890	\$ *	815,890	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.	**	\$ 369	\$	369	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	648		648	16	
17	V	25 Auto expense		Royal Management Corp.	**	10,326		10,326	17	
18	V	26 Insurance general		Royal Management Corp.	**	6,537		6,537	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	81,057		81,057	19	
20	V	30 Depreciation		Royal Management Corp.	**	45,840		45,840	20	
21	V	32 Interest		Royal Management Corp.	**	12,767		12,767	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	1,676		1,676	22	
23	V	33 Property taxes		Royal Management Corp.	**	4,767		4,767	23	
24	V	34 Rent expense		Royal Management Corp.	**	3,474		3,474	24	
25	V	35 Equipment rental		Royal Management Corp.	**	1,061		1,061	25	
26	V	17 Management fees	1,084,168	Royal Management Corp.	**			(1,084,168)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	441		441	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V	** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.								36
37	V								37	
38	V								38	
39	Total		\$ 1,084,168			\$ 168,963	\$ *	(915,205)	39	

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

Facility Name & ID Number

Lexington Health Care Center of Elmhurst, Inc.

0037317

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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 Living	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	of Algonquin, LLC		Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr. of LaGrange, Inc.	LaGrange			Mgmt. Company	3
4			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lexington Square Life	Lombard	Independent and	4
5			Lexington HC Ctr. of Lombard, Inc.	Lombard	Care of Lombard, LLC		Assisted Living	5
6			Lexington HC Ctr. of Orland Park, Inc.	Orland Park			Facility	6
7			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Lexington Square Life	Elmhurst	Independent Living	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Care of Elmhurst, LLC		Facility	8
9			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Vesta Management	Lombard	Mgmt. Company	9
10					Group LLC			10
11					Sambell of Elmhurst II	Elmhurst	Real Estate	11
12					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 Mgmt	Lombard	Mgmt. Company	17
18					Corporation			18
19					Samvest of Lombard I	Lombard	Lessor	19
20					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 Health Care Center of Elmhurst, IL # 0037317 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/Officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 6,828	L 17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,743	L 17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,323	L 17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,869	L 17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	11,693	L 17, C7	5
6	Phil Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,832	L 17, C7	6
7	Jeremy Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,169	L 17, C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,456		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 Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	\$	52,925	\$ 215	1
2	5	Utilities - gas & electric	722,335	10	75,222		52,925	5,511	2
3	5	Utilities - water & sewer	722,335	10	3,135		52,925	230	3
4	5	Utilities - maintenance office	722,335	10	5,869		52,925	430	4
5	6	Management allocation - salaries	722,335	10	1,152,969	1,152,969	52,925	84,477	5
6	6	Repairs & maintenance	722,335	10	74,022		52,925	5,424	6
7	6	Scavenger & exterminating	722,335	10	3,102		52,925	227	7
8	7	Management allocation - employees	722,335	10	153,196		52,925	11,225	8
9	10	Medical consultant	722,335	10	0		52,925	0	9
10	10	Management allocation - salaries	722,335	10	250,218	250,218	52,925	18,333	10
11	15	Management allocation - employees	722,335	10	33,247		52,925	2,436	11
12	17	Management allocation - salaries	722,335	10	593,100	593,100	52,925	43,456	12
13	19	Computer consultant & supplies	722,335	10	354,473		52,925	25,972	13
14	19	Professional fees	722,335	10	262,937		52,925	19,265	14
15	20	Dues & subscriptions	722,335	10	14,411		52,925	1,056	15
16	20	Advertising - help wanted	722,335	10	111,560		52,925	8,174	16
17	21	Management allocation - salaries	722,335	10	7,732,875	7,732,875	52,925	566,583	17
18	21	Bank charges	722,335	10	31,229		52,925	2,288	18
19	21	Office supplies & printing	722,335	10	126,211		52,925	9,247	19
20	21	Postage	722,335	10	37,365		52,925	2,738	20
21	21	Telephone	722,335	10	117,421		52,925	8,603	21
22									22
23									23
24									24
25	TOTALS				\$ 11,135,499	\$ 9,729,162		\$ 815,890	25

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	722,335	10	\$ 5,038	\$ 52,925	\$ 369	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	8,850	52,925	648	2
3	25	Auto expense	Bed Days Available	722,335	10	140,934	52,925	10,326	3
4	26	Insurance general	Bed Days Available	722,335	10	89,225	52,925	6,537	4
5	27	Management allocation - employees	Bed Days Available	722,335	10	1,106,283	52,925	81,057	5
6	30	Depreciation	Bed Days Available	722,335	10	625,643	52,925	45,840	6
7	32	Interest	Bed Days Available	722,335	10	174,244	52,925	12,767	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	22,869	52,925	1,676	8
9	33	Property taxes	Bed Days Available	722,335	10	65,056	52,925	4,767	9
10	34	Rent expense	Bed Days Available	722,335	10	47,418	52,925	3,474	10
11	35	Equipment rental	Bed Days Available	722,335	10	14,486	52,925	1,061	11
12	35	Auto Lease	Bed Days Available	722,335	10	6,017	52,925	441	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	\$	\$ 168,963	25

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.		\$	<u>75,000</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.)	2016	\$	<u>73,680</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,320)</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>81,000</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. (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.	\$	<u>4,767</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>84,447</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>73,433</u>	8
	2013	<u>75,652</u>	9
	2014	<u>76,511</u>	10
	2015	<u>72,948</u>	11
	2016	<u>73,680</u>	12

[See attached real estate accrual sheet](#)

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0037317

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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 Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>06-14-317-008</u>	<u>Land & Building</u>	\$ <u>73,680.00</u>	\$ <u>73,680.00</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>4,767.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>331,467.52</u>	\$ <u>78,447.00</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 Elmhurst, Inc.

0037317 Report Period Beginning:

01/01/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

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

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

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

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

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

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

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>55,000</u>	<u>1991</u>	<u>\$ 1,277,670</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>15,334</u>	<u>2</u>
3	TOTALS	55,000		\$ 1,293,004	3

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

0037317

Report Period Beginning:

01/01/2017 Ending:

12/31/2017

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	133	1991	1991	\$ 4,110,586	\$	35	\$ 117,445	\$ 117,445	\$ 3,066,345	4
5	12	1995	1995	73,302	2,095	35	2,095		47,451	5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvement	1992		693	20	35	20		501	9
10	Land Improvement	1995		7,500		15			7,500	10
11	Fan Coil Units	1996		4,904	140	35	140		3,012	11
12	Patio	1996		2,322		15			2,322	12
13	Basement rehab	1997		17,151		10			17,151	13
14	Baseboards	1997		3,129		10			3,129	14
15	Wiring	1998		3,090		10			3,090	15
16	Lobby Tile	1999		19,354		10			19,354	16
17	Patio	1999		4,196		15			4,196	17
18	Automatic Door	2000		1,300		10			1,300	18
19	Wallpaper	2000		6,853		10			6,853	19
20	Patio	2000		1,242		15			1,242	20
21	Storage closet for HVAC	2000		3,745		15			3,745	21
22	Fire pump system	2001		4,140		10			4,140	22
23	Door releases	2001		4,420		10			4,420	23
24	Infrared curtains for elevators	2001		3,000		10			3,000	24
25	Parking lot	2002		2,532		10			2,532	25
26	Kitchen tile and plumbing	2002		9,661		10			9,661	26
27	Elevator upgrade	2002		2,596		5			2,596	27
28	Facility Rehab-Painting/wallpaper/carpeting	2003		175,251		10			175,251	28
29	Facility Rehab-Floor tile/room upgrade	2003		38,140	1,907	20	1,907		28,446	29
30	Facility Rehab-Carpeting	2003		7,861		10			7,861	30
31	Parking lot	2004		2,000		5			2,000	31
32	Roof	2004		15,000	750	20	750		10,063	32
33	Landscaping	2005		5,396	270	20	270		3,372	33
34	Paint for building	2005		9,000		10			9,000	34
35	Roof	2005		14,300	715	20	715		8,699	35
36										36

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

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

See Page 12A, Line 70 for total

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

0037317

Report Period Beginning:

01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HVAC upgrade	2005	\$ 3,230	\$ 162	20	\$ 162		\$ 2,046	37
38	Sprinkler system	2005	1,060	53	20	53		649	38
39	Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		17,826	39
40	Window treatment	2005	1,932		10			1,932	40
41	Cubicle curtains	2005	820		5			820	41
42	Countertop	2005	845		5			845	42
43	HVAC	2006	3,793	190	20	190		2,103	43
44	Automatic Door Lock	2006	2,784	139	20	139		1,531	44
45	Storeroom Door Lock	2006	1,904	95	20	95		1,063	45
46	Service Door	2006	2,545	127	20	127		1,400	46
47	Landscaping Enhancement-Patio	2006	2,340	156	15	156		1,781	47
48	PT Therapy Room	2006	570	14	40	14		154	48
49									49
50									50
51									51
52	Transitional Unit	2007	1,864	93	20	93		1,002	52
53	Employee Lunch Room	2007	2,827	141	20	141		1,484	53
54	PT Room Rehab	2007	58,628	2,941	20	2,941		30,195	54
55	Landscaping-brick pavers	2008	43,813	2,921	15	2,921		27,018	55
56	Parking Lot	2008	31,700	1,585	20	1,585		15,190	56
57	Roof Repairs	2008	4,200	280	15	280		2,707	57
58	HVAC-New Chillers	2008	118,557	5,928	20	5,928		55,327	58
59	Emergency A/C	2008	5,706	285	20	285		2,662	59
60	Building Addition	2008			27				60
61	Kitchen Upgrade	2008	7,214		27	262	262	2,402	61
62	2nd Floor Remodel-painting, flooring, electrical	2008	561,274		27	20,410	20,410	187,092	62
63	Foundation Stabilization	2008	66,195		27	2,407	2,407	22,064	63
64	Irrigation System	2009	15,485	1,032	15	1,032		8,602	64
65	Landscaping Enhancements	2009	26,798	1,787	15	1,787		15,037	65
66	Patio Fence	2009	9,319	466	20	466		3,999	66
67	Chiller	2009	82,310	4,115	20	4,115		36,010	67
68	Plumbing	2009	4,280	214	20	214		1,712	68
69	2nd floor remodel-MDS office, HR office, Nursing call system	2009	6,853	250	27	250		2,010	69
70	TOTAL (lines 4 thru 69)		\$ 5,649,111	\$ 30,251		\$ 170,775	\$ 140,524	\$ 3,904,895	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 Elmhurst, Inc.

0037317

Report Period Beginning:

01/01/2017 Ending: 12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,649,111	\$ 30,251		\$ 170,775	\$ 140,524	\$ 3,904,895	1
2	Patio Pergola	2009	12814	641	20	641		5,339	2
3	Tub Room carpentry,flooring,electrical	2009	5828	212	27	212		1,695	3
4	2nd Floor remodel-Carpentry,doors,flooring,electrical	2009	455801		27	16,575	16,575	145,031	4
5	painting,sprinkler system								5
6	Landscaping	2010	3314	221	15	221		1,602	6
7	Physician office remodel-carpentry,tiling	2010	6450	235	27	235		1,662	7
8	Front Entrance-door and drain tile	2010	4418	216	27	216		1,556	8
9	Nurse pull cord station	2010	3256	118	27	118		828	9
10	Remodel Pantry-shelves	2010	7146	260	27	260		1,819	10
11	Director of Nursing office painting	2010	5539	201	27	201		1,410	11
12	Cooridor remodel-flag pole,tiling	2010	13777	550	27	550		3,918	12
13	Library/Lounge remodel-art,carpentry,electrical	2010	11870	432	27	432		3,022	13
14	Steel frame remodel	2010	6740	245	27	245		1,838	14
15	2nd Floor remodel-Carpentry,doors,flooring,electrical	2010	17168	624	27	624		4,994	15
16	Tub Room carpentry,plumbing	2010	11731	427	27	427		3,342	16
17	Pergola	2010	8180		5			8,180	17
18	Stamped concrete	2010	17260	628	27	628		4,603	18
19	Landscaping	2011	4443	296	15	296		1,876	19
20	Offices-doors, locks, keys	2011	66131	2,405	27	2,405		15,832	20
21	Seal and stripe parking lot	2011	3500	127	27	127		795	21
22	Laundry room-electrical, painting	2011	6412	233	27	233		1,515	22
23	Floor install	2011	10158	369	27	369		2,524	23
24	2nd floor doors	2011	9654	351	27	351		2,428	24
25									25
26	Front entrance door	2012	3733	136	27	136		713	26
27	Shower-Electrical	2012	4982	181	27	181		936	27
28	Fire Dampers	2012	7392	269	27	269		1,367	28
29	Low voltage wiring	2012	5186	189	27	189		1,069	29
30	EMR Wiring	2012	14543	529	27	529		2,688	30
31	1st floor doors	2012	8476	308	27	308		1,669	31
32	Back patio fence	2012	3536	129	27	129		750	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,388,549	\$ 40,783		\$ 197,882	\$ 157,099	\$ 4,129,896	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 Elmhurst, Inc.

0037317

Report Period Beginning:

01/01/2017 Ending: 12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,388,549	\$ 40,783		\$ 197,882	\$ 157,099	\$ 4,129,896	1
2	1st Fl. Rm. Reconfigure. - labor, electrical, drywall, plumbing	2013	39,603	1,440	27	1,440		7,080	2
3									3
4	MDS Office Millwork & Electrical	2014	15,401	560	27	560		1,913	4
5	Automate Front Doors (Front Entrance)	2014	9,593	349	27	349		1,134	5
6	Install LED Lights throughout facility	2014	44,958	1,635	27	1,635		4,905	6
7	Wiring -Fiber connection throughout facility	2014	5,597	204	27	204		679	7
8									8
9									9
10	Parking Lot - Replace Aprons and Curbs	2015	27,000	1,800	15	1,800		4,350	10
11	EMR Wiring - Entire Facility	2015	5,087	185	27	185		493	11
12									12
13	R&M Reclasp: Parking Lot - crack sealing, coating, and striping	2015	3,800		20	190	190	475	13
14	R&M Reclasp: Landscaping on left and ride side of driveway	2015	8,676		15	578	578	1,445	14
15	and side of building								15
16									16
17	Physical Therapy Room Construction - Surfacing, Equipment	2016	12,981	481	27	481	0	601	17
18	Relocating, Plumbing, Drywalls, Wiring, Painting								18
19	Resident Rooms Remodeling - Chair Rail Installations in First	2016	24,495	907	27	907		1,058	19
20	Floor and Second Floor Rooms								20
21									21
22									22
23	Reconcile to book depreciation			625			(625)		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)		\$ 6,585,740	\$ 48,969		\$ 206,211	\$ 157,242	\$ 4,154,029	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 12C, Carried Forward		\$ 6,585,740	\$ 48,969		\$ 206,211	\$ 157,242	\$ 4,154,029	1
2									2
3	Building - management company	2002	212,198		40	4,773	4,773	98,988	3
4	HVAC, electrical, security system - management company	2003	1,864		30	455	455	1,537	4
5	Key card system - management company	2004	293		20	14	14	196	5
6	VAV TX controls - management company	2005	89		20	4	4	57	6
7	Interior Signs - management company	2006	65		20	4	4	48	7
8	Building improvements - management company	2008	9,614		20	113	113	4,104	8
9	Building improvements - management company	2009	1,890		20	35	35	872	9
10	Building improvements - management company	2010	1,844		20	34	34	791	10
11	Building improvements - management company	2011	1,321		20	61	61	400	11
12	Building improvements - management company	2012	4,467		20	9	9	928	12
13	Building improvements - management company	2013	3,447		20	248	248	1,071	13
14	Building improvements - management company	2014	1,866		20	184	184	655	14
15	Building improvements - management company	2015	328		20	40	40	100	15
16	Building improvements - management company	2016	5,413		20	397	397	557	16
17	Building improvements - management company	2017	3,520		20	44	44	66	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)		\$ 6,833,959	\$ 48,969		\$ 212,626	\$ 163,657	\$ 4,264,399	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	\$ 385,446	\$ 55,223	\$ 55,587	\$ 364	5-10	\$ 314,282	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,006,179				5-7	1,006,179	73
74	Allocated from Mgmt. Co.	431,506		37,794	37,794	5-7	388,084	74
75	TOTALS	\$ 1,823,131	\$ 55,223	\$ 93,381	\$ 38,158		\$ 1,708,545	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.			38,815		1,630	1,630	5	36,118	79
80	TOTALS			\$ 38,815	\$	\$ 1,630	\$ 1,630		\$ 36,118	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)	\$ 9,988,909	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 104,192	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 307,638	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 203,446	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,009,062	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from Management Company</u>				<u>3,474</u>			6
7	TOTAL				\$ <u>3,474</u>			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.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

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: \$ 82,287 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocated from Management Company</u>			<u>441</u>	20
21	TOTAL		\$	\$ <u>441</u>	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 Health Care Center of Elmhurst, Inc.
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	7,789
Printer	3,004
Postage	323
Medical Equip	41,735
Oxygen	28,375
Management Co.	1,061
Total - Line 16	<u><u>82,287</u></u>

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	\$	8,419	\$ 571,873	\$	8,419	\$ 571,873	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,654	143,937		1,654	143,937	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		11,247	633,518	5,609	11,247	639,127	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				459,605		459,605	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39(3)				3,268			3,268	12
13	Other (specify): <u>See Sch 16A</u>	39(2)					12,588		12,588	13
14	TOTAL			\$	21,320	\$ 1,352,596	\$ 477,802	21,320	\$ 1,830,398	14

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

Facility Name: Lexington Health Care Center of Elmhurst, Inc.
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2017

Schedule 16A

XIV. Special Services (Direct Cost)

Line 13 Other (specify)

Description	Amount
Oxygen	5,064
DME	7,524
Total - Line 13	<u>12,588</u>

Facility Name: Lexington Health Care Center of Elmhurst, Inc.
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2017

Schedule 17A

XV. Balance Sheet

Line 22 Other Long-Term Assets (specify):

	Description	Operating	After Consolidation
00-13040-00	Sambell Rent Receivable	-	108,154
00-13701-00	Sambell Due from LLC II	-	35,086
00-13705-00	DUE to/from Sambell of LaGrange LP	-	329,288
00-13720-00	DUE to/from LHCS Wheeling LP	-	1,252,410
00-13731-00	Due from (to) Sambell Chgo Ridge	-	418,014
00-13733-00	Due from Sambell of Elmhurst	-	651,109
00-18000-00	Receivable from Insurance Recoveries	667,114	667,114
	Total - Line 22	667,114	3,461,175

Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
00-10140-00	Cash Patient Trust	36,753	36,753
00-13250-00	Due to/ from Rehab care	2,575	2,575
00-13310-00	Due from LHCS Orland Park - RE	-	-
00-13330-00	Due to/from Republic Construction	(738)	(738)
00-13380-00	Due from Elmhurst Square-AR	(2,133)	(2,133)
00-13850-00	Due from Lexington Fin Serv LLC	-	-
00-14530-00	Prepaid Insurance	11,113	11,113
00-21030-00	COBRA	(11,080)	(11,080)
00-21100-00	401K Withholding	1,941	1,941
00-22030-00	Accrued Expenses	21,882	21,882
00-22040-00	Accrued Resident Tax	35,614	35,614
00-22060-00	Accrued Royal / Vesta Mgmt Fees	917,241	917,241
00-22065-00	Accrued Royal Mgmt Fees	381,375	381,375
00-22120-00	Accrued Rent	108,154	108,154
00-22140-00	Accrued Insurance	58,918	58,918
00-22270-00	Due to Patient Trust Fund	(36,973)	(36,973)
00-22330-00	Advance - Biweekly Part A Payment	8,908	8,908
00-22360-00	Uncollectible Part A Co Pvts	(45,224)	(45,224)
00-23530-00	Due to - Royal Operations	34,760	34,760
00-23760-00	Due to LaGrange	41,503	41,503
00-23770-00	Due to Lake Zurich	(317)	(317)
00-23780-00	Due to LHCC Lombard	-	-
00-23820-00	Due to Wheeling	54	54
00-23870-00	Due to/from Lex financial services	129	129
00-24345-00	Sambell Interest Rate Swap Liability	-	-
	Total - Line 36	1,564,455	1,564,455

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,189,864	1
2	Restatements (describe):		2
3	Post closing adjustment	15,149	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,205,013	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,124,933)	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)	\$ (1,124,933)	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)	\$ 1,080,080	24 *

* This must agree with page 17, line 47.

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

0037317

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

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**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,501,530	1
2	Discounts and Allowances for all Levels	(6,663,623)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,837,907	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,763,334	6
7	Oxygen	35,802	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,799,136	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	108	12
13	Barber and Beauty Care	9,546	13
14	Non-Patient Meals	2,434	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	819,912	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	314,071	19
20	Radiology and X-Ray	57,551	20
21	Other Medical Services	310,511	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,514,133	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,471	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,471	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)	\$ 12,154,647	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,587,395	31
32	Health Care	4,801,247	32
33	General Administration	3,098,438	33
B. Capital Expense			
34	Ownership	1,201,563	34
C. Ancillary Expense			
35	Special Cost Centers	2,362,248	35
36	Provider Participation Fee	228,689	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,279,580	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,124,933)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,124,933)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,428,707	44
45	Private Pay - Net Inpatient Revenue	2,492,214	45
46	Medicare - Net Inpatient Revenue	1,115,176	46
47	Other-(specify) Managed Care	801,810	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,837,907	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 Elmhurst, Inc.

0037317

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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	1,812	2,174	\$ 158,962	\$ 73.11	1
2	Assistant Director of Nursing	1,590	2,133	68,507	32.11	2
3	Registered Nurses	27,590	35,803	1,181,078	32.99	3
4	Licensed Practical Nurses	21,002	25,992	701,786	27.00	4
5	CNAs & Orderlies	63,190	77,211	1,137,226	14.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,687	2,114	43,056	20.37	9
10	Activity Assistants	5,829	6,976	82,385	11.81	10
11	Social Service Workers	6,128	6,983	142,237	20.37	11
12	Dietician	1,890	2,270	51,560	22.72	12
13	Food Service Supervisor	1,982	2,255	55,833	24.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,930	37,484	442,046	11.79	15
16	Dishwashers					16
17	Maintenance Workers	1,778	2,175	47,828	21.99	17
18	Housekeepers	23,766	29,307	325,342	11.10	18
19	Laundry					19
20	Administrator	2,117	2,605	143,511	55.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,197	6,550	163,740	25.00	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	1,571	1,951	35,647	18.27	31
32	Other Health C: <u>See Sch 20A</u>	21,459	26,096	695,035	26.63	32
33	Other(specify) <u>Marketing</u>	2,446	2,916	107,701	36.93	33
34	TOTAL (lines 1 - 33)	220,964	272,997	\$ 5,583,481 *	\$ 20.45	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		1(3)	35
36	Medical Director	Monthly 80,900	9(3)	36
37	Medical Records Consultant	Monthly 813	10(3)	37
38	Nurse Consultant		10(3)	38
39	Pharmacist Consultant	Monthly 13,494	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 3,219	12(3)	45
46	Other(specify) <u>Pulmonary Consultan</u>	Monthly 81,693	10(3)	46
47				47
48	<u>See Sch 20B</u>	44,123	10(3)	48
49	TOTAL (lines 35 - 48)	\$ 226,611		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 Elmhurst, Inc.
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2017

Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Accounts Coordinator	1,811	2,268	35,906	\$ 15.83
Admissions	3,239	3,893	87,190	\$ 22.39
Clinical Coordinator	3,188	3,977	135,351	\$ 34.04
Concierge	40	145	2,357	\$ 16.21
MDS	3,137	3,849	137,974	\$ 35.85
Staffing Coordinator	2,099	2,463	44,766	\$ 18.18
Transitional Care Nurse	1,834	2,159	70,756	\$ 32.77
Unit Secretary	4,315	5,158	110,845	\$ 21.49
Wound Care Coordinator	1,796	2,184	69,891	\$ 32.00
Total - Line 32 Other Health Care (specify):	21,459	26,096	695,035	\$ 26.63

Facility Name: Lexington Health Care Center of Elmhurst, Inc.
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2017

Schedule 20B

XVIII. Staffing and Salary Costs

Consultant Services

Line 48

Description	# of Hrs. Paid and Accrued	Total Consultant Cost	Ref.
Post Acute Consultant	Monthly	35,048	10(3)
Telemedicine Consultant	Monthly	9,075	10(3)
Total - Line 48	Monthly	44,123	

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	
<u>Tremaine Brown</u>	<u>Administrator</u>	<u>0</u>	\$ <u>143,511</u>	<u>Workers' Compensation Insurance</u>	\$	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>50,471</u>	<u>Advertising: Employee Recruitment</u>	<u>5,811</u>	
				<u>FICA Taxes</u>	<u>417,809</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>364,661</u>	(Indicate # of checks performed <u>758</u>)	<u>9,090</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>280</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>3,313</u>	
				<u>401K</u>	<u>18,150</u>	<u>Miscellaneous Subscriptions & Dues</u>	<u>10,075</u>	
				<u>Other Employee Benefits</u>	<u>22,751</u>	<u>IHCA</u>	<u>10,150</u>	
				<u>Uniform Allowance</u>	<u>1,866</u>	<u>Less: Lobbying</u>	<u>(3,456)</u>	
				<u>Tuition</u>	<u>9,297</u>	<u>Allocated from Home Office</u>	<u>9,230</u>	
						<u>Less: Public Relations Expense</u>	()	
						<u>Non-allowable advertising</u>	()	
						<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)				\$ <u>885,005</u>			\$ <u>49,569</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Description	Amount	
<u>Management Fees-Royal Operating</u>			\$ <u>908,595</u>	<u>N/A</u>		<u>Out-of-State Travel</u>	\$	
<u>Management Fees-Vesta Mgmt.</u>			<u>175,573</u>					
<u>Management Fees (Eliminated in Column 7)</u>						<u>In-State Travel</u>		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>1,084,168</u>			<u>Seminar Expense</u>	<u>111</u>	
(Attach a copy of any management service agreement)						<u>Allocated from Home Office</u>	<u>648</u>	
C. Professional Services								
Vendor/Payee	Type			<th colspan="2"></th>				
<u>Various</u>	<u>Legal (Collections)</u>	\$ <u>51,120</u>						
<u>Much Shelist</u>	<u>Legal</u>	<u>4,541</u>						
<u>Generation Law</u>	<u>Legal</u>	<u>3,909</u>						
<u>Howlett & Associate</u>	<u>Legal</u>	<u>428</u>						
<u>Duane Morris</u>	<u>Legal</u>	<u>1,077</u>						
<u>Serpico</u>	<u>Legal</u>	<u>760</u>						
<u>Hughes Socol Piers</u>	<u>Legal</u>	<u>369</u>						
<u>Goldstine, Skrodzki, Russian...</u>	<u>Legal</u>	<u>711</u>						
<u>Personnel Planner</u>	<u>U/C Consulting</u>	<u>780</u>						
<u>RSM US LLP</u>	<u>Accounting</u>	<u>31,465</u>						
<u>Pension Administrator</u>	<u>401K Administration</u>	<u>1,260</u>						
<u>See Sch 21C</u>	<u>See Sch 21C</u>	<u>83,447</u>						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)				\$			\$ <u>759</u>	

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Lexington Health Care Center of Elmhurst, Inc.
 IDPH License ID Number: 0037317
 Fiscal Year End: 12/31/2017

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
From 21C		96,420
Attadale Partners	Operations Consulting	(18)
Secretary of State	Filing Fees	100
Lexington Financial Services LLC	Financial	406
Purchases	Computer services	3,781
Lawson	Computer services	1,252
Computer supply	Computer services	44,306
National datacare corp.	Computer services	1,419
Softchoice	Computer services	11,049
Microsoft	Computer services	9,837
Netsmart	Computer services	6,068
RSM Microsoft GP	Computer services	4,351
Availity	Computer services	28
Symbaria	Computer services	400
Onshift	Computer services	(6)
Salesforce	Computer services	(4,594)
Relias	Computer services	1,392
Ability	Computer services	271
ICIMS	Computer services	2,458
Info controls	Computer services	281
MB	Computer services	50
BSI LUC	Computer services	442
MHC	Computer services	176
Total (agree to Schedule V, line 19, column 3)		179,866
Offset Salesforce:		4,594
Less: Non-Allowable Legal Fees Less:		
	Out of Period Legal	(2,569)
	Non-allowable Legal	(51,120)
Allocated from Real Estate		
	Secretary of State	200
<i>Allocated from Mgmt. Co. Type</i>		
	Much Shelist Legal	1,223
Hinshaw & Culbertson LLP	Legal	168
	Duane Morris Legal	1,443
	Serpico, Petrosino Legal	9
	Golan and Christie Legal	15
	RSM Accounting	1,001
	Friedman & Huey Accounting	535
	IL Secretary of State Filing Fees	35
Gilson Labus & Silverman LLC	Accounting	475
	Marcum LLP Accounting	234
	LaSalle Network Recruiting / Finance	841
Pension Administrators, Inc.	401K Administration	(87)
	Gene Whitehorn Medicaid Reimb Specialist	1,366
M Werner Consulting	Financial Consulting	701
	Eisen Alliance LLC Workplace Consultant	218
	Barry Lazarus Health Care Consultant	187
	Mark Rodeghier Survey Preparation Consultant	483
Pathway Health Services	Operational & Financial Consulti	1,675
	IMEC Operational & Financial Consulti	4,089
	Forest Performance Performance Consulting	1,249
	Reputation.com Performance Consulting	748
	Devree Molnar Strategy/Operations Consulting	105
	Steven Wood Strategy/Operations Consulting	216
	Susan Parker Social Service Consultant	12
	Focus Pointe Global Strategic Planning	859
CLIN-SCIENCE RESEARCH	General Business Consulting	283
	Provinet Solutions Technical Consulting	11
ANDRZJ STANKIEWIC	General Business Consulting	67
	DLC Financial Planning & Analysis	996
	Computer Services Computer Consulting	25,972
Allocated from SV of Lombard II		
	Friedman & Huey Accounting	97
	Illinois Secretary of State Filing Fees	11
Total (agree to Schedule V, line 19, column 8)		176,208

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 - \$10,150
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,097 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 NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO 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. \$ 228,689
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,434
- (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