

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

0041855 Report Period Beginning: 1/1/17 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	275	Skilled (SNF)	275	100,375	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	275	TOTALS	275	100,375	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			10,730	10,730	8
9	SNF/PED					9
10	ICF	39,186	10,711	5,872	55,769	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,186	10,711	16,602	66,499	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.25%

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 7/8/96

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 259 and days of care provided 8,195

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 Orland Par # 0041855 Report Period Beginning: 1/1/17 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	528,877	43,450	8,130	580,457		580,457	-	580,457		1
2	Food Purchase		478,140		478,140		478,140	218	478,358		2
3	Housekeeping	441,970	51,424	-	493,394		493,394	409	493,803		3
4	Laundry	-	25,127	-	25,127	-	25,127	-	25,127		4
5	Heat and Other Utilities			255,548	255,548		255,548	11,703	267,251		5
6	Maintenance	51,433	-	205,954	257,387		257,387	155,686	413,073		6
7	Other (specify):* Alloc. From Mgmt. C	-	-	-	-		-	21,289	21,289		7
8	TOTAL General Services	1,022,280	598,141	469,632	2,090,053	-	2,090,053	189,305	2,279,358		8
	B. Health Care and Programs										
9	Medical Director	-	-	65,563	65,563		65,563	-	65,563		9
10	Nursing and Medical Records	5,706,392	335,402	116,125	6,157,919		6,157,919	34,771	6,192,690		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	184,116	25,752	12,163	222,031		222,031	-	222,031		11
12	Social Services	204,926	-	3,399	208,325		208,325	-	208,325		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):* Alloc. From Mgmt. C	-	-	-	-		-	4,621	4,621		15
16	TOTAL Health Care and Programs	6,095,434	361,154	197,250	6,653,838	-	6,653,838	39,392	6,693,230		16
	C. General Administration										
17	Administrative	143,944	-	2,295,554	2,439,498		2,439,498	(2,213,137)	226,361		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			257,970	257,970		257,970	54,540	312,510		19
20	Dues, Fees, Subscriptions & Promotions			66,813	66,813		66,813	11,267	78,080		20
21	Clerical & General Office Expenses	286,983	30,523	69,052	386,558		386,558	1,117,939	1,504,497		21
22	Employee Benefits & Payroll Taxes			1,211,735	1,211,735		1,211,735	-	1,211,735		22
23	Inservice Training & Education			9,565	9,565		9,565	700	10,265		23
24	Travel and Seminar			111	111		111	1,230	1,341		24
25	Other Admin. Staff Transportation		-	9,604	9,604		9,604	19,583	29,187		25
26	Insurance-Prop.Liab.Malpractice			834,316	834,316		834,316	12,402	846,718		26
27	Other (specify):* Alloc. From Mgmt. C	-	-	-	-		-	153,730	153,730		27
28	TOTAL General Administration	430,927	30,523	4,754,720	5,216,170	-	5,216,170	(841,746)	4,374,424		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,548,641	989,818	5,421,602	13,960,061	-	13,960,061	(613,049)	13,347,012		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			94,911	94,911		94,911	460,089	555,000		30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-		31
32	Interest			163,195	163,195		163,195	500,800	663,995		32
33	Real Estate Taxes			-	-		-	876,547	876,547		33
34	Rent-Facility & Grounds			2,674,008	2,674,008		2,674,008	(2,660,919)	13,089		34
35	Rent-Equipment & Vehicles			59,567	59,567		59,567	2,849	62,416		35
36	Other (specify):*			-	-		-	-	-		36
37	TOTAL Ownership			2,991,681	2,991,681	-	2,991,681	(820,634)	2,171,047		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation	-	-	-	-		-	-	-		38
39	Ancillary Service Centers	-	311,747	1,389,920	1,701,667		1,701,667	-	1,701,667		39
40	Barber and Beauty Shops	(1,269)	-	16,212	14,943		14,943	(14,943)	-		40
41	Coffee and Gift Shops	-	-	2,063	2,063		2,063	(2,063)	-		41
42	Provider Participation Fee			510,212	510,212		510,212	-	510,212		42
43	Other (specify):* Non-Allowable Cos	138,960	-	680,305	819,265		819,265	(819,265)	-		43
44	TOTAL Special Cost Centers	137,691	311,747	2,598,712	3,048,150	-	3,048,150	(836,271)	2,211,879		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,686,332	1,301,565	11,011,995	19,999,892	-	19,999,892	(2,269,954)	17,729,938		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	218	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,322)	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	44,839	30		9
10	Interest and Other Investment Income	22,028	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14,112)	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	(5,145)	43		18
19	Entertainment				19
20	Contributions	(100)	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	(589,984)	43		24
25	Fund Raising, Advertising and Promotional	(18,140)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,409)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(24,609)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (602,736)		\$	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)	(1,667,218)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,667,218)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,269,954)		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	

Lexington Health Care Center of Orland Park, Inc.

ID# 0041855

Report Period Beginning: 1/1/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Diagnostics Managed Care	\$ (2,025)	43	1
2	Labs - Part A	(15,778)	43	2
3	X-Rays - Part A	(16,835)	43	3
4	Marketing Salary	(138,960)	43	4
5	Gift Shop Income	(2,063)	41	5
6	Unrealized loss on FMV swap	377,674	43	6
7	Trust Fees	(75)	43	7
8	Shareholder Interest	(156,000)	32	8
9	Collections	(30,138)	19	9
10	Out of Period Legal	(1,319)	19	10
11	Non-Allowable Dues & Subscription	(6,238)	20	11
12	Dues and subscription - Marketing	(455)	43	12
13	Non-Allowable Finance Charge	(2,204)	32	13
14	Offset barber & beauty	(14,943)	40	14
15	Reclass Repairs & Maintenance to LHI	(15,250)	6	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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30				30
31				31
32				32
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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	(24,609)		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	30 Depreciation	\$	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	\$ 328,311	\$ 328,311	1
2	V	32 Interest Expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	605,719	605,719	2
3	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	3,866	3,866	3
4	V	33 Property Taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	867,508	867,508	4
5	V	34 Rental Expense	2,667,508	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(2,667,508)	5
6	V	43 Unrealized gain on FMV swap	377,674	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(377,674)	6
7	V	43 Trust Fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	75	75	7
8	V	19 Professional Fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	201	201	8
9	V							9
10	V							10
11	V			** The owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Lexington Health Care Systems of Orland Park Ltd. Ptsp.				11
12	V							12
13	V							13
14	Total		\$ 3,045,182			\$ 1,805,680	\$ * (1,239,502)	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.	**	\$ 409	\$	409	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	10,454		10,454	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	434		434	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	815		815	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	160,216		160,216	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	10,287		10,287	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	433		433	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	21,289		21,289	22	
23	V	10 Management allocation - salaries		Royal Management Corp.	**	34,771		34,771	23	
24	V	15 Management allocation - employee benefits		Royal Management Corp.	**	4,621		4,621	24	
25	V	17 Management allocation - salaries		Royal Management Corp.	**	82,417		82,417	25	
26	V	19 Computer consultant & supplies		Royal Management Corp.	**	49,258		49,258	26	
27	V	19 Professional fees		Royal Management Corp.	**	36,538		36,538	27	
28	V	20 Dues & subscriptions		Royal Management Corp.	**	2,003		2,003	28	
29	V	20 Advertising - help wanted		Royal Management Corp.	**	15,502		15,502	29	
30	V	21 Management allocation - salaries		Royal Management Corp.	**	1,074,552		1,074,552	30	
31	V	21 Bank charges		Royal Management Corp.	**	4,339		4,339	31	
32	V	21 Office supplies & printing		Royal Management Corp.	**	17,538		17,538	32	
33	V	21 Postage		Royal Management Corp.	**	5,193		5,193	33	
34	V	21 Telephone		Royal Management Corp.	**	16,317		16,317	34	
35	V								35	
36	V								36	
37	V								37	
38	V	** The owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 1,547,386	\$ *	1,547,386	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.	**	\$ 700	\$ 700
16	V	24 Travel & seminar		Royal Management Corp.	**	1,230	1,230
17	V	25 Auto expense		Royal Management Corp.	**	19,583	19,583
18	V	26 Insurance general		Royal Management Corp.	**	12,402	12,402
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	153,730	153,730
20	V	30 Depreciation		Royal Management Corp.	**	86,939	86,939
21	V	32 Interest		Royal Management Corp.	**	24,213	24,213
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	3,178	3,178
23	V	33 Property taxes		Royal Management Corp.	**	9,039	9,039
24	V	34 Rent expense		Royal Management Corp.	**	6,589	6,589
25	V	35 Equipment rental		Royal Management Corp.	**	2,014	2,014
26	V	17 Management fees	2,295,554	Royal Management Corp.	**		(2,295,554)
27	V	35 Auto Lease		Royal Management Corp.	**	835	835
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** The owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 2,295,554			\$ 320,452	\$ * (1,975,102)

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

Facility Name & ID Number

Lexington Health Care Center of Orland Park, Inc.

0041855

Report Period Beginning:

1/1/17

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

Facility Name & ID Number

Lexington Health Care Center of Orland Park, Inc.

0041855

Report Period Beginning:

1/1/17

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

Facility Name & ID Number Lexington Health Care Center of Orland Park # 0041855 Report Period Beginning: 1/1/17 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	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 12,949	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,995	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	11,993	L17, C7	3
4	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	22,176	L17, C7	4
5	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	16,820	L17, C7	5
6	Phil Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,474	L17, C7	6
7	Jeremy Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,011	L17, C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 82,417		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 Orland Park, Inc. # 0041855 Report Period Beginning: 1/1/17 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	Bed Days Available	722,335	10	\$ 2,937	\$ 100,375	\$ 409	1
2	5	Utilities - gas & electric	Bed Days Available	722,335	10	75,222	100,375	10,454	2
3	5	Utilities - water & sewer	Bed Days Available	722,335	10	3,135	100,375	434	3
4	5	Utilities - maintenance office	Bed Days Available	722,335	10	5,869	100,375	815	4
5	6	Management allocation - salaries	Bed Days Available	722,335	10	1,152,969	1,152,969	160,216	5
6	6	Repairs & maintenance	Bed Days Available	722,335	10	74,022	100,375	10,287	6
7	6	Scavenger & exterminating	Bed Days Available	722,335	10	3,102	100,375	433	7
8	7	Management allocation - employees	Bed Days Available	722,335	10	153,196	100,375	21,289	8
9	10	Management allocation - salaries	Bed Days Available	722,335	10	250,218	250,218	34,771	9
10	15	Management allocation - employees	Bed Days Available	722,335	10	33,247	100,375	4,621	10
11	17	Management allocation - salaries	Bed Days Available	722,335	10	593,100	593,100	82,417	11
12	19	Computer consultant & supplies	Bed Days Available	722,335	10	354,473	100,375	49,258	12
13	19	Professional fees	Bed Days Available	722,335	10	262,937	100,375	36,538	13
14	20	Dues & subscriptions	Bed Days Available	722,335	10	14,411	100,375	2,003	14
15	20	Advertising - help wanted	Bed Days Available	722,335	10	111,560	100,375	15,502	15
16	21	Management allocation - salaries	Bed Days Available	722,335	10	7,732,875	7,732,875	1,074,552	16
17	21	Bank charges	Bed Days Available	722,335	10	31,229	100,375	4,339	17
18	21	Office supplies & printing	Bed Days Available	722,335	10	126,211	100,375	17,538	18
19	21	Postage	Bed Days Available	722,335	10	37,365	100,375	5,193	19
20	21	Telephone	Bed Days Available	722,335	10	117,421	100,375	16,317	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 11,135,499	\$ 9,729,162	\$ 1,547,386	25

Facility Name & ID Number Lexington Health Care Center of Orland Park, Inc. # 0041855 Report Period Beginning: 1/1/17 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	23	Inservice Training	Bed Days Available	722,335	10	\$ 5,038	\$ 100,375	\$ 700	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	8,850	100,375	1,230	2
3	25	Auto expense	Bed Days Available	722,335	10	140,934	100,375	19,583	3
4	26	Insurance general	Bed Days Available	722,335	10	89,225	100,375	12,402	4
5	27	Management allocation - employees	Bed Days Available	722,335	10	1,106,283	100,375	153,730	5
6	30	Depreciation	Bed Days Available	722,335	10	625,643	100,375	86,939	6
7	32	Interest	Bed Days Available	722,335	10	174,244	100,375	24,213	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	22,869	100,375	3,178	8
9	33	Property taxes	Bed Days Available	722,335	10	65,056	100,375	9,039	9
10	34	Rent expense	Bed Days Available	722,335	10	47,418	100,375	6,589	10
11	35	Equipment rental	Bed Days Available	722,335	10	14,486	100,375	2,014	11
12	35	Auto Lease	Bed Days Available	722,335	10	6,017	100,375	835	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	\$	\$ 320,452	25

Facility Name & ID Number Lexington Health Care Center of Orland Par # 0041855 Report Period Beginning: 1/1/17 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 Services					\$	\$			\$	1									
2	L.L.C.	X		Mortgage	Varies	5/22/08	11,354,000	8,662,037	1/1/2033	Variable	605,719	2								
3												3								
4												4								
5				Finance Charge - Insurance Policy							2,204	5								
Working Capital																				
6	Bank of America		X	Line of Credit	Varies	9/30/13	13,700,000		1/31/2018	Prime/Libor	4,434	6								
7	Shareholder loan	X		Working capital	Varies	5/3/12	1,200,000	1,200,000	Demand	0.0800	96,000	7								
8	Shareholder loan	X		Working capital	Varies	9/30/13	750,000	750,000	Demand	0.0800	60,000	8								
9	TOTAL Facility Related						\$ 27,004,000	\$ 10,612,037			\$ 768,357	9								
B. Non-Facility Related*																				
10										Amortization of Mortgage Cost	3,866	10								
11										Shareholder Interest	(156,000)	11								
12										Interest Income Offset	22,028	12								
13										See Sch. 9A	25,744	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (104,362)	14								
15	TOTALS (line 9+line14)						\$ 27,004,000	\$ 10,612,037			\$ 663,995	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.)

Facility Name: Lexington Health Care Center of Orland Park, Inc.
 IDPH License II 0041855
 Fiscal Year End: 12/31/17

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$0.00		\$ 0	\$ 0			\$ 0	9
	B. Non-Facility Related*											
10											(2,204)	10
11											557	11
12												12
13											27,391	13
14	TOTAL Non-Facility Related				\$0.00		\$ 0	\$ 0			25,744	14

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.			\$	699,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2016	\$	685,216	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(13,784)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	860,300	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.)			\$	20,992	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.)			\$	9,039	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	876,547	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	623,105	8	FOR BHF USE ONLY	
	2013	623,620	9	13	FROM R. E. TAX STATEMENT FOR 2016 \$
	2014	668,583	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2015	678,633	11	15	LESS REFUND FROM LINE 6 \$
	2016	685,216	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
See attached real estate accrual sheet					

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Orland Park, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

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>27-10-100-099-0000</u>	<u>Land & Building</u>	\$ <u>685,215.54</u>	\$ <u>685,215.54</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>9,039.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>943,003.06</u></u>	\$ <u><u>694,254.54</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 Orland Park, Inc.

0041855 Report Period Beginning:

1/1/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block & 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).

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Resident Care, Management Company Allocation, and TOTALS.

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	250	1996	1996	\$ 8,569,286	\$ -	40	\$ 214,232	\$ 214,232	\$ 4,603,416	4
5	10	1998	1998	63,790	1,595	40	1,595		30,302	5
6	18	2001	2001							6
7										7
8										8
	Improvement Type**									
9	Electrical wiring	1996		2,304	58	40	58		1,223	9
10	Paving	1997		11,589		40			11,589	10
11	Wiring	1998		3,932		40			3,932	11
12	Additional building costs - 10 bed addition	1999		1,808	45	10	45		857	12
13	Seal/restrip parking lot	1999		3,450		40			3,450	13
14	Wiring	1999		1,798	45	15	45		832	14
15	Roof repairs	2000		23,201		40			23,201	15
16	Electrical wiring	2000		5,732	164	15	164		2,868	16
17	Ceiling mount curtain rod hardware	2000		6,952	199	35	199		3,480	17
18	Automatic door closer/sensors	2000		3,624		35			3,624	18
19	Seal and restripe parking lot	2001		2,277		15			2,277	19
20	HVAC control	2001		2,548		10			2,548	20
21	Infrared curtains for elevator doors	2001		4,500		10			4,500	21
22	Fire alarm panel	2002		5,120		10			5,120	22
23	Parking lot lights	2002		9,975		10			9,975	23
24	Chiller room compressor	2002		8,879		10			8,879	24
25	Carpeting	2002		7,038		5			7,038	25
26	Pave and seal parking lot	2005		4,180	209	20	209		2,578	26
27	HVAC	2005		6,143	307	20	307		3,710	27
28	Electrical wiring	2005		3,637	182	20	182		2,214	28
29	Kitchen rehab	2005		6,360	318	20	318		4,054	29
30	Elevator rehab	2005		8,948	447	20	447		5,663	30
31	Lounge, lobby, and reception area rehab	2005		27,662	1,383	20	1,383		16,827	31
32	Landscaping enhancements	2006		5,795	386	20	386		4,375	32
33	HVAC	2006		9,300		15	465	465	5,154	33
34	LHI-therapy room rehab LL TCU/main therapy	2006		33,184	1,659	20	1,659		18,802	34
35										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 Orland Park, Inc.

0041855

Report Period Beginning:

1/1/17

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	Landscaping	2007	\$ 17,383	\$ 1,159	15	\$ 1,159	\$	\$ 12,073	37
38	Parking lot	2007	1,120	56	20	56		579	38
39	Plumbing-Fine Dining	2007	2,068	103	20	103		1,125	39
40	Laundry Room Rehab	2007	37,283	1,864	20	1,864		20,038	40
41	Employee lunch room	2007	2,865	143	20	143		1,537	41
42	Basement Renovation	2007	1,148	57	20	57		594	42
43	Patio Improvements	2007	7,000	350	20	350		3,588	43
44	1st floor remodel-carpentry, flooring, plumbing, electrical-	2007	1,481,886		40	37,426	37,426	389,855	44
45	fixtures, painting	2007							45
46									46
47	Basement Renovation	2007	20,191		20	1,010	1,010	10,096	47
48	Therapy Room Renovation	2007	978		20	49	49	490	48
49	Landscaping	2008	4,300	287	15	287		2,607	49
50	Spot Coolers	2008	3,790	189	20	189		1,701	50
51	Emergency A/C	2008	32,295	807	40	807		7,599	51
52	Plumbing & Sprinkler-Showers	2008	5,047	126	40	126		1,134	52
53	Parking lot repairs	2008	5,285	264	20	264		2,530	53
54	Phone closet	2008	5,954	149	40	149		1,428	54
55	Landscaping	2009	4,190	279	15	279		2,255	55
56	1st floor admin room-heating, fire protection	2009	16,422	821	20	821		7,115	56
57	Quick connectors	2009	7,091	355	20	355		2,958	57
58	Electrical Room	2009	4,692	235	20	235		1,880	58
59	Glass and Mirrors Med Room	2009	4,954	142	35	142		1,207	59
60	Key pad common areas	2009	3,757	107	35	107		937	60
61	2nd Floor remodel-Doors and Locks	2009	32,130	803	40	803		7,026	61
62	Patio Pergola	2009	7,930	529	15	529		4,364	62
63	Patio Fence	2009	11,293	712	15	712		5,755	63
64	2nd floor remodel-carpentry, flooring, electrical, painting	2009	1,014,056		27	36,875	36,875	331,875	64
65	2nd floor remodel-carpentry	2009	17,258		27	628	628	5,599	65
66	Office carpentry, flooring, electrical, painting, plumbing	2010	70,270	2,666	27	2,666		24,359	66
67	Landscaping	2010	11,399	760	15	760		5,510	67
68	Physican office carpentry	2010	2,926	106	27	106		742	68
69	Repave/Seal Cracks in parking lot	2010	21,817	1,091	20	1,091		8,000	69
70	TOTAL (lines 4 thru 69)		\$ 11,701,790	\$ 21,157		\$ 311,842	\$ 290,685	\$ 5,659,044	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,701,790	\$ 21,157		\$ 311,842	\$ 290,685	\$ 5,659,044	1
2	Roof	2010	74000	2,691	27	2,691		20,407	2
3	HVAC-Exhaust Modification	2010	4202	153	27	153		1,096	3
4	Nurse pull cord station	2010	3933	143	27	143		1,001	4
5	Paint lights over bed	2010	7738	281	27	281		1,991	5
6	Trench/Awning	2010	11666	424	27	424		3,058	6
7	Remodel Library/Lounge-art, flooring, carpentry	2010	4120	150	27	150		1,050	7
8	3rd floor remodel-carpentry, electrical, plumbing	2010	868782.69		27	67,183	67,183	498,274	8
9									9
10	Office-carpentry, flooring, electrical, painting, plumbing and signs	2011	6710	244	27	244		1,586	10
11	Office Remodel- Doors and Locks	2011	31324	1,139	27	1,139		8,827	11
12	Office Remodel- Doors and Locks	2011	5282	192	27	192		1,312	12
13	Additional parking spaces	2011	196376	7,141	27	7,141		44,631	13
14	Roof Repairs	2011	58800	2,138	27	2,138		13,897	14
15	Fire Dampers	2011	5586	203	27	203		1,235	15
16	Pantry Remodel - Millwork and Flooring	2011	3730	136	27	136		839	16
17	Laundry Room Remodel - Flooring, Painting and Electrical	2011	9172	334	27	334		2,087	17
18	2nd Floor Remodel - Doors	2011	12612	459	27	459		2,907	18
19									19
20	Parking lot	2012	12906	469	27	469		2,384	20
21	Chiller replacement kitchen	2012	108732	3,954	27	3,954		21,417	21
22									22
23	Fire Pump- Basement	2013	5000	125	40	125		615	23
24	EMR Wiring- Entire Facility	2013	19542	711	27	711		2,903	24
25	New Countertop, wall, tile- Kitchen	2013	3026	110	27	110		449	25
26	Stairway Access Control- Entire Facility (1st-3rd floor stairs)	2013	6463	235	27	235		960	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,161,493	\$ 42,589		\$ 400,457	\$ 357,868	\$ 6,291,970	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 Orland Park, Inc.

0041855

Report Period Beginning:

1/1/17

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		\$ 13,161,493	\$ 42,589		\$ 400,457	\$ 357,868	\$ 6,291,970	1
2									2
3	Parking lot paving	2014	119,164	4,333	27	4,333		12999	3
4	Kitchen Chiller Replacement	2014	126,990	4,618	27	4,618		16548	4
5	Kitchen sink, drywall, tile	2014	15,968	581	27	581		2081	5
6	Create Workspace in 1st floor library	2014	16,429	597	27	597		2140	6
7									7
8	R/M Repair Concrete Walk (Front Entrance)	2014	3,393		15	226	226	791	8
9	R/M Replace Radiator/Thermostat	2014	7,190		10	719	719	2517	9
10									10
11	EMR Building Wiring - Entire Facility	2015	5,038	183	27	183		473	11
12	Room Remodel - First Floor Semi-private room								12
13	converted to Private room	2015	5,375	195	27	195		407	13
14									14
15	R/M Parking Lot - Remove and replace asphalt	2015	5,200		20	260	260	650	15
16									16
17	Asphalt Removal/Replacement and Trench/Drain Installation in	2016	12,750	638	20	638		1,010	17
18	Parking Lot								18
19	Floor Tiling in First Floor Front Offices	2016	4,888	489	10	489		815	19
20	Chair Rail Installation in First Floor Rooms	2016	14,378	533	27	533		620	20
21									21
22	R/M: Frame/Drywall Installation in Boiler Room Exit Vestibule	2016	3,630		27	134	134	201	22
23									23
24	R/M: Striping Parking Lot	2017	2,600		27	48	48	48	24
25	R/M: Replace Canopy Roof and Block - Front Entrance	2017	2,900		15	97	97	97	25
26	R/M: Remove and replace underground pipe - Kitchen	2017	7,000		20	175	175	175	26
27	R/M: Millwork needed to install TV per drawing - common area	2017	2,750		15	92	92	92	27
28									28
29	Reconcile to book depreciation			1,448			(1,448)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,517,135	\$ 56,203		\$ 414,374	\$ 358,171	\$ 6,333,634	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 Orland Park, Inc.

0041855

Report Period Beginning:

1/1/17

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		\$ 13,517,135	\$ 56,203		\$ 414,374	\$ 358,171	\$ 6,333,634	1
2									2
3	Building - management company	2002	381,957		40	9,052	9,052	178,181	3
4	HVAC, electrical, security system - management company	2003	3,357		30	864	864	2,767	4
5	Key card system - management company	2004	528		20	27	27	356	5
6	VAV TX controls - management company	2005	162		20	8	8	105	6
7	Interior Signs - management company	2006	116		20	8	8	89	7
8	Building improvements - management company	2008	17,306		20	215	215	7,386	8
9	Building improvements - management company	2009	3,402		20	66	66	1,567	9
10	Building improvements - management company	2010	3,320		20	65	65	1,422	10
11	Building improvements - management company	2011	2,376		20	115	115	717	11
12	Building improvements - management company	2012	8,042		20	16	16	1,671	12
13	Building improvements - management company	2013	6,206		20	470	470	1,929	13
14	Building improvements - management company	2014	3,356		20	349	349	1,176	14
15	Building improvements - management company	2015	590		20	75	75	177	15
16	Building improvements - management company	2016	9,746		20	753	753	1,003	16
17	Building improvements - management company	2017	6,335		20	84	84	118	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)		\$ 13,963,934	\$ 56,203		\$ 426,541	\$ 370,338	\$ 6,532,298	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	\$ 488,205	\$ 38,578	\$ 53,559	\$ 14,981	5-10	\$ 402,719	71
72	Current Year Purchases	7,753	130	130		7	130	72
73	Fully Depreciated Assets	838,734				5-10	838,734	73
74	Allocated from Mgmt. Co.	776,709		71,678	71,678	5-7	698,548	74
75	TOTALS	\$ 2,111,401	\$ 38,708	\$ 125,367	\$ 86,659		\$ 1,940,131	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.			69,870		3,092	3,092	5	65,015	79
80	TOTALS			\$ 69,870	\$	\$ 3,092	\$ 3,092		\$ 65,015	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)	\$ 16,949,217	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,911	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 555,000	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 460,089	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,537,444	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				6,500			5
6	Allocated from Management Company				6,589			6
7	TOTAL				\$ 13,089			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: \$ 61,581 Description: See Sch 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Management Company			835	20
21	TOTAL		\$	\$ 835	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 Orland Park, Inc.
IDPH License ID Number: 0041855
Fiscal Year End: 12/31/17

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	7,459
Printer	3,588
Postage	323
Med Equip	14,068
Oxygen	34,129
Mgmt Alloc.	2,014
Total - Line 16	<u>61,581</u>

Facility Name & ID Number Lexington Health Care Center of Orland Park, Inc. # 0041855 Report Period Beginning: 1/1/17 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	\$	11,483	\$ 558,686	\$	11,483	\$ 558,686	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,569	189,119		3,569	189,119	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		14,067	639,999	5,402	14,067	645,401	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				295,512		295,512	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39(3)				2,116			2,116	12
13	Other (specify): <u>See Sch16A</u>	39(2)					10,833		10,833	13
14	TOTAL			\$	29,119	\$ 1,389,920	\$ 311,747	29,119	\$ 1,701,667	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 Orland Park, Inc.
IDPH License ID Number: 0041855
Fiscal Year End: 12/31/17

Schedule 16A

XIV. Special Services (Direct Cost)

Line 13 Other (specify)

<u>Description</u>	<u>Ref</u>	<u>Amount</u>
DME	39(2)	3,330
Oxygen	39(2)	7,503
Total - Line 13		<u><u>10,833</u></u>

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

0041855

Report Period Beginning: 1/1/17

Ending: 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	\$ 1,354,570	\$ 1,370,818	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>2,661,377</u>)	1,946,230	1,946,230	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	163,593	163,593	6
7	Other Prepaid Expenses	48,183	48,183	7
8	Accounts Receivable (owners or related parties)	1,000	1,000	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,513,576	\$ 3,529,824	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	114,386	114,386	12
13	Land		804,012	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	1,475,866	5,394,648	15
16	Equipment, at Historical Cost	636,220	2,181,271	16
17	Accumulated Depreciation (book methods)	(981,804)	(8,537,444)	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>Rec. fr. Ins. Recovery</u>)	720,025	720,025	22
23	Other(specify): <u>Mortgage cost net</u>		63,481	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,964,693	\$ 9,309,665	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,478,269	\$ 12,839,489	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 496,395	\$ 496,395	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	531,203	531,203	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,743	25,743	31
32	Accrued Real Estate Taxes(Sch.IX-B)		860,300	32
33	Accrued Interest Payable		63,354	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	12,043,738	4,761,411	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,097,079	\$ 6,738,406	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,950,000	1,950,000	39
40	Mortgage Payable		8,662,037	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,950,000	\$ 10,612,037	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,047,079	\$ 17,350,443	46
47	TOTAL EQUITY(page 18, line 24)	\$ (9,568,810)	\$ (4,510,954)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,478,269	\$ 12,839,489	48

*(See instructions.)

Facility Name: Lexington Health Care Center of Orland Park, Inc.
 IDPH License ID Number: 0041855
 Fiscal Year End: 12/31/17

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Acct. No.	Description	After	
		Operating	Consolidation
00-10140-00	CASH PATIENT TRUST	(53,315)	(53,315)
00-13040-00	Rent Receivable	-	(7,484,276)
00-13240-00	DUE TO LEX FIN SVCS I	10,486	10,486
00-13250-00	DUE TO / FROM REHAB CARE THERAPY	20,365	20,365
00-13700-00	Due from LLC	-	2,273
00-13709-00	Due from/(to) Lhcc Orland Park	-	49,844
00-14530-00	PREPAID INSURANCE	46,738	46,738
00-21030-00	COBRA	(985)	(985)
00-21040-00	WITHHOLDING - DENTAL INSURANCE	(2,732)	(2,732)
00-21050-00	WITHHOLDING - EP/CI/WL	(41,404)	(41,404)
00-21060-00	WITHHOLDING - SHORT TERM DISAB	23,918	23,918
00-21065-00	Life Insurance Withholding	19,147	19,147
00-21085-00	Vision Withholding	(991)	(991)
00-21100-00	401K WITHHOLDING	299	299
00-22030-00	ACCRUED EXPENSES	27,991	27,991
00-22040-00	ACCRUED RESIDENT TAX	58,565	58,565
00-22060-00	ACCRUED VESTA 3% MANAGEMENT FEES	3,011,697	3,011,697
00-22065-00	ACCRUED ROYAL MANAGEMENT FEES	(69,835)	(69,835)
00-22120-00	ACCRUED RENT	7,484,276	7,484,276
00-22140-00	ACCRUED INSURANCE	136,464	136,464
00-22270-00	DUE TO PATIENT TRUST FUND	53,315	53,315
00-22330-00	ADVANCE - BIWEEKLY PART A PAYM	(14,462)	(14,462)
00-22360-00	UNCOLLECTIBLE PART A CO PVTS	-	-
00-23530-00	DUE TO - ROYAL OPERATIONS	32,594	32,594
00-23710-00	Due to LHCS Orland Park LP	(49,844)	(49,844)
00-23720-00	DUE TO REPUBLIC	2,140	2,140
00-23750-00	Due to LHCC Elmhurst	317	317
00-23760-00	Due to LaGrange	11,052	11,052
00-24345-00	Interest Rate Swap Liability	-	149,832
00-24400-00	PROFESSIONAL LIABILITIES CLAIMS	1,337,942	1,337,942
Total - Line 36		12,043,738	4,761,411

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,743,107)	1
2	Restatements (describe):		2
3	Post closing adjustment	(62,323)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,805,430)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,763,380)	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)	\$ (2,763,380)	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)	\$ (9,568,810)	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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 22,524,133	1
2	Discounts and Allowances for all Levels	(10,788,210)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,735,923	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,522,962	6
7	Oxygen	328	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,523,290	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	3,075	12
13	Barber and Beauty Care	18,036	13
14	Non-Patient Meals	(218)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	488,574	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	167,247	19
20	Radiology and X-Ray	26,668	20
21	Other Medical Services	295,945	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 999,327	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(22,028)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (22,028)	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)	\$ 17,236,512	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,090,053	31
32	Health Care	6,653,838	32
33	General Administration	5,216,170	33
B. Capital Expense			
34	Ownership	2,991,681	34
C. Ancillary Expense			
35	Special Cost Centers	2,537,938	35
36	Provider Participation Fee	510,212	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,999,892	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,763,380)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,763,380)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,660,172	44
45	Private Pay - Net Inpatient Revenue	2,235,273	45
46	Medicare - Net Inpatient Revenue	1,141,467	46
47	Other-(specify) Managed Care	2,699,011	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,735,923	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 Orland Park, Inc.

0041855

Report Period Beginning:

1/1/17

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	2,181	2,684	\$ 168,851	\$ 62.91	1
2	Assistant Director of Nursing	1,237	1,360	65,430	48.10	2
3	Registered Nurses	32,921	40,570	1,345,630	33.17	3
4	Licensed Practical Nurses	39,590	47,944	1,288,128	26.87	4
5	CNAs & Orderlies	118,700	141,947	1,999,390	14.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,296	1,430	24,774	17.33	9
10	Activity Assistants	12,531	14,475	159,342	11.01	10
11	Social Service Workers	8,371	9,945	204,926	20.61	11
12	Dietician	3,847	4,316	101,469	23.51	12
13	Food Service Supervisor	2,044	2,314	53,474	23.10	13
14	Head Cook	2,084	2,314	47,154	20.37	14
15	Cook Helpers/Assistants	26,504	31,108	326,780	10.50	15
16	Dishwashers					16
17	Maintenance Workers	1,994	2,535	51,433	20.29	17
18	Housekeepers	34,510	41,587	441,970	10.63	18
19	Laundry					19
20	Administrator	2,141	2,462	143,944	58.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,267	12,998	286,983	22.08	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	1,963	2,635	57,105	21.68	31
32	Other Health C: See Sch 20A	24,520	30,004	781,858	26.06	32
33	Other(specify) <u>Marketing/Barber</u>	3,278	3,728	137,691	36.93	33
34	TOTAL (lines 1 - 33)	329,979	396,357	\$ 7,686,332 *	\$ 19.39	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 65,563	9(3)	36
37	Medical Records Consultant	Monthly 423	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 20,624	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 2,957	11(3)	44
45	Social Service Consultant	Monthly 3,399	12(3)	45
46	Other(specify) <u>Pulmonary Consultant</u>	Monthly 85,605	10(3)	46
47	<u>Post Acute Consultant</u>	Monthly 1,148	10(3)	47
48	<u>Telemedicine Consultant</u>	Monthly 8,325	10(3)	48
49	TOTAL (lines 35 - 48)	\$ 188,044		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 Orland Park, Inc.
IDPH License ID Number: 0041855
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
Accounts Coordinator	1,879	2,207	31,164	14.12
Admissions	3,358	4,024	110,357	27.42
Clinical Coordinator	3,500	4,291	149,012	34.73
Concierge	84	206	3,145	15.27
MDS	3,442	4,347	153,193	35.24
Staffing Coordinator	1,893	2,308	44,031	19.08
Unit Secretary	7,438	8,961	173,716	19.39
Wound Care Coordinator	2,926	3,660	117,239	32.03
Total - Line 32 Other Health Care (specify):	24,520	30,004	781,858	26.06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Nikki Dinsmore</u>	<u>Administrator</u>	<u>0</u>	\$ <u>116,194</u>	<u>Workers' Compensation Insurance</u>	\$ <u>167,073</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
<u>Bonny Lawrence</u>	<u>Administrator</u>	<u>0</u>	<u>27,750</u>	<u>Unemployment Compensation Insurance</u>	<u>92,044</u>	<u>Advertising: Employee Recruitment</u>	<u>26,481</u>	
				<u>FICA Taxes</u>	<u>572,480</u>	<u>Health Care Worker Background Check</u>	<u>1,780</u>	
				<u>Employee Health Insurance</u>	<u>319,393</u>	(Indicate # of checks performed <u>148</u>)	<u>1,780</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>470</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>5,896</u>	
				<u>401K</u>	<u>17,982</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>6,735</u>	
				<u>Tuition</u>	<u>2,000</u>	<u>IHCA</u>	<u>18,292</u>	
				<u>Uniform Allowance</u>	<u>9,881</u>	<u>Management Company Allocation</u>	<u>17,505</u>	
				<u>Other Employee Benefits</u>	<u>30,882</u>	<u>Less: Non-Allowable Dues</u>	<u>(6,238)</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)			\$ 143,944	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,211,735		
(List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 78,080		
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>MANAGEMENT FEES-ROYAL OPERATIONS</u>			\$ <u>1,785,868</u>	<u>N/A</u>		\$	<u>Out-of-State Travel</u>	\$
<u>MANAGEMENT FEES- VESTA MGMT</u>			<u>509,686</u>					
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,295,554	TOTAL			\$	
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	
							<u>111</u>	
C. Professional Services			Amount	G. Schedule of Travel and Seminar**			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount
<u>SECRETARY OF STATE</u>	<u>Filing Fees</u>	\$ <u>100</u>					<u>Allocated from Home Office</u>	<u>1,230</u>
<u>RSM US LLP</u>	<u>Accounting</u>	<u>34,381</u>					<u>Entertainment Expense</u>	()
<u>ATTADALE</u>	<u>Operations Consulting</u>	<u>(18)</u>					TOTAL (agree to Sch. V, line 24, col. 8)	
<u>PERSONNEL PLANNERS INC</u>	<u>U/C Consulting</u>	<u>2,340</u>					\$ 1,341	
<u>SERPICO, PETROSINO, DIPIERO</u>	<u>Legal</u>	<u>20,143</u>						
<u>MUCH SHELIST</u>	<u>Legal</u>	<u>6,422</u>						
<u>HUGHES SOCOL PIERS</u>	<u>Legal</u>	<u>369</u>						
<u>GENERATION LAW LTD</u>	<u>Legal</u>	<u>1,250</u>						
<u>DUANE MORRIS</u>	<u>Legal</u>	<u>5,763</u>						
<u>MCGUIRE WOODS</u>	<u>Legal</u>	<u>7,635</u>						
<u>VARIOUS</u>	<u>Collections</u>	<u>30,138</u>						
<u>See Sch 21C</u>	<u>See Sch 21C</u>	<u>149,447</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 257,970	TOTAL			\$	
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Lexington Health Care Center of Orland Park, Inc.
 IDPH License ID Number: 0041855
 Fiscal Year End: 12/31/17

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
LEXINGTON FINANCIAL SERVICES	Financial	37,082
Pension Administrator	401K Administration	1,542
AMERICAN RETRIEVAL	Document Retrieval	83
BSI LUC	Computer Services	1,593
Purchases	Computer Services	5,240
Computer Supply	Computer Services	30,347
MHC	Computer Services	382
INFOR	Computer Services	2,140
RYL	Computer Services	377
Replacement Local Servers	Computer Services	1,667
Softechoice Corporation	Computer Services	3,302
Softechoice	Computer Services	7,611
Salesforce	Computer Services	(4,594)
OnShift	Computer Services	10,580
Relias	Computer Services	9,772
Information Controls	Computer Services	3,079
eHDS (Carewatch/UB Watch)	Computer Services	2,567
Symbria	Computer Services	400
Ability Network	Computer Services	271
ICIMS	Computer Services	3,725
National Datacare	Computer Services	3,433
MB	Computer Services	50
Availity	Computer Services	28
MRK	Computer Services	1,025
Microsoft Software	Computer Services	10,204
Microsoft Software Licensing-Sales Tax Refu	Computer Services	1,557
HealthMEDX Software	Computer Services	1,169
NetSmart	Computer Services	9,352
RSM US LLP	Computer Services	5,463
Total (agree to Schedule V, line 19, column 3)		257,970
Less: Non-Allowable Legal Fees		
Out of Period Legal		(1,319)
Non-allowable Legal		(30,138)
<i>Allocated from Management Company Type</i>		
Much Shelist Legal		2,320
Hinshaw & Culbertson LLP Legal		319
Duane Morris Legal		2,737
Serpico, Petrosino Legal		17
Golan and Christie Legal		28
RSM Accounting		1,899
Friedman & Huey Accounting		1,016
IL Secretary of State Filing Fees		66
Gilson Labus & Silverman LLC Accounting		902
Marcum LLP Accounting		444
LaSalle Network Recruiting / Finance		1,596
Pension Administrators, Inc. 401K Administration		(164)
Gene Whitehorn Medicaid Reimb Specialist		2,592
M Werner Consulting Financial Consulting		1,329
Eisen Alliance LLC Workplace Consultant		414
Barry Lazarus Health Care Consultant		354
Mark Rodeghier Survey Preparation Consultant		917
Pathway Health Services Operational & Financial Consulti		3,184
IMEC Operational & Financial Consulti		7,739
Forest Performance Performance Consulting		2,370
Reputation.com Performance Consulting		1,419
Devree Molnar Strategy/Operations Consulting		199
Steven Wood Strategy/Operations Consulting		410
Susan Parker Social Service Consultant		23
Focus Pointe Global Strategic Planning		1,630
CLIN-SCIENCE RESEARCH General Business Consulting		536
Provinet Solutions Technical Consulting		20
ANDRZJ STANKIEWIC General Business Consulting		127
DLC Financial Planning & Analysis		1,890
Computer Services Computer Consulting		49,258
<i>Allocated from SV of Lombard II Type</i>		
Friedman & Huey Accounting		185
Illinois Secretary of State Filing Fees		20
Allocated from Real estate Professional Services		201
Total (agree to Schedule V, line 19, column 8)		312,510

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 - \$18,292
- (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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 72,274 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. \$ 510,212
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. \$ (218)
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? Adequate records have been maintained
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees