FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0038083

Facility Name: Lexington Health Care Center of LaGrange, Inc.

Address: 4735 Willow Springs Road (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 352-6900 Fax # (708) 482-0239

HFS ID Number:

Date of Initial License for Current Owners: 7/31/92

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 1/1/17 to 12/31/17 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 Health Care Center of LaGrange, Inc. # 0038083 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 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			18,207	18,207	8
9	SNF/PED					9
10	ICF	5,629	3,728	300	9,657	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,629	3,728	18,507	27,864	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.62%

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 [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 7/31/92

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 120 and days of care provided 12,825

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: 12/31/2017 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 LaGrange, I # 0038083 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	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	397,227	20,957	3,728	421,912		421,912	-	421,912			1
2	Food Purchase		194,198		194,198		194,198	(3,150)	191,048			2
3	Housekeeping	342,269	25,693	-	367,962		367,962	178	368,140			3
4	Laundry	-	8,189	-	8,189	-	8,189	-	8,189			4
5	Heat and Other Utilities			204,313	204,313		204,313	5,107	209,420			5
6	Maintenance	40,885	-	115,238	156,123		156,123	74,588	230,711			6
7	Other (specify):* Alloc. Mgmt Co. Bene	-	-	-	-		-	9,289	9,289			7
8	TOTAL General Services	780,381	249,037	323,279	1,352,697	-	1,352,697	86,012	1,438,709			8
	B. Health Care and Programs											
9	Medical Director	-	-	44,064	44,064		44,064	-	44,064			9
10	Nursing and Medical Records	3,500,965	310,928	118,961	3,930,854		3,930,854	15,172	3,946,026			10
10a	Therapy	-	-	-	-		-	-	-			10a
11	Activities	92,805	10,955	8,282	112,042		112,042	-	112,042			11
12	Social Services	147,886	-	3,819	151,705		151,705	-	151,705			12
13	CNA Training	-	-	-	-		-	-	-			13
14	Program Transportation	-	-	-	-		-	-	-			14
15	Other (specify):* Alloc. Mgmt Co. Bene	-	-	-	-		-	2,016	2,016			15
16	TOTAL Health Care and Programs	3,741,656	321,883	175,126	4,238,665	-	4,238,665	17,188	4,255,853			16
	C. General Administration											
17	Administrative	134,506	-	999,904	1,134,410		1,134,410	(963,940)	170,470			17
18	Directors Fees			-	-		-	-	-			18
19	Professional Services			132,661	132,661		132,661	24,535	157,196			19
20	Dues, Fees, Subscriptions & Promotions			37,763	37,763		37,763	4,563	42,326			20
21	Clerical & General Office Expenses	166,962	22,193	79,298	268,453		268,453	487,829	756,282			21
22	Employee Benefits & Payroll Taxes			752,628	752,628		752,628	-	752,628			22
23	Inservice Training & Education			9,862	9,862		9,862	305	10,167			23
24	Travel and Seminar			1,187	1,187		1,187	(539)	648			24
25	Other Admin. Staff Transportation		-	6,264	6,264		6,264	8,546	14,810			25
26	Insurance-Prop.Liab.Malpractice			629,241	629,241		629,241	5,410	634,651			26
27	Other (specify):* Alloc. Mgmt Co. Bene	-	-	-	-		-	67,081	67,081			27
28	TOTAL General Administration	301,468	22,193	2,648,808	2,972,469	-	2,972,469	(366,210)	2,606,259			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,823,505	593,113	3,147,213	8,563,831	-	8,563,831	(263,010)	8,300,821			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 Health Care Center of LaGrange, Inc. #0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

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			86,208	86,208		86,208	267,656	353,864			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			465	465		465	249,841	250,306			32
33	Real Estate Taxes			-	-		-	431,773	431,773			33
34	Rent-Facility & Grounds			1,207,828	1,207,828		1,207,828	(1,204,953)	2,875			34
35	Rent-Equipment & Vehicles			72,056	72,056		72,056	1,243	73,299			35
36	Other (specify):*			-	-		-	-	-			36
37	**TOTAL Ownership**			1,366,557	1,366,557	-	1,366,557	(254,440)	1,112,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	485,663	1,758,815	2,244,478		2,244,478	-	2,244,478			39
40	Barber and Beauty Shops	-	-	8,043	8,043		8,043	-	8,043			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			157,607	157,607		157,607	-	157,607			42
43	Other (specify):* Non-Allowable Cos	109,837	-	428,013	537,850		537,850	(537,850)	-			43
44	**TOTAL Special Cost Centers**	109,837	485,663	2,352,478	2,947,978	-	2,947,978	(537,850)	2,410,128			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,933,342	1,078,776	6,866,248	12,878,366	-	12,878,366	(1,055,300)	11,823,066			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 Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	(3,150)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,170)	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	(463)	30		9
10	Interest and Other Investment Income	(2,186)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,047)	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	(789)	43		18
19	Entertainment				19
20	Contributions	(2,000)	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	(327,160)	43		24
25	Fund Raising, Advertising and Promotional	(17,208)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(907)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(122,214)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (491,294)		$	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)	(564,006)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (564,006)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,055,300)		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 Health Care Center of LaGrange, Inc.

ID# 0038083

Report Period Beginning: 1/1/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (28,964)	43	1
2	X-Rays-Part A	(18,769)	43	2
3	Diagnostics Managed Care	(4,750)	43	3
4	Trust Fees	(75)	43	4
5	Collections	(11,392)	19	5
6	Marketing Salary	(109,837)	43	6
7	Unrealized Loss on FMV Swap	69,686	43	7
8	Pharmacy - Part A	(12,249)	43	8
9	Disallowed Lobbying	(2,908)	20	9
10	Dues & Subsciptions Marketing	(168)	20	10
11	Travel and Seminar Marketing	(1,076)	24	11
12	Disallow Salesforce	(1,712)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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42				42
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44				44
45				45
46				46
47				47
48				48
49	**Total**	(122,214)		49

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	19	Professional Fees	$	Sambell of LaGrange Limited Partnership	**	$ 201	$ 201	1
2	V	30	Depreciation		Sambell of LaGrange Limited Partnership	**	230,182	230,182	2
3	V	32	Interest Expense		Sambell of LaGrange Limited Partnership	**	220,319	220,319	3
4	V	32	Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	19,755	19,755	4
5	V	33	Property Taxes		Sambell of LaGrange Limited Partnership	**	427,828	427,828	5
6	V	34	Rental Income	1,207,828	Sambell of LaGrange Limited Partnership	**		(1,207,828)	6
7	V	43	Trust Fees		Sambell of LaGrange Limited Partnership	**	75	75	7
8	V	43	Unrealized loss on FMV swap	89,653	Sambell of LaGrange Limited Partnership	**		(89,653)	8
9	V	43	Gain/Loss on Sale on Disposal		Sambell of LaGrange Limited Partnership	**	19,967	19,967	9
10	V				Sambell of LaGrange Limited Partnership	**			10
11	V								11
12	V				** The owners of Lexington Health Care Center of LaGrange, Inc				12
13	V				of Sambell of LaGrange Limited Partnership.				13
14	Total			$ 1,297,481			$ 918,327	$ * (379,154)	14

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

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.	**	$ 178	$ 178	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	4,561	4,561	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	190	190	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	356	356	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	69,912	69,912	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	4,488	4,488	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	188	188	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	9,289	9,289	22
23	V	10	Medical consultant		Royal Management Corp.	**			23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	15,172	15,172	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	2,016	2,016	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	35,964	35,964	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	21,494	21,494	27
28	V	19	Professional fees		Royal Management Corp.	**	15,944	15,944	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	874	874	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	6,765	6,765	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	468,896	468,896	31
32	V	21	Bank charges		Royal Management Corp.	**	1,894	1,894	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	7,653	7,653	33
34	V	21	Postage		Royal Management Corp.	**	2,266	2,266	34
35	V	21	Telephone		Royal Management Corp.	**	7,120	7,120	35
36	V								36
37	V								37
38	V		**The owners of Lexington Health Care Center of LaGrange, Inc. ov						38
39	Total			$			$ 675,220	$ * 675,220	39

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 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.	**	$ 305	$ 305	15
16	V	24	Travel & seminar		Royal Management Corp.	**	537	537	16
17	V	25	Auto expense		Royal Management Corp.	**	8,546	8,546	17
18	V	26	Insurance general		Royal Management Corp.	**	5,410	5,410	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	67,081	67,081	19
20	V	30	Depreciation		Royal Management Corp.	**	37,937	37,937	20
21	V	32	Interest		Royal Management Corp.	**	10,566	10,566	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,387	1,387	22
23	V	33	Property taxes		Royal Management Corp.	**	3,945	3,945	23
24	V	34	Rent expense		Royal Management Corp.	**	2,875	2,875	24
25	V	35	Equipment rental		Royal Management Corp.	**	878	878	25
26	V	17	Management fees	999,904	Royal Management Corp.	**	0	(999,904)	26
27	V	35	Auto Lease		Royal Management Corp.	**	365	365	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V		**The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						36
37	V								37
38	V								38
39	Total			$ 999,904			$ 139,832	$ * (860,072)	39

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 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	33.33%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Lexington Square	Lombard	Independent and	3
4			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Life Care		Assisted Living	4
5			Lexington HC Ctr. of Lombard, Inc.	Lombard	of Lombard, LLC		Facility	5
6			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Life Care		Living Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	of Elmhurst, LLC			8
9			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Vesta Management	Lombard	Mgmt. Company	9
10					Group LLC			10
11					Sambell of	LaGrange	Real Estate	11
12					LaGrange Ltd. Ptsp.		Property	12
13					Royal Management	Lombard	Mgmt. Company	13
14					Corporation			14
15					Lexington Financial	Lombard	Finance Company	15
16					Services II, LLC			16
17					Heron Point	Lombard	Mgmt. Company	17
18					Management Corp			18
19					Samvest of Lombard	Lombard	Lessor	19
20					II, LLC			20
21					North Heron	Lombard	Finance Company	21
22					Investments, LLC			22
23					Lexington Home	Lombard	Home Health	23
24					Health Care, Inc.			24
25					Lexington Hospice	Lombard	Hospice	25
26					Services, LLC			26
27					Lexington Private	Lombard	Healthcare	27
28					Home Care			28
29		0			Merit Sleep	Lombard	Mgmt. Company	29
30		0			Management, LLC			30

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 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	Bloomingdale	Real Estate	1
2					Bloomingdale Ltd.		Property	2
3					Ptsp.			3
4					Sambell of Chicago	Chicago Ridge	Real Estate	4
5					Ridge Ltd. Ptsp.		Property	5
6					Sambell of Elmhurst	Elmhurst	Real Estate	6
7					II Ltd. Ptsp.		Property	7
8					Lexington HC Sys	Lake Zurich	Real Estate	8
9					of Lake Zurich Ltd.		Property	9
10					Ptsp.			10
11					Lexington HC Sys	Lombard	Real Estate	11
12					of Lombard Ltd. Ptsp.		Property	12
13					Lexington HC Sys	Orland Park	Real Estate	13
14					of Orland Park Ltd.		Property	14
15					Ptsp.			15
16					Sambell of	Schaumburg	Real Estate	16
17					Schaumburg Ltd. Ptsp		Property	17
18					Sambell of	Streamwood	Real Estate	18
19					Streamwood Ltd. Ptsp		Property	19
20					Lexington HC Sys	Wheeling	Real Estate	20
21					of Wheeling Ltd. Ptsp.		Property	21
22					Samvest of Algonquin	Algonquin	Real Estate	22
23					Ltd. Ptsp.		Property	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington Health Care Center of LaGrange, # 0038083 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	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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 5,650	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,925	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,233	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,340	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,677	L17, C7	5
6	Phil Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,516	L17, C7	6
7	Jeremy Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,623	L17, C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 35,964		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 LaGrange, Inc. # 0038083 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 [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	722,335	10	$ 2,937	$	43,800	$ 178	1
2	5	Utilities - gas & electric	Bed Days Available	722,335	10	75,222		43,800	4,561	2
3	5	Utilities - water & sewer	Bed Days Available	722,335	10	3,135		43,800	190	3
4	5	Utilities - maintenance office	Bed Days Available	722,335	10	5,869		43,800	356	4
5	6	Management allocation - salaries	Bed Days Available	722,335	10	1,152,969	1,152,969	43,800	69,912	5
6	6	Repairs & maintenance	Bed Days Available	722,335	10	74,022		43,800	4,488	6
7	6	Scavenger & exterminating	Bed Days Available	722,335	10	3,102		43,800	188	7
8	7	Management allocation - employee	Bed Days Available	722,335	10	153,196		43,800	9,289	8
9	10	Medical consultant	Bed Days Available	722,335	10	0		43,800	0	9
10	10	Management allocation - salaries	Bed Days Available	722,335	10	250,218	250,218	43,800	15,172	10
11	15	Management allocation - employee	Bed Days Available	722,335	10	33,247		43,800	2,016	11
12	17	Management allocation - salaries	Bed Days Available	722,335	10	593,100	593,100	43,800	35,964	12
13	19	Computer consultant & supplies	Bed Days Available	722,335	10	354,473		43,800	21,494	13
14	19	Professional fees	Bed Days Available	722,335	10	262,937		43,800	15,944	14
15	20	Dues & subscriptions	Bed Days Available	722,335	10	14,411		43,800	874	15
16	20	Advertising - help wanted	Bed Days Available	722,335	10	111,560		43,800	6,765	16
17	21	Management allocation - salaries	Bed Days Available	722,335	10	7,732,875	7,732,875	43,800	468,896	17
18	21	Bank charges	Bed Days Available	722,335	10	31,229		43,800	1,894	18
19	21	Office supplies & printing	Bed Days Available	722,335	10	126,211		43,800	7,653	19
20	21	Postage	Bed Days Available	722,335	10	37,365		43,800	2,266	20
21	21	Telephone	Bed Days Available	722,335	10	117,421		43,800	7,120	21
22										22
23										23
24										24
25	TOTALS					$ 11,135,499	$ 9,729,162		$ 675,220	25

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 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 [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	722,335	10	$ 5,038	$	43,800	$ 305	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	8,850		43,800	537	2
3	25	Auto expense	Bed Days Available	722,335	10	140,934		43,800	8,546	3
4	26	Insurance general	Bed Days Available	722,335	10	89,225		43,800	5,410	4
5	27	Management allocation - employee	Bed Days Available	722,335	10	1,106,283		43,800	67,081	5
6	30	Depreciation	Bed Days Available	722,335	10	625,643		43,800	37,937	6
7	32	Interest	Bed Days Available	722,335	10	174,244		43,800	10,566	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	22,869		43,800	1,387	8
9	33	Property taxes	Bed Days Available	722,335	10	65,056		43,800	3,945	9
10	34	Rent expense	Bed Days Available	722,335	10	47,418		43,800	2,875	10
11	35	Equipment rental	Bed Days Available	722,335	10	14,486		43,800	878	11
12	35	Auto Lease	Bed Days Available	722,335	10	6,017		43,800	365	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	$		$ 139,832	25

Facility Name & ID Number Lexington Health Care Center of LaGrange, # 0038083 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** 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	MB Financial		X	Mortgage	Varies	9/15/2017	4,481,325	4,436,515	9/15/2019	Libor + 3.5%	67,012	2
3	Lexington Financial											3
4	Sevices II, LLC	X		Mortgage	Varies	4/30/2007	5,991,000		9/15/2017	0.0650	148,383	4
5	Sambell of Elmhurt II LP	X		Loan	Varies	9/15/2017	329,288	329,288	9/15/2019	Libor + 3.5%	4,924	5
	Working Capital											
6	MB Financial		X	Line of Credit	Various	9/15/2017	2,000,000		9/15/2019	Libor + 2.5%		6
7												7
8												8
9	TOTAL Facility Related						$ 12,801,613	$ 4,765,803			$ 220,319	9
	B. Non-Facility Related*											
10								Amortization of Loan Cost			19,755	10
11								Microsoft			465	11
12								Interest Income			(2,186)	12
13								Allocated from Mgmt Co.			11,953	13
14	TOTAL Non-Facility Related						$	$			$ 29,987	14
15	TOTALS (line 9+line14)						$ 12,801,613	$ 4,765,803			$ 250,306	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 & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 390,000	1
	2016		
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.)		$ 386,004	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,996)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 477,000	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.)**		$ 20,029	5
	Alloc Fr. Mgmt Co.	3,945	
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** $ 65,205 **For** 14 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (65,205)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 431,773	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	345,195	8
	2013	355,813	9
	2014	363,484	10
	2015	369,109	11
	2016	386,004	12

See attached real estate accrual sheet

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

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of LaGrange, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-08-207-017-0000	Land & Building	$ 220,315.81	$ 220,315.80
2.	18-08-207-018-0000	Land & Building	$ 165,687.91	$ 165,687.91
3.	Royal Management Corp. (Samvest		$	$
4.	05-01-202-021	Land & Building	$ 257,788.00	$ 3,945.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 643,791.72	$ 389,948.71

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 LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,072 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [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	40,000	1991	$ 500,000	1
2	Management Company Allocation			11,143	2
3	TOTALS	40,000		$ 511,143	3

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 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 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	120		1992	1992	$ 2,661,448	$ -	35	$ 76,041	$ 76,041	$ 1,939,051	4
5			1995	1995	79,363	-	10	-		79,363	5
6			2005	2005	2,321,014	-	21	110,524	110,524	1,381,552	6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Land Improvements			1992	1,152		20			1,152	9
10	Building Improvements			1992	2,714		31			2,714	10
11	Building Improvements			1993	2,901		35	83	83	2,073	11
12	Leasehold Improvements			1994	6,402		10			6,402	12
13	Leasehold Improvements - Corner Guards			1996	2,195		10			2,122	13
14	Wiring			1998	3,378		10			3,378	14
15	Resurface & Restripe Parking Lot			1998	3,753		10			3,753	15
16	Lobby Tile			1998	19,488		10			19,488	16
17	Resurface & Restripe Parking Lot			2000	1,997		10			1,997	17
18	Automatic Door			2000	1,300		10			1,300	18
19	Kitchen Rehab			2001	1,441		10			1,441	19
20	Infrared curtains for elevator			2001	3,000		10			3,000	20
21	Dining room, resident rooms, and corridors renovations			2002	150,083	7,505	20	7,505		113,196	21
22	Elevator upgrade			2002	5,398		10			5,398	22
23	Air conditioner compressor			2003	9,218		10			9,218	23
24	Sidewalk and fencing			2005	46,701	2,335	20	2,335		28,409	24
25	HVAC			2005	8,141	407	20	407		4,918	25
26	Wiring			2005	4,506	225	20	225		2,757	26
27	Lobby, lounge and reception renovations			2005	24,362	1,218	20	1,218		15,022	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors			2005	326,862		20	16,343	16,343	196,116	28
29	Wallcoverings			2005	10,822		5			10,822	29
30	Medical records room rehab			2006	19,739	987	20	987		10,857	30
31	Activity/PT Room Rehab			2006	1,158	58	20	58		638	31
32	Land scape enhancement			2006	8,726	582	15	582		6,596	32
33	Roof			2006	29,700	1,980	15	1,980		22,440	33
34	HVAC			2006	3,254	163	20	163		1,847	34
35	Plumbing and sprinkler system			2006	20,725	1,036	20	1,036		12,433	35
36	Laundry Combustion Air			2006	16,814	841	20	841		9,881	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 LaGrange, Inc. # 0038083 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 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	Lobby/Lounge/Reception rehab	2006	$ 14,033	$	10	$	$	$ 14,033	37
38	Cubicle curtains/drapery	2006	6,955		5			6,955	38
39	Cabinets/counters for 2nd FI library	2006	2,665		10			2,665	39
40	TCU rehab	2006	2,402	120	20	120		1,330	40
41	First floor remodel	2006	212,084		20	10,604	10,604	116,644	41
42	Kitchen rehab	2006	8,165	408	20	408		4,693	42
43	Bath fixtures-2nd foor	2006	2,076		10			2,076	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		1,937	44
45	Landscaping	2007	3,862	257	15	257		2,720	45
46	HVAC	2007	58,326	2,916	20	2,916		30,375	46
47	Common Areas Remodel	2007	2,059		10			2,059	47
48	First Floor Remodel	2007	6,517		20	326	326	3,503	48
49	Garage	2007	16,487	824	20	824		8,309	49
50	Land Improvements	2008	3,745	250	15	250		2,271	50
51	Parking lot-paving	2008	8,720	436	20	436		4,106	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		1,260	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	16,260	16,260	159,890	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		30,943	55
56	Irrigation System	2009	16,740	1,116	15	1,116		9,207	56
57	Landscaping	2009	10,321	688	15	688		5,676	57
58	Parking lot repairs	2009	3,500	175	20	175		1,502	58
59	HVAC Chiller	2009	2,594	130	20	130		1,094	59
60	Patio Pergola	2009	6,760	338	20	338		2,986	60
61	Stamped Concrete	2009	16,658	833	20	833		6,942	61
62	Fence	2009	4,084	204	20	204		1,649	62
63	Patio Wall	2009	8,212	411	20	411		3,391	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		2,297	64
65									65
66	Brick Panel Replacement	2010	16,578	603	27	603		4,623	66
67	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	17,565	641	27	641		4,487	67
68	Landscaping Enhancements	2010	15,258	1,017	15	1,017		7,628	68
69	Drain tile,sewer concrete	2010	3,221	214	15	214		1,544	69
70	TOTAL (lines 4 thru 69)		$ 6,882,020	$ 33,327		$ 263,508	$ 230,181	$ 4,348,129	70

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 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 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		$ 6,882,020	$ 33,327		$ 263,508	$ 230,181	$ 4,348,129	1
2	Retaining wall	2010	15736	1,049	15	1,049		7,343	2
3	Canopy Installation	2010	4466	163	27	163		1,168	3
4	Dining Room HVAC	2010	4169	152	27	152		1,140	4
5	Pantry carpentry,flooring,plumbing	2010	2911	106	27	106		777	5
6	Director of Nursing office painting	2010	4245	155	27	155		1,085	6
7	Remodel Library/Lounge-art,painting,flooring	2010	6477	236	27	236		1,652	7
8	2nd floor doors	2010	3046	111	27	111		860	8
9	Office changes-carpentry, painting, flooring	2011	2487	90	27	90		593	9
10	Fence	2011	2750	183	15	183		1,129	10
11	Mulch and stone	2011	2662	177	15	177		1,092	11
12	Laundry Room-Tile, Painting	2011	7311	266	27	266		1,685	12
13	Locker Room - Installation of 6 tier box lockers	2011	2573	94	27	94		619	13
14	Place beds back into service - Carpentry, Flooring, Electrical,	2011	117350	4,267	27	4,267		28,091	14
15	-Painting and Plumbing								15
16									16
17									17
18	Electrical wiring for EMR	2012	13699	498	27	498		2,532	18
19									19
20	Landscaping (Planting roses and day lilies Main Entrance)	2014	10648	177	15	177		708	20
21	Install Automatic Doors (Front Entrance)	2014	6859.38	83	15	83		332	21
22	Install LED Lights throughout facility	2014	22199.99	67	27	67		268	22
23	R/M Reclass: Elevator door restrictor (Front Entrance)	2014	3500		10	350	350	1,225	23
24									24
25	Install LED Lights throughout facility	2015	22799	829	27	829		1,727	25
26	Electrical wiring throughout facility	2015	5832	212	27	212		548	26
27	R/M Reclass: asphalt and concrete work in parking lot	2015	15650		20	783	783	1,957	27
28									28
29	Private Room Rehab - 1st floor install of chair rails	2016	17444	634	27	634		740	29
30									30
31									31
32									32
33	Reconcile to book depreciation			1,595			(1,595)		33
34	TOTAL (lines 1 thru 33)		$ 7,176,834	$ 44,471		$ 274,190	$ 229,719	$ 4,405,400	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 LaGrange, Inc. # 0038083 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 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		$ 7,176,834	$ 44,471		$ 274,190	$ 229,719	$ 4,405,400	1
2									2
3	Building - management company	2002	154,197		40	3,950	3,950	71,931	3
4	HVAC, electrical, security system - management company	2003	1,354		30	377	377	1,117	4
5	Key card system - management company	2004	213		20	12	12	143	5
6	VAV TX controls - management company	2005	65		20	4	4	42	6
7	Interior Signs-management company	2006	47		20	4	4	35	7
8	Building - management company	2008	6,986		20	94	94	2,983	8
9	Building - management company	2009	1,373		20	29	29	633	9
10	Building - management company	2010	1,341		20	28	28	575	10
11	Building - management company	2011	959		20	50	50	290	11
12	Building - management company	2012	3,246		20	7	7	675	12
13	Building - management company	2013	2,505		20	205	205	778	13
14	Building - management company	2014	1,356		20	152	152	476	14
15	Building - management company	2015	238		20	33	33	73	15
16	Building - management company	2016	3,933		20	328	328	405	16
17	Building - management company	2017	2,558		20	36	36	48	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,357,205	$ 44,471		$ 279,499	$ 235,028	$ 4,485,604	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 LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 242,144	$ 41,737	$ 41,737	$	5-10	$ 174,173	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets	492,045				5-7	492,045	73
74	Allocated from Mgmt. Co.	313,561		31,278	31,278	5-7	282,008	74
75	TOTALS	$ 1,047,750	$ 41,737	$ 73,015	$ 31,278		$ 948,226	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.			28,206		1,350	1,350	5	26,246	79
80	TOTALS			$ 28,206	$	$ 1,350	$ 1,350		$ 26,246	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)	$ 8,944,304	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,208	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 353,864	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 267,656	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,460,076	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 Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Company				2,875			6
7	TOTAL				$ 2,875 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 72,934 Description: See Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20	Allocated from Management Company			365	20
21	TOTAL		$	$ 365	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 LaGrange, Inc.**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/17**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	6,974
Mailing System	323
Printer	2,711
Oxygen	31,981
Medical Equipment	30,067
Management Co.	878
Total - Line 16	**72,934**

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 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.)

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.

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	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	$	18,359	$ 786,923	$	18,359	$ 786,923	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		7,375	123,887		7,375	123,887	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		17,378	843,809		17,378	843,809	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				472,167		472,167	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Sch 16A	39(2)					13,496		13,496	12
13	Other (specify): Ambulance	39(3)				4,196			4,196	13
14	TOTAL			$	43,112	$ 1,758,815	$ 485,663	43,112	$ 2,244,478	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 LaGrange, Inc.**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/17**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

Description	Reference	Amount
Oxygen	39(2)	8,958
DME	39(2)	4,538
Total - Line 12	**-**	**13,496**

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. **#** 0038083 **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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,436,571	$ 2,621,559	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 900,009)	1,332,528	1,332,528	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,780	72,780	6
7	Other Prepaid Expenses	31,434	31,434	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,873,313	$ 4,058,301	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		511,143	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	1,148,024	4,695,757	15
16	Equipment, at Historical Cost	424,167	1,075,956	16
17	Accumulated Depreciation (book methods)	(927,497)	(5,460,076)	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 **See Sch 17A**	998,108	998,108	22
23	Other(specify): **Mortgage cost, net**		110,484	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,649,854	$ 4,599,872	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,523,167	$ 8,658,173	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 665,833	$ 665,833	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	338,735	338,735	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,413	17,413	31
32	Accrued Real Estate Taxes(Sch.IX-B)		477,000	32
33	Accrued Interest Payable		23,395	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,408,016	908,924	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,429,997	$ 2,431,300	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,765,803	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Professional Liabilities Claims	1,318,935	1,318,935	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,318,935	$ 6,084,738	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,748,932	$ 8,516,038	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,774,235	$ 142,135	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,523,167	$ 8,658,173	48

***(See instructions.)**

Facility Name: **Lexington Health Care Center of LaGrange, Inc.**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/17**

Schedule 17A

XV. Balance Sheet
Line 22 Other Long - Term Assets (specify):

Description	Operating	Consolidation
Receivable from Insurance Recoveries	998,108	998,108

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

Description	Operating	After Consolidation
CASH PATIENT TRUST	602	602
Sambel Rent Receivable	-	(499,092)
DUE FRM IRS	-	-
DUE TO LEX FIN SVCS I	(314)	(314)
DUE FROM LOMARD SQUARE- AR	(19,556)	(19,556)
DUE FROM ELMHURST SQUARE-AR	(19,871)	(19,871)
Due from LLC II	-	-
DUE FROM -/Lexington Fin Serv LLC	-	-
PREPAID INSURANCE	2,129	2,129
WITHHOLDING - DENTAL INSURANCE	576	576
401K WITHHOLDING	4,186	4,186
ACCRUED EXPENSES	15,458	15,458
ACCRUED RESIDENT TAX	15,254	15,254
ACCRUED VESTA 3% MANAGEMENT FEES	926,085	926,085
ACCRUED RENT	499,092	499,092
ACCRUED INSURANCE	46,069	46,069
DUE TO PATIENT TRUST FUND	(2,042)	(2,042)
ADVANCE - BIWEEKLY PART A PAYM	(4,623)	(4,623)
UNCOLLECTIBLE PART A CO PVTS	(76,496)	(76,496)
DUE TO - ROYAL OPERATIONS	29,366	29,366
Due to Republic	(2,843)	(2,843)
Due to LHCC Elmhurst	2,251	2,251
Due to Lake Zurich	(190)	(190)
Due to LHCC Lombard	(8,186)	(8,186)
Due to Wheeling	185	185
DUE/TO FROM VESTA	740	740
Due to/from Lex Fincl Svcs II LLC	144	144
Total - Line 36	**1,408,016**	**908,924**

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,578,681	1
2	Restatements (describe):		2
3	**Post Closing Adjustment**	(124,501)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,454,180	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(259,945)	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	(420,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (679,945)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,774,235	24 *

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 12,147,005	1
2	Discounts and Allowances for all Levels	(7,478,900)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,668,105	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,374,482	6
7	Oxygen	35,616	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,410,098	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		12
13	Barber and Beauty Care	9,219	13
14	Non-Patient Meals	3,150	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	819,693	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	269,933	19
20	Radiology and X-Ray	36,547	20
21	Other Medical Services	399,490	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,538,032	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,186	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,186	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,618,421	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,352,697	31
32	Health Care	4,238,665	32
33	General Administration	2,972,469	33
	B. Capital Expense		
34	Ownership	1,366,557	34
	C. Ancillary Expense		
35	Special Cost Centers	2,790,371	35
36	Provider Participation Fee	157,607	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,878,366	40
41	**Income before Income Taxes (line 30 minus line 40)****	(259,945)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (259,945)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 634,195	44
45	Private Pay - Net Inpatient Revenue	998,562	45
46	Medicare - Net Inpatient Revenue	2,074,756	46
47	Other-(specify) **Managed Care**	960,592	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,668,105	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 LaGrange, Inc. # 0038083 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,685	2,037	$ 118,340	$ 58.10	1
2	Assistant Director of Nursing	1,665	2,037	88,825	43.61	2
3	Registered Nurses	25,969	31,000	1,013,164	32.68	3
4	Licensed Practical Nurses	16,915	20,138	536,720	26.65	4
5	CNAs & Orderlies	54,265	63,943	948,736	14.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,801	2,060	39,666	19.26	9
10	Activity Assistants	3,773	4,492	53,139	11.83	10
11	Social Service Workers	6,773	7,514	147,886	19.68	11
12	Dietician	1,877	2,321	58,367	25.15	12
13	Food Service Supervisor	1,738	2,073	48,155	23.23	13
14	Head Cook	1,833	2,133	37,994	17.81	14
15	Cook Helpers/Assistants	19,769	22,773	252,711	11.10	15
16	Dishwashers					16
17	Maintenance Workers	1,744	2,083	40,885	19.63	17
18	Housekeepers	23,563	28,834	342,269	11.87	18
19	Laundry					19
20	Administrator	2,029	2,408	134,506	55.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,379	9,939	166,962	16.80	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	1,687	2,040	38,307	18.78	31
32	Other Health C: See Sch 20A	23,469	28,575	756,872	26.49	32
33	Other(specify) Marketing	2,410	3,088	109,838	35.57	33
34	TOTAL (lines 1 - 33)	201,344	239,488	$ 4,933,342 *	$ 20.60	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	44,064	9(3)	36
37	Medical Records Consultant	Monthly	1,235	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,333	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	8,282	11(3)	44
45	Social Service Consultant	Monthly	3,819	12(3)	45
46	Other(specify) Pulmonary	Monthly	94,920	10(3)	46
47	Post Acute Consulting	Monthly	1,398	10(3)	47
48	Telemedicine Consulting	Monthly	9,075	10(3)	48
49	TOTAL (lines 35 - 48)		$ 175,126		49

C. CONTRACT NURSES

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

Facility Name: **Lexington Health Care Center of LaGrange, Inc.**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/17**

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	1,743	2,109	40,326	$ 19.12
Admissions	714	807	26,218	$ 32.49
Clinical Coordinator	4,199	5,164	185,414	$ 35.91
Concierge	29	150	2,557	$ 17.05
MDS	1,567	2,103	87,360	$ 41.55
Staffing Coordinator	2,689	3,164	61,167	$ 19.33
Transitional Care Nurse	1,692	2,037	63,505	$ 31.17
Unit Secretary	8,881	10,710	231,223	$ 21.59
Wound Care Coordinator	1,953	2,331	59,101	$ 25.35
Total - Line 32 Other Health Care (specify):	**23,469**	**28,575**	**756,871**	

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonny Lawrence	Administrator	0	$ 98,694
Rachael Mabe	Administrator	0	35,812
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,506

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 816,205
Management Fees-Vesta Mgmt.	183,699
Eliminated in Column 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 999,904
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM LLP	Accounting	$ 31,670
Much Shelist	Legal	3,998
Secretary Of State	Legal	100
Much Shelist	Legal	2,350
Law Offices Of Serpico	Legal	870
Duane Morris	Legal	510
Personnel Planners Inc	Other	3,636
Pension Administrators	LLC & 401K Audit	549
Lawson	Computer Services	4,980
Ability	Computer Services	271
See Sch 21C		83,727
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 132,661

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	40,747
FICA Taxes	369,375
Employee Health Insurance	303,027
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	20,475
Other Employee Benefits	12,292
Uniform Expense	2,117
Tuition	4,595
TOTAL (agree to Schedule V, line 22, col.8)	$ 752,628

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	$
Advertising: Employee Recruitment	5,624
Health Care Worker Background Check	
(Indicate # of checks performed 215)	2,575
Patient Background Checks 716	8,590
Miscellaneous Licenses & Fees	2,480
Miscellaneous Dues & Subscriptions	10,574
IHCA Dues	7,920
Management Company Allocation	7,639
Less: Non-Allowable Dues	(3,076)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,326

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	111
Management Company Allocation	537
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 648

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Lexington Health Care Center of LaGrange, Inc.**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/17**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Symbria	Computer Services	400
Carewatch	Computer Services	321
Relias	Computer Services	2,521
Icims	Computer Services	237
Sales Force	Computer Services	1,712
Softchoice	Computer Services	35,434
National Datacare Corp.	Computer Services	613
Availity	Computer Services	2,901
Softchoice	Computer Services	1,027
Microsoft	Computer Services	9,837
Health Medx	Computer Services	5,443
Softchoice	Computer Services	4,157
Much Shelist	Collections	11,392
Network Infrastructure	Computer Services	7,732
Total (agree to Schedule V, line 19, column 3)		83,727

Allocated from Real Estate Entity	201
Less: Non-Allowable Legal Fees	(11,392)
Less: Non-Allowable computer service	(1,712)

Allocated from Mgmt. Co.	Type	Amount
Much Shelist	Legal	1,012
Hinshaw & Culbertson LLP	Legal	139
Duane Morris	Legal	1,194
Serpico, Petrosino	Legal	7
Golan and Christie	Legal	13
RSM	Accounting	829
Friedman & Huey	Accounting	443
IL Secretary of State	Filing Fees	29
Gilson Labus & Silverman LLC	Accounting	393
Marcum LLP	Accounting	194
LaSalle Network	Recruiting / Finance	696
Pension Administrators, Inc.	401K Administration	(72)
Gene Whitehorn	Medicaid Reimb Specialist	1,131
M Werner Consulting	Financial Consulting	580
Eisen Alliance LLC	Workplace Consultant	181
Barry Lazarus	Health Care Consultant	155
Mark Rodeghier	Survey Preparation Consultant	400
Pathway Health Services	Operational & Financial Consultin	1,389
IMEC	Operational & Financial Consultin	3,377
Forest Performance	Performance Consulting	1,034
Reputation.com	Performance Consulting	619
Devree Molnar	Strategy/Operations Consulting	87
Steven Wood	Strategy/Operations Consulting	179
Susan Parker	Social Service Consultant	10
Focus Pointe Global	Strategic Planning	711
CLIN-SCIENCE RESEARCH	General Business Consulting	234
Provinet Solutions	Technical Consulting	9
ANDRZJ STANKIEWIC	General Business Consulting	56
DLC	Financial Planning & Analysis	825
Computer Services	Computer Consulting	21,494
Allocated from SV of Lombard II		
Friedman & Huey	Accounting	81
Illinois Secretary of State	Filing Fees	9
Total (agree to Schedule V, line 19, column 8)		157,196

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 - $8,448**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,472** 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. $ **157,607**
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? **No** Indicate the amount. $ **3,150**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees