

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: <u>0035188</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Lexington Health Care Center of Bloomingdale, Inc.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> 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.																							
Address: <u>165 S. Bloomingdale Road</u> <u>Bloomingdale</u> <u>60108</u>																									
Number City Zip Code																									
County: <u>Dupage</u>																									
Telephone Number: <u>(630) 980-8700</u> Fax # <u>(630) 980-6170</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS PREPERATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS PREPERATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) <u>SEE ACCOUNTANTS PREPERATION REPORT</u>																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>																								
	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																								
Date of Initial License for Current Owners: <u>5/1/89</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☒ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u>																									
Email Address: _____																									

Facility Name & ID Number Lexington Health Care Center of Bloomingda # 0035188 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	346,219	41,130	14,426	401,775		401,775		401,775			1
2	Food Purchase		290,761		290,761		290,761	(14,536)	276,225			2
3	Housekeeping	310,963	33,228		344,191		344,191	303	344,494			3
4	Laundry	55,153	22,206		77,359		77,359		77,359			4
5	Heat and Other Utilities			222,542	222,542		222,542	8,298	230,840			5
6	Maintenance	34,113		170,896	205,009		205,009	62,497	267,506			6
7	Other (specify):* Mgmt Co.-Allocated B							7,484	7,484			7
8	TOTAL General Services	746,448	387,325	407,864	1,541,637		1,541,637	64,046	1,605,683			9
	B. Health Care and Programs											
9	Medical Director			82,073	82,073		82,073		82,073			9
10	Nursing and Medical Records	3,850,279	255,613	108,544	4,214,436		4,214,436	51,313	4,265,749			10
10a	Therapy			1,283,344	1,283,344		1,283,344		1,283,344			10a
11	Activities	232,787	27,360	5,641	265,788		265,788		265,788			11
12	Social Services	130,758		11,141	141,899		141,899		141,899			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co.-Allocated B							7,097	7,097			15
16	TOTAL Health Care and Programs	4,213,824	282,973	1,490,743	5,987,540		5,987,540	58,410	6,045,950			16
	C. General Administration											
17	Administrative	107,119		1,251,309	1,358,428		1,358,428	(1,229,073)	129,355			17
19	Directors Fees											19
19	Professional Services			145,149	145,149		145,149	18,127	163,276			19
20	Dues, Fees, Subscriptions & Promotions			37,799	37,799		37,799	6,023	43,822			20
21	Clerical & General Office Expenses	201,708	33,669	39,560	274,937		274,937	494,327	769,264			21
22	Employee Benefits & Payroll Taxes			802,570	802,570		802,570	14,536	817,106			22
23	Inservice Training & Education			15,985	15,985		15,985	1,323	17,308			23
24	Travel and Seminar			2,512	2,512		2,512	(233)	2,279			24
25	Other Admin. Staff Transportation			1,845	1,845		1,845	16,053	17,898			25
26	Insurance-Prop.Liab.Malpractice			349,949	349,949		349,949	5,549	355,498			26
27	Other (specify):* Mgmt Co.-Allocated B							71,315	71,315			27
28	TOTAL General Administration	308,827	33,669	2,646,678	2,989,174		2,989,174	(602,053)	2,387,121			29
29	TOTAL Operating Expense (sum of lines 9, 16 & 29)	5,269,099	703,967	4,545,285	10,518,351		10,518,351	(479,597)	10,038,754			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			182,250	182,250		182,250	359,255	541,505			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,339	9,339		9,339	286,804	296,143			32
33	Real Estate Taxes							154,291	154,291			33
34	Rent-Facility & Grounds			1,229,294	1,229,294		1,229,294	(1,225,929)	3,365			34
35	Rent-Equipment & Vehicles			68,386	68,386		68,386	2,715	71,101			35
36	Other (specify):*											36
37	TOTAL Ownership			1,489,269	1,489,269		1,489,269	(422,864)	1,066,405			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											39
39	Ancillary Service Centers		329,515	6,149	335,664		335,664		335,664			39
40	Barber and Beauty Shops			19,247	19,247		19,247		19,247			40
41	Coffee and Gift Shops			2,106	2,106		2,106		2,106			41
42	Provider Participation Fee			229,785	229,785		229,785		229,785			42
43	Other (specify):* Non-Allow Costs	103,693		154,278	257,971		257,971	(257,971)				43
44	TOTAL Special Cost Centers	103,693	329,515	411,565	844,773		844,773	(257,971)	586,802			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,372,792	1,033,482	6,446,119	12,852,393		12,852,393	(1,160,432)	11,691,961			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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				4
5	Telephone, TV & Radio in Resident Rooms	(4,794)	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	(2,980)	30		9
10	Interest and Other Investment Income	(29,617)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,656)	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	(33,361)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,542)	43		24
25	Fund Raising, Advertising and Promotional	(35,976)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,452)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(488,793)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (644,171)		\$	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)	(516,261)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (516,261)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,160,432)		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

Report Period Beginning: Ending:

ID# 003518801/01/201112/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Radiology	\$ (17,349)	43	1
2	Laboratory	(9,533)	43	2
3	Personal Item Replacement	(1,523)	43	3
4	Trust Fees	(50)	43	4
5	Collection Fees	(1,473)	19	5
6	Nonallowable Marketing Salaries	(103,693)	43	6
7	Customer Service-Marketing	(5,529)	43	7
8	Reclass LHI to Repairs and Maintenance	6,714	6	8
9	Education and training marketing	(2,512)	24	9
10	Unrealized loss on FMV swap	(353,845)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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	(488,793)		49

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	\$	Sambell of Bloomingdale Limited Partnership	**	\$ 200	\$ 200	1
2	V	30	Depreciation Expense		Sambell of Bloomingdale Limited Partnership	**	323,432	323,432	2
3	V	32	Interest	86,880	Sambell of Bloomingdale Limited Partnership	**	387,928	301,048	3
4	V	32	Amortization of Mortgage Cost		Sambell of Bloomingdale Limited Partnership	**	2,171	2,171	4
5	V	33	Property Tax		Sambell of Bloomingdale Limited Partnership	**	149,294	149,294	5
6	V	34	Rent	1,229,294	Sambell of Bloomingdale Limited Partnership	**		(1,229,294)	6
7	V	43	Trust Fees		Sambell of Bloomingdale Limited Partnership	**	50	50	7
8	V	43	State Replacement Tax		Sambell of Bloomingdale Limited Partnership	**	2,437	2,437	8
9	V	43	Unrealized lose on FMV of Swap		Sambell of Bloomingdale Limited Partnership	**	353,845	353,845	9
10	V								10
11	V				** Certain owners of Lexington Health Care Center of Bloomingdale, Inc.				11
12	V				own 100% of Sambell of Bloomingdale Limited Partnership				12
13	V								13
14	Total			\$ 1,316,174			\$ 1,219,357	\$ * (96,817)	14

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 303	\$ 303	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,221	7,221	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	164	164	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	913	913	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	50,855	50,855	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,652	4,652	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	276	276	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	7,484	7,484	22
23	V	10 Medical consultant		Royal Management Corp.	**	3,090	3,090	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	48,223	48,223	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	7,097	7,097	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	22,236	22,236	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	14,089	14,089	27
28	V	19 Professional fees		Royal Management Corp.	**	5,311	5,311	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,090	1,090	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	4,933	4,933	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	462,349	462,349	31
32	V	21 Bank charges		Royal Management Corp.	**	8,845	8,845	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,240	10,240	33
34	V	21 Postage		Royal Management Corp.	**	3,313	3,313	34
35	V							35
36	V							36
37	V	**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Sambell Bloomingdale Partnership						37
38	V							38
39	Total		\$			\$ 662,684	\$ * 662,684	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Telephone	\$	Royal Management Corp.	**	\$ 9,580	\$ 9,580	15
16	V	24	Travel & seminar		Royal Management Corp.	**	2,279	2,279	16
17	V	25	Auto expense		Royal Management Corp.	**	16,053	16,053	17
18	V	26	Insurance general		Royal Management Corp.	**	5,549	5,549	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	71,315	71,315	19
20	V	30	Depreciation		Royal Management Corp.	**	38,803	38,803	20
21	V	32	Interest		Royal Management Corp.	**	13,172	13,172	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	30	30	22
23	V	33	Property taxes		Royal Management Corp.	**	4,997	4,997	23
24	V	34	Rent expense		Royal Management Corp.	**	3,365	3,365	24
25	V	35	Equipment rental		Royal Management Corp.	**	971	971	25
26	V	17	Management fees	1,251,309	Royal Management Corp.	**		(1,251,309)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,744	1,744	27
28	V	23	Inservice Training		Royal Management Corp.	**	1,323	1,323	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V		**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Sambell Bloomingdale Partnership						36
37	V								37
38	V								38
39	Total			\$ 1,251,309			\$ 169,181	\$ * (1,082,128)	39

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

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	<u>James Samatas Discretionary Trust</u>	<u>22.33%</u>	<u>Lexington HC Ctr. of Lombard, Inc.</u>	<u>Lombard</u>	<u>Eastgate Manor</u>	<u>Algonquin</u>	<u>Supportive</u>	1
2	<u>John Samatas Discretionary Trust</u>	<u>22.33%</u>	<u>Lexington HC Ctr. of Lake Zurich, Inc.</u>	<u>Lake Zurich</u>	<u>of Algonquin, LLC</u>		<u>Living Facility</u>	2
3	<u>Cynthia Thiem Discretionary Trust</u>	<u>22.34%</u>	<u>Lexington HC Ctr. of Elmhurst, Inc.</u>	<u>Elmhurst</u>	<u>Vesta Mgmt</u>	<u>Lombard</u>	<u>Mgmt. Company</u>	3
4	<u>Jeffrey J. Bell Revocable Trust</u>	<u>8.25%</u>	<u>Lexington HC Ctr. of LaGrange, Inc.</u>	<u>LaGrange</u>	<u>Group, LLC</u>			4
5	<u>Lawrence W. Bell Revocable Trust</u>	<u>8.25%</u>	<u>Lexington HC Ctr. of Wheeling, Inc.</u>	<u>Wheeling</u>	<u>Sambell of</u>	<u>Bloomingtondale</u>	<u>Real Estate</u>	5
6	<u>David S. Bell Revocable Trust</u>	<u>8.25%</u>	<u>Lexington HC Ctr. of Schaumburg, Inc.</u>	<u>Schaumburg</u>	<u>Bloomingtondale Ltd. Pts.</u>		<u>Property</u>	6
7	<u>David S. Bell 2001 Trust</u>	<u>2.75%</u>	<u>Lexington HC Ctr. of Chicago Ridge, Inc.</u>	<u>Chicago Ridge</u>	<u>Royal Management</u>	<u>Lombard</u>	<u>Mgmt. Company</u>	7
8	<u>Jeffrey J. Bell 2001 Trust</u>	<u>2.75%</u>	<u>Lexington HC Ctr. of Streamwood, Inc.</u>	<u>Streamwood</u>	<u>Corporation</u>			8
9	<u>Lawrence W. Bell 2001 Trust</u>	<u>2.75%</u>	<u>Lexington HC Ctr. of Orland Park, Inc.</u>	<u>Orland Park</u>	<u>Lexington Financial</u>	<u>Lombard</u>	<u>Finance Company</u>	9
10					<u>Services, LLC</u>			10
11					<u>Lexington Square</u>	<u>Lombard</u>	<u>Independent and</u>	11
12					<u>Life Care of</u>		<u>Assisted Living</u>	12
13					<u>Lombard, LLC</u>		<u>Facility</u>	13
14					<u>Lexington Square</u>	<u>Elmhurst</u>	<u>Independent</u>	14
15					<u>Life Care of</u>		<u>Living Facility</u>	15
16					<u>Elmhurst, LLC</u>			16
17					<u>Samvest of</u>	<u>Lombard</u>	<u>Lessor</u>	17
18					<u>Lombard II, LLC</u>			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

Facility Name & ID Number Lexington Health Care Center of Bloomingd # 0035188 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 8,156	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,879	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,201	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,919	L21, C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,155		13

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

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

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc. # 0035188 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	Housekeeping supplies	Bed Days	722,420	10	\$ 3,612	\$	60,590	\$ 303	1
2	5	Utilities - gas & electric	Bed Days	722,420	10	86,099		60,590	7,221	2
3	5	Utilities - water & sewer	Bed Days	722,420	10	1,961		60,590	164	3
4	5	Utilities - maintenance office	Bed Days	722,420	10	10,885		60,590	913	4
5	6	Management allocation - salaries	Bed Days	722,420	10	606,344	606,344	60,590	50,855	5
6	6	Repairs & maintenance	Bed Days	722,420	10	55,471		60,590	4,652	6
7	6	Scavenger & exterminating	Bed Days	722,420	10	3,293		60,590	276	7
8	7	Management allocation - employees	Bed Days	722,420	10	89,234		60,590	7,484	8
9	10	Medical consultant	Bed Days	722,420	10	36,843		60,590	3,090	9
10	10	Management allocation - salaries	Bed Days	722,420	10	574,970	574,970	60,590	48,223	10
11	15	Management allocation - employees	Bed Days	722,420	10	84,616		60,590	7,097	11
12	17	Management allocation - salaries	Bed Days	722,420	10	265,116	265,116	60,590	22,236	12
13	19	Computer consultant & supplies	Bed Days	722,420	10	167,987		60,590	14,089	13
14	19	Professional fees	Bed Days	722,420	10	63,319		60,590	5,311	14
15	20	Dues & subscriptions	Bed Days	722,420	10	13,000		60,590	1,090	15
16	20	Advertising - help wanted	Bed Days	722,420	10	58,818		60,590	4,933	16
17	21	Management allocation - salaries	Bed Days	722,420	10	5,512,623	5,512,623	60,590	462,349	17
18	21	Bank charges	Bed Days	722,420	10	105,454		60,590	8,845	18
19	21	Office supplies & printing	Bed Days	722,420	10	122,091		60,590	10,240	19
20	21	Postage	Bed Days	722,420	10	39,500		60,590	3,313	20
21	21	Telephone	Bed Days	722,420	10	114,221		60,590	9,580	21
22	24	Travel and Seminar	Bed Days	722,420	10	27,173		60,590	2,279	22
23										23
24										24
25	TOTALS					\$ 8,042,630	\$ 6,959,053		\$ 674,543	25

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc. # 0035188 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	25	Auto expense	Bed Days	722,420	10	\$ 191,407	\$	60,590	\$ 16,053	1
2	26	Insurance general	Bed Days	722,420	10	66,156		60,590	5,549	2
3	27	Management allocation - employees	Bed Days	722,420	10	850,290		60,590	71,315	3
4	30	Depreciation	Bed Days	722,420	10	462,650		60,590	38,803	4
5	32	Interest	Bed Days	722,420	10	157,045		60,590	13,172	5
6	32	Amortization of mortgage costs	Bed Days	722,420	10	354		60,590	30	6
7	33	Property taxes	Bed Days	722,420	10	59,576		60,590	4,997	7
8	34	Rent expense	Bed Days	722,420	10	40,122		60,590	3,365	8
9	35	Equipment rental	Bed Days	722,420	10	11,581		60,590	971	9
10	35	Auto Lease	Bed Days	722,420	10	20,791		60,590	1,744	10
11	23	Inservice Training	Bed Days	722,420	10	15,778		60,590	1,323	11
12										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					\$ 1,875,750	\$		\$ 157,322	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						\$				\$	1
2	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,375,000	5,904,185	1/1/2033	Variable	359,465	2
3												3
4												4
5							Interest on financing insurance premium				850	5
	Working Capital											
6	Bank of America		X	Working Capital	Varies	4/6/02	1,600,000	1,300,000	6/30/12	Prime/Libor	8,489	6
7	Shareholder	X		Capital Improvements	Varies	6/29/10	783,500	533,332	12/1/13	Prime +1%	28,463	7
8												8
9	TOTAL Facility Related						\$ 8,758,500	\$ 7,737,517			\$ 397,267	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			2,171	10
11								Interest Income offset			(88,034)	11
12								Management company allocation			13,202	12
13								Non-allowable shareholder interest			(28,463)	13
14	TOTAL Non-Facility Related						\$				\$ (101,124)	14
15	TOTALS (line 9+line14)						\$ 8,758,500	\$ 7,737,517			\$ 296,143	15

16)

Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ N/A

Line #

N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	134,400	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.)		2010	\$	133,694	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(706)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	150,000	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.		Allocated from Mgmt. Co.		4,997	
			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	154,291	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	129,132	8	
		2007	126,167	9	
		2008	128,400	10	
		2009	129,666	11	
		2010	133,694	12	
See attached real estate accrual sheet					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>02-15-401-003</u>	<u>Land & Building</u>	\$ <u>133,694.22</u>	\$ <u>133,694.22</u>
2.	<u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>229,415.60</u>	\$ <u>4,997.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>363,109.82</u></u>	\$ <u><u>138,691.22</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 34,554

B. General Construction Type: Exterior Concrete BlockFrame SteelNumber of Stories 1
- C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:

4. Dates Incurred:

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	43,000	1987	\$ 402,548	1
2	Management Company Allocation			16,920	2
3	TOTALS	43,000		\$ 419,468	3

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

0035188

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82		1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 1,931,018	4
5	9		1992	1992	178,974		35	5,114	5,114	102,273	5
6	75		1994	1994	2,022,894		35	57,797	57,797	1,011,446	6
7											7
8											8
	Improvement Type**										
9	Capitalized repairs		1989		9,080		10			9,080	9
10	Building Improvements		1990		3,674		10			3,674	10
11	Building Improvements		1991		2,586		10			2,586	11
12	Building Improvements		1992		3,154		10			2,997	12
13	Building Improvements		1993		1,582		10			1,503	13
14	Building Improvements		1994		15,734		10			15,734	14
15	Land Improvements		1994		1,381		10			1,381	15
16	Land Improvements		1995		1,074		15			1,068	16
17	Building Improvements		1995		1,288		35	37	37	625	17
18	Building Improvements		1995		9,433	270	35	270		4,455	18
19	Building Improvements		1995		43,839	1,252	35	1,252		20,659	19
20	Concrete flooring, fire doors, tile, sprinkler heads,										20
21	and basement renovation		1996		8,706		15			3,606	21
22	Land improvements		1996		7,858		15	261	261	7,858	22
23											23
24	Resident room heaters		1997		3,563	102	35	102		1,528	24
25	Automatic doors		1997		12,950	370	35	370		5,211	25
26	Basement renovation		1997		59,358		10			59,358	26
27	Land Improvement - outdoor flagpoles		1997		1,574	105	15	105		1,521	27
28	1st Floor Remodel (Nurses Station/Lounge)		1998		76,487		10			76,487	28
29	Wiring for MDS		1998		4,506		10			4,506	29
30	Flag Pole		1998		787		10			787	30
31	Resurface/Stripe Parking Lot		1998		9,777		10			9,777	31
32	Kitchen tile/paint		1999		718		10			718	32
33	1st Floor Remodel		1999		3,296		10			3,296	33
34	Roof repairs		2000		5,748	383	15	383		4,406	34
35	Sump pump		2000		2,534		10			2,534	35
36	Sump pump basin repair		2000		6,307		10			6,307	36

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

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

See Page 12A, Line 70 for total

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

0035188

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic door closers	2000	\$ 1,300	\$ 87	15	\$ 87	\$	\$ 998	37
38	Infrared curtains for elevator doors	2001	3,000	150	10	150		3,000	38
39	Ejector pump	2002	3,050		5			3,050	39
40	Lift station pump	2002	3,359		5			3,359	40
41	New asphalt parking lot	2003	16,450	1,645	10	1,645		13,434	41
42	Roof repairs	2003	2,900	290	10	290		2,344	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		1,685	43
44	Kitchen remodel	2003	7,188	359	20	359		3,024	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		26,782	45
46	Floor tile	2003	16,305	815	20	815		7,337	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		30,626	47
48	Rehab-floor tile	2003	8,117	406	20	406		3,281	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		17,258	49
50	Foundation repair	2003	4,800	240	20	240		2,020	50
51	Parking lot	2004	24,550	2,455	10	2,455		18,208	51
52	Kitchen walk-in cooler floor	2004	7,161	716	10	716		5,251	52
53	Old Towne rehab	2004	13,967	698	20	698		5,062	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		73,999	54
55	Create first floor therapy room	2004	185	9	20	9		45	55
56	Transitional unit	2005	213	11	20	11		54	56
57	Landscaping	2005	8,814	441	20	441		2,719	57
58	Roof repairs	2005	3,250	163	20	163		1,004	58
59	HVAC upgrade	2005	7,048	352	20	352		2,231	59
60	Kitchen repair	2005	1,631	82	20	82		531	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		5,970	61
62	Window treatments	2005	3,606	479	5	479		4,085	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		2,507	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		12,643	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		11,095	65
66	Basement renovation	2005	14,176	709	20	709		4,253	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,126,921	\$ 37,395		\$ 185,796	\$ 148,401	\$ 3,564,254	70

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

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

0035188

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,126,921	\$ 37,395		\$ 185,796	\$ 148,401	\$ 3,564,254	1
2	Landscaping Enhancement	2006	7,084	472	15	472		2,518	2
3	Install Kitchen Sink	2006	2,915	146	20	146		839	3
4	Common area rehab	2006	2,382	119	20	119		675	4
5	Paint Building Exterior	2006	19,500	2,275	5	2,275		19,500	5
6	Patio	2006	53,305	3,554	15	3,554		18,065	6
7	Retaining Wall	2007	2,950	197	15	197		919	7
8	Roof Repair	2007	17,050	853	20	853		4,051	8
9	Air Conditioning units	2007	4,338	217	20	217		1,067	9
10	Paver walk and stairway	2007	10,500	525	20	525		2,450	10
11	Fire exit stairways	2007	9,379	469	20	469		1,954	11
12	Landscaping	2008	35,147	2,343	15	2,343		7,224	12
13	Parking Lot - Seal & Striping	2008	6,460	323	20	323		1,131	13
14	Roof	2008	15,300	765	20	765		2,805	14
15	HVAC - Spot Coolers	2008	5,589	140	40	140		420	15
16	Electrical - Storage Room	2008	4,768	238	20	238		813	16
17	Electrical - Fire Alarm Panel	2008	118,395	5,920	20	5,920		18,253	17
18	1st floor remodel-Carpentry,Flooring,Electrical,Parking fixtures	2008	557,202		27	20,262	20,262	74,294	18
19	Lawn Irrigation	2009	14,435	962	15	962		2,245	19
20	Landscaping	2009	12,950	863	15	863		1,870	20
21	Roof	2009	49,330	2,467	20	2,467		5,345	21
22	Front Entrance	2009	19,392	485	40	485		1,051	22
23	HVAC-Window unit	2009	41,315	4,131	10	4,131		11,361	23
24	HVAC Quick connectors	2009	7,058	706	10	706		1,941	24
25	Lift pump	2009	14,783	1,478	10	1,478		3,202	25
26	Fire alarm panel	2009	93,279	4,664	20	4,664		9,717	26
27	Pantry Cabinets	2009	3,523	352	10	352		763	27
28	Therapy Room counter tops-carpentry	2009	2,500	250	10	250		688	28
29	Patio Pergola	2009	7,930	397	20	397		926	29
30	Patio Stamped Concrete	2009	13,901	927	15	927		2,240	30
31	Lobby 1st floor remodel-Carpentry,doors frames,electrical	2009	52,018		27	1,892	1,892	3,784	31
32	painting,wallpaper								32
33	OT Remodel-carpentry,electrical	2010	791,224		27	62,223	62,223	72,594	33
34	TOTAL (lines 1 thru 33)		\$ 8,122,823	\$ 73,633		\$ 306,411	\$ 232,778	\$ 3,838,959	34

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

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

0035188

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,122,823	\$ 73,633		\$ 306,411	\$ 232,778	\$ 3,838,959	1
2									2
3	Lawn irrigation system	2010	5,503	367	15	367		550	3
4	Roof work	2010	15,268	557	27	557		835	4
5	HVAC Chiller	2010	84,004	3,064	27	3,064		3,575	5
6	Pantry-shelves	2010	23,805	868	27	868		1,230	6
7	Wanderguard	2010	3,747	137	27	137		171	7
8	Concrete work	2010	7,080	258	27	258		301	8
9	Automatic Doors	2010	4,903	490	10	490		735	9
10	Physician office carpentry and electrical update	2010	4,677	171	27	171		185	10
11	Library/Lounge-art, painting	2010	13,763	502	27	502		628	11
12	Pergola and patio wall	2010	21,186	3,982	27	3,982		6,300	12
13	Office carpentry and electrical changes	2010	5,744	209	27	209		244	13
14	Payroll office-painting, carpentry	2011	18,505	112	27	112		112	14
15	Mulch stone and perennials	2011	4,364	48	15	48		48	15
16	Admissions office-painting, carpentry	2011	2,868	17	27	17		17	16
17	Parking lot lights	2011	6,070	37	27	37		37	17
18	Roof work	2011	93,530	283	27	283		283	18
19	Front entrance-awning, doors	2011	11,869	359	27	359		359	19
20	Duct extension	2011	3,476	116	27	116		116	20
21	HVAC unit	2011	23,400	142	27	142		142	21
22	Fluid pump	2011	8,400	255	27	255		255	22
23	Plumbing valves	2011	9,257	28	27	28		28	23
24	Laundry room-painting, electrical, tile	2011	8,386	76	27	76		76	24
25	Elevator-electrical work	2011	60,523	367	27	367		367	25
26	VCT Floor OT-painting, electrical, carpentry	2011	49,344	150	27	150		150	26
27									27
28									28
29	Reconcile to book depreciation								29
30				2,981			(2,981)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,612,494	\$ 89,209		\$ 319,006	\$ 229,797	\$ 3,855,703	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 8,612,494	\$ 89,209		\$ 319,006	\$ 229,797	\$ 3,855,703	1
2								2
3								3
4								4
5								5
6								6
7								7
8 Building - management company	2002	234,133		40	6,862	6,862	69,064	8
9 HVAC, electrical, security system - management company	2003	2,056		30	393	393	1,197	9
10 Key card system - management company	2004	323		20	16	16	120	10
11 VAV TX controls - management company	2005	98		20	5	5	34	11
12 Interior Signs - management company	2006	72		5	5	5	25	12
13 Building improvements - management company	2008	11,345		5	586	586	2,345	13
14 Building improvements - management company	2009	2,118		15	39	39	281	14
15 Building improvements - management company	2010	2,064		15	84	84	213	15
16 Building improvements - management company	2011	1,457			32	32	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 TOTAL (lines 1 thru 33)		\$ 8,866,160	\$ 89,209		\$ 327,028	\$ 237,819	\$ 3,929,014	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,048,078	\$ 80,469	\$ 171,124	\$ 90,655	5	\$ 636,083	71
72	Current Year Purchases	174,588	12,572	12,572		5	12,572	72
73	Fully Depreciated Assets	157,777				5	157,777	73
74	Allocated from Mgmt. Co.	272,751		26,923	26,923	5	212,649	74
75	TOTALS	\$ 1,653,194	\$ 93,041	\$ 210,619	\$ 117,578		\$ 1,019,081	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from Mgmt Co.			38,370		3,858	3,858		29,728	79
80	TOTALS			\$ 38,370	\$	\$ 3,858	\$ 3,858		\$ 29,728	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 10,977,192	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 182,250	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 541,505	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 359,255	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,977,823	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		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				3,365			6
7	TOTAL				\$ 3,365			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:
-
- *

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: \$ 69,357
- Description:
- Copier-\$8,533, Mailing System-\$183, Medical Equip.-\$33,639, Oxygen Equip.-\$26,031, Mgmt. Co.-\$971
- (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			1,744	20
21	TOTAL		\$	\$ 1,744	21

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			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	10A(3)	hrs	\$	7,939	\$ 519,503	\$	7,939	\$ 519,503	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,305	101,847		2,305	101,847	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		10,365	661,994		10,365	661,994	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				329,515		329,515	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Ambulance/Dentist	39(3)					6,149		6,149	13
14	TOTAL			\$	20,609	\$ 1,283,344	\$ 335,664	20,609	\$ 1,619,008	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 144,502	\$ 154,482	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>226,560</u>)	3,402,186	3,402,186	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		595	7
8	Accounts Receivable (owners or related parties)	51,067	1,372,331	9
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,597,755	\$ 4,929,594	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,261	64,261	12
13	Land		419,468	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	2,001,334	3,683,429	15
16	Equipment, at Historical Cost	785,568	1,691,564	16
17	Accumulated Depreciation (book methods)	(1,030,980)	(4,977,823)	17
18	Deferred Charges			19
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mort Cost/Accum Amort Mort C</u>		46,428	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,820,183	\$ 6,110,058	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,417,938	\$ 11,039,652	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 491,355	\$ 491,355	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			29
29	Short-Term Notes Payable		533,332	29
30	Accrued Salaries Payable	346,963	346,963	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,780	12,780	31
32	Accrued Real Estate Taxes(Sch.IX-B)		150,000	32
33	Accrued Interest Payable		25,324	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	1,091,209	1,950,448	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,942,307	\$ 3,510,202	39
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,300,000	1,300,000	39
40	Mortgage Payable		5,904,185	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,300,000	\$ 7,204,185	45
46	TOTAL LIABILITIES (sum of lines 39 and 45)	\$ 3,242,307	\$ 10,714,387	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,175,631	\$ 325,265	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,417,938	\$ 11,039,652	49

*(See instructions.)

Lexington Health Care Center of Bloominingdale, Inc.
Provider # 0035188
1/1/11-12/31/11

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to/from Rehab Care Therapy	25,075	25,075
Due from Republic Construction	32,853	32,853
Accrued Expenses	32,794	32,794
Accrued Resident Tax	138,900	138,900
Accrued Roysl/Vesta Mgmt. Fees	32,879	32,879
Accrued Sales Tax	2,106	2,106
Accrued Rent	401,464	-
Due to Patient Trust Fund	(24,490)	(24,490)
Advance Bi-weekly part A payments	(51,232)	(51,232)
Uncollectible Part A Co PVTs	(83,385)	(83,385)
Deferred Income	313,905	313,905
Due to-Royal Operations	39,080	39,080
Due to Wheeling	(1,790)	(1,790)
Sambel Interest Rate Swap Liability		1,260,703
Accrued Insurance	105,317	105,317
Prepaid Insurance	33,816	33,816
Escrow-Insurance	93,917	93,917
	<u>1,091,209</u>	<u>1,950,448</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,971,806	1
2	Restatements (describe):		2
3	Post closing adjustment	(38,415)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,933,391	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	242,240	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)	\$ 242,240	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)	\$ 2,175,631	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc # 0035188 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,250,019	1
2	Discounts and Allowances for all Levels	(5,592,654)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,657,365	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,848,650	6
7	Oxygen	11,710	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,860,360	9
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,384	12
13	Barber and Beauty Care	21,369	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	338,778	17
18	Sale of Supplies to Non-Patients		19
19	Laboratory	97,690	19
20	Radiology and X-Ray		20
21	Other Medical Services	115,533	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 575,754	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,154	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,154	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			29
29a			29a
29	SUBTOTAL Other Revenue (lines 27, 29 and 29a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 9, 23, 26 and 29)	\$ 13,094,633	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,541,637	31
32	Health Care	5,987,540	32
33	General Administration	2,989,174	33
	B. Capital Expense		
34	Ownership	1,489,269	34
	C. Ancillary Expense		
35	Special Cost Centers	614,988	35
36	Provider Participation Fee	229,785	36
	D. Other Expenses (specify):		
37			37
38			39
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,852,393	40
41	Income before Income Taxes (line 30 minus line 40)**	242,240	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 242,240	43

* 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.
Entity is cash basis tax payer.

*** 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.

Facility Name & ID Number Lexington Health Care Center of Bloomingdale, Inc.# 0035188Report Period Beginning: 01/01/2011Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,418	1,711	\$ 85,676	\$ 50.07	1
2	Assistant Director of Nursing	26,503	32,082	837,820	26.11	2
3	Registered Nurses	22,699	27,870	867,673	31.13	3
4	Licensed Practical Nurses	18,865	22,629	579,063	25.59	4
5	CNAs & Orderlies	95,261	112,668	1,323,094	11.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,239	8,636	125,059	14.48	8
9	Activity Director					9
10	Activity Assistants	14,170	16,641	232,787	13.99	10
11	Social Service Workers	6,580	7,534	130,758	17.36	11
12	Dietician	31	35	558	15.94	12
13	Food Service Supervisor	1,815	2,179	43,735	20.07	13
14	Head Cook	1,866	2,179	33,143	15.21	14
15	Cook Helpers/Assistants	10,147	12,048	118,887	9.87	15
16	Dishwashers	14,429	16,929	149,896	8.85	16
17	Maintenance Workers	2,144	2,083	34,113	16.38	17
18	Housekeepers	27,918	33,463	310,963	9.29	18
19	Laundry	5,080	6,166	55,153	8.94	19
20	Administrator	1,294	2,187	107,119	48.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,898	16,817	201,708	11.99	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	1,693	2,048	31,894	15.57	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,381	2,801	103,693	37.02	33
34	TOTAL (lines 1 - 33)	272,431	328,706	\$ 5,372,792 *	\$ 16.35	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	12	\$ 14,426	1(3)	35
36	Medical Director	Monthly	82,073	9(3)	36
37	Medical Records Consultant	Monthly	1,412	10(3)	37
38	Nurse Consultant	Monthly	35,523	10(3)	38
39	Pharmacist Consultant	Monthly	9,542	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	12	4,673	11(3)	44
45	Social Service Consultant	12	4,992	12(3)	45
46	Other(specify) <u>Psychosocial</u>	7	1,920	12(3)	46
47	<u>Pulmonary</u>	Monthly	60,244	10(3)	47
48	<u>Medical Consultant</u>	Monthly	3,090	10(7)	48
49	TOTAL (lines 35 - 48)	43	\$ 217,895		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	9	\$ 442	10(3)	50
51	Licensed Practical Nurses	34	1,381	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	43	\$ 1,823		53

Facility Name & ID Number				STATE OF ILLINOIS		Page 21	
Lexington Health Care Center of Bloomingdale, Inc.				# 0035188		Report Period Beginning: 01/01/2011 Ending: 12/31/2011	
XIX. SUPPORT SCHEDULES							
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Rupal Mistry	Administrator	0	\$ 76,201	Workers' Compensation Insurance	\$ 106,169	IDPH License Fee	\$ 850
Lawrence Putz	Administrator	0	30,918	Unemployment Compensation Insurance	44,511	Advertising: Employee Recruitment	30,628
				FICA Taxes	403,471	Health Care Worker Background Check	
				Employee Health Insurance	182,402	(Indicate # of checks performed 99)	1,185
				Employee Meals	14,536	Patient Background Checks	336 4,033
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	255
				401(k) Contributions	23,897	Miscellaneous Dues & Subscriptions	585
				Other Employee Benefits	37,926	AANC	263
				Uniform Allowance	4,194		
TOTAL (agree to Schedule V, line 17, col. 1)						Management Company Allocation	6,023
(List each licensed administrator separately.)			\$ 107,119			Less: Public Relations Expense	()
B. Administrative - Other						Non-allowable advertising	()
Description			Amount			Yellow page advertising	()
Management Fees-Royal Operating			\$ 813,193				
Management Fees-Vesta Mgmt.			387,380				
Management Fees-Capital			50,736				
Management Fees (Eliminated in Column 7)							
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,251,309	TOTAL (agree to Schedule V, line 22, col.8)		\$ 817,106	TOTAL (agree to Sch. V, line 20, col. 8)
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description
Vendor/Payee	Type		Amount				Amount
Ability Newwork Inc.	Computer Services		\$ 870				Out-of-State Travel
Survey Analytics LLC	Computer Services		300	N/A			
BSKLIVE INC.	Computer Services		1,055				
E-Fax Corporate	Computer Services		2,105				In-State Travel
E-Health Data Solutions	Computer Services		2,400				
Information Control	Computer Services		1,044				
Lintech LLC	Computer Services		5,050				
Micro Center	Computer Services		38				Seminar Expense
My Innerview	Computer Services		6,033				
National Datacare	Computer Services		1,930				
On Shift	Computer Services		3,968				
See Schedule 21C			120,356				Management Company Allocation
TOTAL (agree to Schedule V, line 19, column 3)							2,279
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 145,149	TOTAL	\$		Entertainment Expense
							()
							(agree to Sch. V, line 24, col. 8)
							TOTAL
							\$ 2,279

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/11 - 12/31/11

Schedule 21C

XIX. Support Schedules
C. Professional Services

Vendor/Payee			
Paragon	Computer Services	1,100	
QuestionPro	Computer Services	67	
Silverchair Learning Systems	Computer Services	8,610	
Softchoice	Computer Services	2,513	
Telemedicine Solutions	Computer Services	7,200	
Tympani	Computer Services	8,781	
Vision Share	Computer Services	85	
XO Communications	Computer Services	1,046	
MS License	Computer Services	6,316	
Right Now Technologies	Computer Services	8,927	
TWAT	Computer Services	150	
Capital Salary Ryl B/O	Computer Services	884	
ADI	Computer Services	717	
System Design	Computer Services	44	
Kronos	Computer Services	1,400	
Ace-Action Computer	Computer Services	616	
Avtech	Computer Services	174	
Facility Wizard Software	Computer Services	358	
Information Connection	Computer Services	75	
Elton Designs Inc.	Computer Services	2,376	
Cassiday Schade	Legal	7	
CT Corp.	Legal	220	
Duane Morris LLP	Legal	4,299	
McGladrey & Pullen	Accounting	32,130	
Grabowski Law Center, LLC	Collections	1,473	
Pension Administrators	401 (K) Administration	650	
Personnel Planners	U/C Consulting	1,130	
Polsinelli Shughart	Legal	8,406	
Realmed	Workers Compensation	392	
Much Shelist	Legal	7,635	
RSM McGladrey	Accounting	12,375	
Secretary of State	Filing Fees	200	
			120,356
Total, Agrees to Schedule V, Line 19, Column 3			145,149

Allocated from Management Co.

Katten, Muchin, Rosenman	Legal	351
Much Shelist	Legal	317
Laner Muchin	Legal	13
Syfarth Shaw LLP	Legal	240
McGladrey & Pullen LLP	Accounting	1,196
Illinois Secretary of State	Filing Fees	33
LaSalle Network	Recruiting/Finance	1,470
Gilson Labus & Silverman	KEP	163
Pension Administrators, Inc.	401K Administration	227

Susan Parker	Social Service Consulting	25
M Werner Consulting	Financial Consultant	3
Christine Toolan	Social Service Consulting	5
Gene Whitehorn	Medicaid Reimb Specialist	875
Computer Services	Computer Consulting	14,090
Allocated from Samvest of Lombard II	Accounting	191
	Legal	201
Allocated from Sambell		
Secretary of State	Filing Fees	200
Nonallowable legal fees		
Nonallowable collection fees		(1,473)
Total, Agrees to Schedule V, Line 19, Column 8		<u><u>163,276</u></u>

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?

No

If YES, give association name and amount.

N/A

(3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(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?

5 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

44,471

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.

\$

229,785

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.

\$

14,536

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

N/A
- (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 out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.