FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0041855

Facility Name: Lexington of Orland Park

Address: 14601 S J Humphry Dr (Number) Orland Park (City) 60462 (Zip Code)

County: Cook

Telephone Number: (708) 349-8300 **Fax #** (708) 349-4093

HFS ID Number:

Date of Initial License for Current Owners: 7/8/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 02/23/16

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	278	Skilled (SNF)	275	100,809	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	278	TOTALS	275	100,809	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			16,751	16,751	8
9	SNF/PED					9
10	ICF	47,811	8,135	4,164	60,110	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,811	8,135	20,915	76,861	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.24%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 259 and days of care provided 12,544

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name: **Lexington of Orland Park**
IDPH License ID Number: **0041855**
Fiscal Year End: **12/31/2016**

Schedule 2A

III. Statistical Data
Bed Days Computation

Licensure Level of Care	# of Beds	Start Date	End Date	# of Days	Bed Days Available
Skilled (SNF)	278	1/1/16	2/22/16	53	14,734
Skilled (SNF)	275	2/23/16	12/31/16	313	86,075
			Total - Line 1, Column 4		100,809

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	535,203	49,895	4,296	589,394		589,394		589,394			1
2	Food Purchase		507,585		507,585		507,585	(1,981)	505,604			2
3	Housekeeping	516,151	62,100		578,251		578,251	453	578,704			3
4	Laundry		27,232		27,232		27,232		27,232			4
5	Heat and Other Utilities			271,954	271,954		271,954	11,100	283,054			5
6	Maintenance	78,408		186,022	264,430		264,430	109,330	373,760			6
7	Other (specify):* Alloc. From Mgmt. Co							14,521	14,521			7
8	TOTAL General Services	1,129,762	646,812	462,272	2,238,846		2,238,846	133,423	2,372,269			8
	B. Health Care and Programs											
9	Medical Director			61,938	61,938		61,938		61,938			9
10	Nursing and Medical Records	6,339,880	494,221	235,297	7,069,398		7,069,398	50,404	7,119,802			10
10a	Therapy											10a
11	Activities	190,784	22,172	10,346	223,302		223,302		223,302			11
12	Social Services	245,769		3,772	249,541		249,541		249,541			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt. Co							6,579	6,579			15
16	TOTAL Health Care and Programs	6,776,433	516,393	311,353	7,604,179		7,604,179	56,983	7,661,162			16
	C. General Administration											
17	Administrative	134,534		2,264,488	2,399,022		2,399,022	(2,186,804)	212,218			17
18	Directors Fees											18
19	Professional Services			433,388	433,388		433,388	13,032	446,420			19
20	Dues, Fees, Subscriptions & Promotions			57,148	57,148		57,148	17,523	74,671			20
21	Clerical & General Office Expenses	290,098	35,486	74,831	400,415		400,415	992,445	1,392,860			21
22	Employee Benefits & Payroll Taxes			1,506,533	1,506,533		1,506,533		1,506,533			22
23	Inservice Training & Education			12,302	12,302		12,302	504	12,806			23
24	Travel and Seminar							1,522	1,522			24
25	Other Admin. Staff Transportation			8,480	8,480		8,480	16,579	25,059			25
26	Insurance-Prop.Liab.Malpractice			898,293	898,293		898,293	4,105	902,398			26
27	Other (specify):* Alloc. From Mgmt. Co							145,662	145,662			27
28	TOTAL General Administration	424,632	35,486	5,255,463	5,715,581		5,715,581	(995,432)	4,720,149			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,330,827	1,198,691	6,029,088	15,558,606		15,558,606	(805,026)	14,753,580			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of Orland Park #0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			144,295	144,295		144,295	522,031	666,326			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			172,766	172,766		172,766	435,523	608,289			32
33	Real Estate Taxes							691,152	691,152			33
34	Rent-Facility & Grounds			2,487,981	2,487,981		2,487,981	(2,475,415)	12,566			34
35	Rent-Equipment & Vehicles			87,752	87,752		87,752	3,163	90,915			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,892,794	2,892,794		2,892,794	(823,546)	2,069,248			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		599,911	1,905,006	2,504,917		2,504,917		2,504,917			39
40	Barber and Beauty Shops			21,262	21,262		21,262		21,262			40
41	Coffee and Gift Shops			2,355	2,355		2,355	(2,355)				41
42	Provider Participation Fee			545,442	545,442		545,442		545,442			42
43	Other (specify):* Non-Allowable Cos	75,802		559,918	635,720		635,720	(635,720)				43
44	**TOTAL Special Cost Centers**	75,802	599,911	3,033,983	3,709,696		3,709,696	(638,075)	3,071,621			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,406,629	1,798,602	11,955,865	22,161,096		22,161,096	(2,266,647)	19,894,449			45

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,981)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,663)	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	43,938	30		9
10	Interest and Other Investment Income	(1,374)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14,504)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,030)	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	(435,474)	43		24
25	Fund Raising, Advertising and Promotional	(34,804)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,440)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	31,483	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (431,849)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 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)	(1,834,798)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,834,798)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,266,647)		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 Yes	2 No	3 Amount	4 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

Lexington of Orland Park

ID# 0041855

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (4,137)	43	1
2	Labs - Part A	(21,199)	43	2
3	X-Rays - Part A	(30,392)	43	3
4	Marketing Salary	(75,802)	43	4
5	Gift Shop Income	(2,355)	41	5
6	Misc. Income	(191)	21	6
7	Unrealized loss on FMV swap	369,124	43	7
8	Trust Fees	(75)	43	8
9	Shareholder Interest	(156,000)	32	9
10	Reclass Repairs & Maintenance to LHI	(3,630)	6	10
11	Tax Consulting	(2,785)	19	11
12	Collections	(18,152)	19	12
13	Out of Period Legal	(10,350)	19	13
14	Salesforce.com Marketing	(6,498)	19	14
15	Non-Allowable Dues & Subscription	(3,801)	20	15
16	Non-Allowable Finance Charge	(2,274)	32	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	31,483		49

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	$ 339,422	$ 339,422	1
2	V	32	Interest Expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	566,090	566,090	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	**	682,081	682,081	4
5	V	34	Rental Expense	2,482,081	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(2,482,081)	5
6	V	43	Unrealized gain on FMV swap	369,124	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(369,124)	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	**	350	350	8
9	V								9
10	V								10
11	V				** The owners of Lexington Health Care Center of Orland Park, Inc. own 100%				11
12	V				of Lexington Health Care Systems of Orland Park Ltd. Ptsp.				12
13	V								13
14	Total			$ 2,851,205			$ 1,591,884	$ * (1,259,321)	14

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 453	$ 453	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	10,004	10,004	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	423	423	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	673	673	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	103,009	103,009	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	9,518	9,518	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	433	433	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	14,521	14,521	22
23	V	10	Medical consultant		Royal Management Corp.	**	3,759	3,759	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	46,645	46,645	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	6,579	6,579	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	77,684	77,684	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	20,794	20,794	27
28	V	19	Professional fees		Royal Management Corp.	**	30,487	30,487	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	3,096	3,096	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	17,953	17,953	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	955,522	955,522	31
32	V	21	Bank charges		Royal Management Corp.	**	3,826	3,826	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	12,921	12,921	33
34	V	21	Postage		Royal Management Corp.	**	4,805	4,805	34
35	V	21	Telephone		Royal Management Corp.	**	14,748	14,748	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			$			$ 1,337,853	$ * 1,337,853	39

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	23	Inservice Training	$	Royal Management Corp.	**	$ 504	$ 504	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,522	1,522	16
17	V	25	Auto expense		Royal Management Corp.	**	16,579	16,579	17
18	V	26	Insurance general		Royal Management Corp.	**	4,105	4,105	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	145,662	145,662	19
20	V	30	Depreciation		Royal Management Corp.	**	138,671	138,671	20
21	V	32	Interest		Royal Management Corp.	**	22,094	22,094	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	3,121	3,121	22
23	V	33	Property taxes		Royal Management Corp.	**	9,071	9,071	23
24	V	34	Rent expense		Royal Management Corp.	**	6,666	6,666	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,939	1,939	25
26	V	17	Management fees	2,264,488	Royal Management Corp.	**	0	(2,264,488)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,224	1,224	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								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			$ 2,264,488			$ 351,158	$ * (1,913,330)	39

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Estate	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					Corportation			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 of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Bloomingdale	Real Estate	1
2					Bloomingdale Ltd. Pts		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	Algonquin	Real Estate	22
23					Ltd. Ptsp.		Property	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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	$ 12,954	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,011	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	12,015	L17, C7	3
4	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	25,707	L17, C7	4
5	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	17,995	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 77,684		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days Available	724,314	10	$ 3,263	$	100,650	$ 453	1
2	5	Utilities - gas & electric	Bed Days Available	724,314	10	72,000		100,650	10,005	2
3	5	Utilities - water & sewer	Bed Days Available	724,314	10	3,036		100,650	422	3
4	5	Utilities - maintenance office	Bed Days Available	724,314	10	4,835		100,650	672	4
5	6	Management allocation - salaries	Bed Days Available	724,314	10	741,281	741,281	100,650	103,008	5
6	6	Repairs & maintenance	Bed Days Available	724,314	10	68,481		100,650	9,516	6
7	6	Scavenger & exterminating	Bed Days Available	724,314	10	3,101		100,650	431	7
8	7	Management allocation - employee	Bed Days Available	724,314	10	104,504		100,650	14,522	8
9	10	Medical consultant	Bed Days Available	724,314	10	27,047		100,650	3,758	9
10	10	Management allocation - salaries	Bed Days Available	724,314	10	335,674	335,674	100,650	46,645	10
11	15	Management allocation - employee	Bed Days Available	724,314	10	47,322		100,650	6,576	11
12	17	Management allocation - salaries	Bed Days Available	724,314	10	559,036	559,036	100,650	77,683	12
13	19	Computer consultant & supplies	Bed Days Available	724,314	10	149,651		100,650	20,795	13
14	19	Professional fees	Bed Days Available	724,314	10	219,386		100,650	30,486	14
15	20	Dues & subscriptions	Bed Days Available	724,314	10	22,289		100,650	3,097	15
16	20	Advertising - help wanted	Bed Days Available	724,314	10	129,203		100,650	17,954	16
17	21	Management allocation - salaries	Bed Days Available	724,314	10	6,876,284	6,876,284	100,650	955,522	17
18	21	Bank charges	Bed Days Available	724,314	10	27,523		100,650	3,825	18
19	21	Office supplies & printing	Bed Days Available	724,314	10	92,982		100,650	12,921	19
20	21	Postage	Bed Days Available	724,314	10	34,606		100,650	4,809	20
21	21	Telephone	Bed Days Available	724,314	10	106,126		100,650	14,747	21
22										22
23										23
24										24
25	TOTALS					$ 9,627,630	$ 8,512,275		$ 1,337,847	25

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	23	Inservice Training	Bed Days Available	724,314	10	$ 3,621	$	100,650	$ 503	1
2	24	Travel and Seminar	Bed Days Available	724,314	10	10,947		100,650	1,521	2
3	25	Auto expense	Bed Days Available	724,314	10	119,337		100,650	16,583	3
4	26	Insurance general	Bed Days Available	724,314	10	29,556		100,650	4,107	4
5	27	Management allocation - employee	Bed Days Available	724,314	10	1,048,208		100,650	145,658	5
6	30	Depreciation	Bed Days Available	724,314	10	997,930		100,650	138,671	6
7	32	Interest	Bed Days Available	724,314	10	158,994		100,650	22,094	7
8	32	Amortization of mortgage costs	Bed Days Available	724,314	10	22,462		100,650	3,121	8
9	33	Property taxes	Bed Days Available	724,314	10	65,273		100,650	9,070	9
10	34	Rent expense	Bed Days Available	724,314	10	47,968		100,650	6,666	10
11	35	Equipment rental	Bed Days Available	724,314	10	13,953		100,650	1,939	11
12	35	Auto Lease	Bed Days Available	724,314	10	8,793		100,650	1,222	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					$ 2,527,042	$		$ 351,155	25

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	9,017,525	1/1/2033	Variable	566,090	2
3												3
4				Finance Charge - Insurance Policy							2,274	4
5												5
	Working Capital											
6	Bank of America		X	Line of Credit	Varies	9/30/13	13,700,000	370,000	4/30/17	Prime/Libor	14,492	6
7	Shareholder loan	X		Working capital	Varies	5/3/12	1,200,000	1,200,000	Demand	Prime	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	$ 11,337,525			$ 738,856	9
	B. Non-Facility Related*											
10								Amortization of Mortgage Cost			3,866	10
11								Interest Income Offset			(1,374)	11
12								Shareholder Interest			(156,000)	12
13								See Sch. 9A			22,941	13
14	TOTAL Non-Facility Related						$	$			$ (130,567)	14
15	TOTALS (line 9+line14)						$ 27,004,000	$ 11,337,525			$ 608,289	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 of Orland Park
IDPH License ID Number: 0041855
Fiscal Year End: 12/31/2016

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related* YES	Related* NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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							Non-Allowable Finance Charge				(2,274)	10
11												11
12												12
13							Allocated from Mgmt Co.				25,215	13
14	TOTAL Non-Facility Related				$0.00		$ 0	$ 0			$ 22,941	14

Facility Name & ID Number Lexington of Orland Park # 0041855 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 682,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2015	$ 678,633	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,167)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 699,000	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.)**		$ 27,775	5
	Alloc. Fr. Mgmt Co.	9,071	
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** $ 40,527 **For** ** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (40,527)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 691,152	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	595,423	8
	2012	623,105	9
	2013	623,620	10
	2014	668,583	11
	2015	678,633	12

See attached real estate accrual sheet

** Real Estate Tax refunds recorded on line 6 are for tax years 2004, 2012 and 2013.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	27-10-100-099-0000	Land & Building	$ 678,632.62	$ 678,632.62
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-021	Land & Building	$ 249,002.30	$ 9,071.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 927,634.92	$ 687,703.62

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	152,460	1995	$ 776,408	1
2	Management Company Allocation			26,754	2
3	TOTALS	152,460		$ 803,162	3

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	250		1996	1996	$ 8,569,286	$	40	$ 214,232	$ 214,232	$ 4,389,184	4
5	10		1998	1998	63,790	1,595	40	1,595		28,707	5
6	18		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Electrical wiring			1996	2,304	58	40	58		1,165	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		812	12
13	Seal/restrip parking lot			1999	3,450		40			3,450	13
14	Wiring			1999	1,798	45	15	45		787	14
15	Roof repairs			2000	23,201		40			23,201	15
16	Electrical wiring			2000	5,732	164	15	164		2,704	16
17	Ceiling mount curtain rod hardware			2000	6,952	199	35	199		3,281	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	5	209		2,369	26
27	HVAC			2005	6,143	307	20	307		3,403	27
28	Electrical wiring			2005	3,637	182	20	182		2,032	28
29	Kitchen rehab			2005	6,360	318	20	318		3,736	29
30	Elevator rehab			2005	8,948	447	20	447		5,216	30
31	Lounge, lobby, and reception area rehab			2005	27,662	1,383	20	1,383		15,444	31
32	Landscaping enhancements			2006	5,795	386	20	386		3,989	32
33	HVAC			2006	9,300		15	465	465	4,689	33
34	LHI-therapy room rehab LL TCU/main therapy			2006	33,184	1,659	20	1,659		17,143	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 of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Landscaping	2007	$ 17,383	$ 1,159	15	$ 1,159	$	$ 10,914	37
38	Parking lot	2007	1,120	56	20	56		523	38
39	Plumbing-Fine Dining	2007	2,068	103	20	103		1,022	39
40	Laundry Room Rehab	2007	37,283	1,864	20	1,864		18,174	40
41	Employee lunch room	2007	2,865	143	20	143		1,394	41
42	Basement Renovation	2007	1,148	57	20	57		537	42
43	Patio Improvements	2007	7,000	350	20	350		3,238	43
44	1st floor remodel-carpentry, flooring, plumbing, electrical-	2007	1,481,886		40	37,426	37,426	352,429	44
45	fixtures, painting	2007							45
46									46
47	Basement Renovation	2007	20,191		20	1,010	1,010	9,086	47
48	Therapy Room Renovation	2007	978		20	49	49	441	48
49	Landscaping	2008	4,300	287	15	287		2,320	49
50	Spot Coolers	2008	3,790	189	20	189		1,512	50
51	Emergency A/C	2008	32,295	807	40	807		6,792	51
52	Plumbing & Sprinkler-Showers	2008	5,047	126	40	126		1,008	52
53	Parking lot repairs	2008	5,285	264	20	264		2,266	53
54	Phone closet	2008	5,954	149	40	149		1,279	54
55	Landscaping	2009	4,190	279	15	279		1,976	55
56	1st floor admin room-heating, fire protection	2009	16,422	821	20	821		6,294	56
57	Quick connectors	2009	7,091	355	20	355		2,603	57
58	Electrical Room	2009	4,692	235	20	235		1,645	58
59	Glass and Mirrors Med Room	2009	4,954	142	35	142		1,065	59
60	Key pad common areas	2009	3,757	107	35	107		830	60
61	2nd Floor remodel-Doors and Locks	2009	32,130	803	40	803		6,223	61
62	Patio Pergola	2009	7,930	529	15	529		3,835	62
63	Patio Fence	2009	11,293	712	15	712		5,043	63
64	2nd floor remodel-carpentry,flooring,electrical,painting	2009	1,014,056		27	36,875	36,875	295,000	64
65	2nd floor remodel-carpentry	2009	17,258		27	628	628	4,971	65
66	Office carpentry,flooring,electrical,painting,plumbing	2010	70,270	2,666	27	2,666		21,693	66
67	Landscaping	2010	11,399	760	15	760		4,750	67
68	Physican office carpentry	2010	2,926	106	27	106		636	68
69	Repave/Seal Cracks in parking lot	2010	21,817	1,091	20	1,091		6,909	69
70	TOTAL (lines 4 thru 69)		$ 11,701,790	$ 21,157		$ 311,842	$ 290,685	$ 5,347,202	70

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,701,790	$ 21,157		$ 311,842	$ 290,685	$ 5,347,202	1
2	Roof	2010	74,000	2,691	27	2,691		17,716	2
3	HVAC-Exhaust Modification	2010	4,202	153	27	153		943	3
4	Nurse pull cord station	2010	3,933	143	27	143		858	4
5	Paint lights over bed	2010	7,738	281	27	281		1,710	5
6	Trench/Awning	2010	11,666	424	27	424		2,634	6
7	Remodel Library/Lounge-art,flooring,carpentry	2010	4,120	150	27	150		900	7
8	3rd floor remodel-carpentry,electrical,plumbing	2010	868,783		27	67,183	67,183	431,091	8
9									9
10	Office-carpentry, flooring, electrical, painting, plumbing and signs	2011	6,710	244	27	244		1,342	10
11	Office Remodel- Doors and Locks	2011	31,324	1,139	27	1,139		7,688	11
12	Office Remodel- Doors and Locks	2011	5,282	192	27	192		1,120	12
13	Additional parking spaces	2011	196,376	7,141	27	7,141		37,490	13
14	Roof Repairs	2011	58,800	2,138	27	2,138		11,759	14
15	Fire Dampers	2011	5,586	203	27	203		1,032	15
16	Pantry Remodel - Millwork and Flooring	2011	3,730	136	27	136		703	16
17	Laundry Room Remodel - Flooring, Painting and Electrical	2011	9,172	334	27	334		1,753	17
18	2nd Floor Remodel - Doors	2011	12,612	459	27	459		2,448	18
19									19
20	Parking lot	2012	12,906	469	27	469		1,915	20
21	Chiller replacement kitchen	2012	108,732	3,954	27	3,954		17,463	21
22									22
23	Fire Pump- Basement	2013	5,000	125	40	125		490	23
24	EMR Wiring- Entire Facility	2013	19,542	711	27	711		2,192	24
25	New Countertop, wall, tile- Kitchen	2013	3,026	110	27	110		339	25
26	Stairway Access Control- Entire Facility (1st-3rd floor stairs)	2013	6,463	235	27	235		725	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	$ 5,891,513	34

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 13,161,493	$ 42,589		$ 400,457	$ 357,868	$ 5,891,513	1
2									2
3	Parking lot paving	2014	119,164	4,333	27	4,333		8,666	3
4	Kitchen Chiller Replacement	2014	126,990	4,618	27	4,618		11,930	4
5	Kitchen sink, drywall, tile	2014	15,968	581	27	581		1,500	5
6	Create Workspace in 1st floor library	2014	16,429	597	27	597		1,543	6
7									7
8	R/M Repair Concrete Walk (Front Entrance)	2014	3,393		15	226	226	565	8
9	R/M Replace Radiator/Thermostat	2014	7,190		10	719	719	1,798	9
10									10
11	EMR Building Wiring - Entire Facility	2015	5,038	183	27	183		290	11
12	Room Remodel - First Floor Semi-private room								12
13	converted to Private room	2015	5,375	195	27	195		212	13
14									14
15	R/M Parking Lot - Remove and replace asphalt	2015	5,200		20	260	260	390	15
16									16
17	Asphalt Removal/Replacement and Trench/Drain Installation in	2016	12,750	372	20	372		372	17
18	Parking Lot								18
19	Floor Tiling in First Floor Front Offices	2016	4,888	326	10	326		326	19
20	Chair Rail Installation in First Floor Rooms	2016	14,378	87	27	87		87	20
21									21
22	R/M: Frame/Drywall Installation in Boiler Room Exit Vestibule	2016	3,630		27	67	67	67	22
23									23
24									24
25	Reconcile to book depreciation			1,458			(1,458)		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,501,885	$ 55,339		$ 413,021	$ 357,682	$ 5,919,259	34

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 13,501,885	$ 55,339		$ 413,021	$ 357,682	$ 5,919,259	1
2									2
3	Building - management company	2002	370,255		40	11,455	11,455	164,286	3
4	HVAC, electrical, security system - management company	2003	3,251		30	814	814	2,580	4
5	Key card system - management company	2004	511		20	27	27	318	5
6	VAV TX controls - management company	2005	157		20	8	8	94	6
7	Interior Signs - management company	2006	112		20	8	8	75	7
8	Building improvements - management company	2008	17,942		20	208	208	7,842	8
9	Building improvements - management company	2009	3,346		20	64	64	1,359	9
10	Building improvements - management company	2010	3,262		20	63	63	1,254	10
11	Building improvements - management company	2011	2,306		20	112	112	590	11
12	Building improvements - management company	2012	7,961		20	16	16	1,357	12
13	Building improvements - management company	2013	6,017		20	456	456	1,431	13
14	Building improvements - management company	2014	3,254		20	339	339	815	14
15	Building improvements - management company	2015	571		20	73	73	105	15
16	Building improvements - management company	2016	9,448		20	282	282	282	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,930,278	$ 55,339		$ 426,946	$ 371,607	$ 6,101,647	34

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 1,072,944	$ 87,314	$ 112,991	$ 25,677	5-10	$ 960,278	71
72	Current Year Purchases	28,019	1,642	1,642	-	7-10	1,642	72
73	Fully Depreciated Assets	813,576			-	5-10	813,576	73
74	Allocated from Mgmt. Co.	767,930		121,140	121,140	5-7	633,622	74
75	TOTALS	$ 2,682,469	$ 88,956	$ 235,773	$ 146,817		$ 2,409,118	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.			69,229		3,607	3,607	5	61,472	79
80	TOTALS			$ 69,229	$ -	$ 3,607	$ 3,607		$ 61,472	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)	$ 17,485,138	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 144,295	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 666,326	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 522,031	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,572,237	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.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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				5,900			5
6	Allocated from Management Company				6,666			6
7	TOTAL				$ 12,566 **			7

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 89,691 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			1,224	20
21	TOTAL		$	$ 1,224	21

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

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

Facility Name: **Lexington of Orland Park**
IDPH License ID Number: **0041855**
Fiscal Year End: **12/31/2016**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	8,726
Printer	4,189
Postage	423
Med Equip	29,050
Oxygen	45,363
Mgmt Alloc.	1,939
Total - Line 16	**89,691**

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	11,220	$ 619,535	$	11,220	$ 619,535	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,015	165,157		3,015	165,157	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		27,901	1,117,701		27,901	1,117,701	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 prescrpts				587,389		587,389	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				2,613			2,613	12
13	Other (specify): See Sch 16A	39(2)					12,522		12,522	13
14	TOTAL			$	42,136	$ 1,905,006	$ 599,911	42,136	$ 2,504,917	14

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

Facility Name: **Lexington of Orland Park**
IDPH License ID Number: **0041855**
Fiscal Year End: **12/31/2016**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 13 Other (specify)

Description	Ref	Amount
DME	39(2)	3,659
Oxygen	39(2)	8,863
Total - Line 13		**12,522**

Facility Name & ID Number Lexington of Orland Park **#** 0041855 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,926,069	$ 1,932,465	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,501,363)	4,192,071	4,192,071	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	150,503	150,503	6
7	Other Prepaid Expenses	18,646	18,646	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	26,583	26,583	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,313,872	$ 6,320,268	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	114,386	114,386	12
13	Land		803,162	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	1,475,866	5,360,992	15
16	Equipment, at Historical Cost	628,467	2,751,698	16
17	Accumulated Depreciation (book methods)	(886,893)	(8,572,237)	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			22
23	Other(specify): Mortgage cost net		63,347	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,331,826	$ 9,090,634	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,645,698	$ 15,410,902	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 665,475	$ 665,475	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,320,000	2,320,000	29
30	Accrued Salaries Payable	587,155	587,155	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,364	37,364	31
32	Accrued Real Estate Taxes(Sch.IX-B)		699,000	32
33	Accrued Interest Payable		42,544	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	10,778,811	4,880,932	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 14,388,805	$ 9,232,470	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,017,525	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)**	$	$ 9,017,525	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 14,388,805	$ 18,249,995	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,743,107)	$ (2,839,093)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,645,698	$ 15,410,902	48

***(See instructions.)**

Facility Name: **Lexington of Orland Park**
IDPH License ID Number: **0041855**
Fiscal Year End: **12/31/2016**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Acct. No.	Account Description	Operating	After Consolidation
00-10140-00	Cash Patient Trust	(25,706)	(25,706)
00-12020-00	PA Audit Settlement	1,282	1,282
00-13040-00	Rent Receivable	0	(6,427,761)
00-13240-00	Due to Lex Fin Svcs I	691	691
00-13700-00	Due from LLC	0	2,376
00-13890-00	Due from - Royal General	(1,000)	(1,000)
00-14530-00	Prepaid Insurance	56,635	56,635
00-14540-00	Prepaid Interest - Short Term	(2,552)	(2,552)
00-21030-00	COBRA	(540)	(540)
00-21040-00	Withholding - Dental Insurance	(2,109)	(2,109)
00-21050-00	Withholding - EP/CI/WL	540	540
00-21085-00	Vision Withholding	(336)	(336)
00-21100-00	401K Withholding	51	51
00-22030-00	Accrued Expenses	257,077	257,077
00-22040-00	Accrued Resident Tax	103,348	103,348
00-22060-00	Accrued Royal / Vesta Mgmt Fees	2,515,704	2,515,704
00-22120-00	Accrued Rent	6,427,761	6,427,761
00-22140-00	Accrued Insurance	37,603	37,603
00-22270-00	Due to Patient Trust Fund	27,070	27,070
00-22330-00	Advance - Biweekly Part A Payment	(36,084)	(36,084)
00-22360-00	Uncollectible Part A Co Pvts	(256,200)	(256,200)
00-23530-00	Due to - Royal Operations	17,484	17,484
00-23720-00	Due to Republic	56	56
00-23750-00	Due to LHCC Elmhurst	904	904
00-23830-00	Due to/from Vesta Management	214	214
00-24345-00	Interest Rate Swap Liability	0	527,506
00-24400-00	Professional Liabilities Claims	1,656,918	1,656,918
	Total - Line 36	**10,778,811**	**4,880,932**

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,966,443)	1
2	Restatements (describe):		2
3	**Post closing adjustment**	521,165	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,445,278)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,297,829)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,297,829)	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)**	$ (6,743,107)	24 *

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 29,606,456	1
2	Discounts and Allowances for all Levels	(16,715,739)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,890,717	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,402,113	6
7	Oxygen	147	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,402,260	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	2,608	12
13	Barber and Beauty Care	24,237	13
14	Non-Patient Meals	1,981	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	893,723	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	208,376	19
20	Radiology and X-Ray	31,557	20
21	Other Medical Services	406,243	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,568,725	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,374	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,374	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	191	27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 191	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,863,267	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,238,846	31
32	Health Care	7,604,179	32
33	General Administration	5,715,581	33
	B. Capital Expense		
34	Ownership	2,892,794	34
	C. Ancillary Expense		
35	Special Cost Centers	3,164,254	35
36	Provider Participation Fee	545,442	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 22,161,096	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,297,829)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,297,829)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,759,306	44
45	Private Pay - Net Inpatient Revenue	1,496,370	45
46	Medicare - Net Inpatient Revenue	1,711,266	46
47	Other-(specify) Managed Care	923,775	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,890,717	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

^ - Entity is a cash basis taxpayer

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,921	3,566	$ 220,224	$ 61.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,569	39,178	1,308,162	33.39	3
4	Licensed Practical Nurses	46,163	58,000	1,542,327	26.59	4
5	CNAs & Orderlies	140,212	170,262	2,355,305	13.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,195	1,998	32,578	16.30	9
10	Activity Assistants	12,217	14,662	158,206	10.79	10
11	Social Service Workers	10,083	11,956	245,769	20.56	11
12	Dietician	3,676	4,091	101,265	24.76	12
13	Food Service Supervisor	1,917	2,160	49,735	23.02	13
14	Head Cook	1,963	2,160	42,789	19.81	14
15	Cook Helpers/Assistants	29,062	34,067	341,414	10.02	15
16	Dishwashers					16
17	Maintenance Workers	3,766	4,360	78,408	17.98	17
18	Housekeepers	43,115	50,448	516,151	10.23	18
19	Laundry					19
20	Administrator	1,482	1,835	134,534	73.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,663	13,864	290,098	20.93	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	1,867	2,314	50,531	21.83	31
32	Other Health C: See SCH 20A	27,794	33,776	863,331	25.56	32
33	Other(specify) Marketing	1,983	2,261	75,803	33.52	33
34	TOTAL (lines 1 - 33)	371,649	450,960	$ 8,406,629 *	$ 18.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	61,938	9(3)	36
37	Medical Records Consultant	Monthly	878	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	17,473	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	2,548	11(3)	44
45	Social Service Consultant	Monthly	3,772	12(2)	45
46	Other(specify) Pulmonary Consultan	Monthly	96,427	10(3)	46
47	Post Acute Consultant	Monthly	2,206	10(3)	47
48	See Sch 20B	Monthly	13,943	10(3) & 10(7)	48
49	TOTAL (lines 35 - 48)		$ 199,185		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	353	$ 19,816	10(3)	50
51	Licensed Practical Nurses	1,988	88,313	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,341	$ 108,129		53

Facility Name: **Lexington of Orland Park**
IDPH License ID Number: **0041855**
Fiscal Year End: **12/31/2016**

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	1,745	2,115	29,367	13.89
Admissions	3,549	4,180	95,783	22.92
Clinical Coordinator	2,004	2,521	82,177	32.59
Concierge	972	1,155	17,686	15.31
MDS	4,456	5,441	190,004	34.92
Staffing Coordinator	3,039	3,681	62,158	16.89
Transitional Care Nurse	1,621	2,083	75,406	36.19
Unit Secretary	7,593	9,001	196,306	21.81
Wound Care Coordinator	2,815	3,599	114,445	31.80
Total - Line 32 Other Health Care (specify):	**27,794**	**33,776**	**863,331**	**25.56**

Facility Name: **Lexington of Orland Park**
IDPH License ID Number: **0041855**
Fiscal Year End: **12/31/2016**

Schedule 20B

XVIII. Staffing and Salary Costs
Line 48 Other Consultants (specify):

	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
Telemedicine Consultant	Monthly	10,184	10(3)
Medical Consultant	Monthly	3,759	10(7)
Total Line 48		13,943	

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brandon Davidson	Administrator	0	$ 134,534
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,534

B. Administrative - Other

Description	Amount
MANAGEMENT FEES-ROYAL OPERATIONS	$ 1,640,568
MANAGEMENT FEES- VESTA MGMT	623,920
Eliminated in col. 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,264,488
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Collections	$ 175
Attadale	Operations Consulting	9,990
Cassiday Schade, LLP	Legal	240,451
Generation Law	Legal	7,986
Grabowski Law	Collections	3,441
RSM US LLP	Accounting	49,707
Duane Morris	Legal	1,243
Much Shelist- Collections	Collections	14,536
Much Shelist- Legal	Legal	5,505
Pension Administrators	401K Administration	820
Personnel Planners	U/C Consulting	2,865
See Sch 21C	Various	96,669
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 433,388

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 280,920
Unemployment Compensation Insurance	146,531
FICA Taxes	619,842
Employee Health Insurance	383,946
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	12,937
Tuition	6,889
Uniform Allowance	15,567
Other Employee Benefits	39,901
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,506,533

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	22,702
Health Care Worker Background Check	
(Indicate # of checks performed 243)	2,920
Patient Background Checks 771	9,247
Miscellaneous Licenses & Fees	4,730
Miscellaneous Dues & Subscriptions	7,721
IHCA	7,838
Less: Non-Allowable Dues	(3,526)
Management Company Allocation	21,049
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 74,671

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocation from Home Office	1,522
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,522

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Lexington of Orland Park**
IDPH License ID Number: **0041855**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
SB2 Inc.	Medicaid Consulting	2,484
Secretary of State	Filing Fees	236
SNR Denton	Legal	3,567
Amalgamated Bank	Service Fees	814
Standard and Poor	Financial	950
Jefferies	Tax Consulting	2,785
Voya	Financial	4
INFOR	Computer Services	8,210
NTT Data	Computer Services	9,212
Ability Network	Computer Services	5,981
Avatier	Computer Services	227
Cinetec	Computer Services	851
Citrix	Computer Services	702
CorePoint	Computer Services	1,792
DocuSign	Computer Services	462
eHealth	Computer Services	863
Information Controls	Computer Services	(3,181)
MHC Software	Computer Services	1,069
OnShift	Computer Services	10,686
Relias	Computer Services	12,531
Salesforce	Computer Services	6,498
Softchoice	Computer Services	2,314
Symbria	Computer Services	2,400
Tableau Software	Computer Services	411
Provinet	Computer Services	112
Availity	Computer Services	252
HealthMEDX Software	Computer Services	18,864
National Datacare	Computer Services	3,395
Softchoice Corporation	Computer Services	2,480
Microcenter	Computer Services	157
Microsoft Licensing-Sales Tax Refund	Computer Services	(458)
	Total of Above	**96,669**
	Total (agree to Schedule V, line 19, column 3)	**433,388**
	Less:	
	Bank Fee Reclass	(814)
	Non-allowable tax consulting	(2,785)
	Salesforce.com	(6,498)
	Out of Period Legal	(10,350)
	Non-allowable Legal	(18,152)
	Total Disallowance	**(38,599)**
	Allocated from Real Estate	
	Secretary of State	350
	Samvest of Lombard	
	Accounting	168
	Filing Fees	12
		180
Allocated from Mgmt Co.		
RSM US LLP	Accounting	4,612
Marcum LLP	Accounting	551
Gilson Labus & Silverman	Accounting	143
Illinois Secretary of State	Filing Fees	66
LaSalle Network	Recruiting/Finance	3,206
Callan Associates, Ltd.	Recruiting	17,175
Pension Administrators, Inc.	401K Administration	550
Voya Financial	401K Administration	23
Gene Whitehorn	Medicaid Reimb Specialist	2,476
M. Werner Consulting	Financial Consultant	1,317
M. Rodeghier Consulting	Process Improvement Consultant	100
Wordy.com	Proofreading	88
Computer Services	Computer Consulting	20,794
		51,101
	Total (agree to Schedule V, line 19, column 8)	446,420

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 - $7,838**

(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? **7-10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **86,286** 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. $ **545,442**
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. $ **-** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,981**

(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