

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0028860</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Lexington HCC-Lombard</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</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>2100 S Finley Rd</u> <u>Lombard</u> <u>60148</u>																									
Number City Zip Code																									
County: <u>Dupage</u>																									
Telephone Number: <u>(630) 495-4000</u> Fax # <u>(630) 495-2809</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____														
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	(Date) _____																								
Paid Preparer	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>10/09/84</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 _____	_____
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:																									
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u>																									
Email Address: _____																									

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 HCC-Lombard# 0028860 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>224</u>	Skilled (SNF)	<u>224</u>	<u>81,984</u>	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	<u>224</u>	TOTALS	<u>224</u>	<u>81,984</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>16,997</u>	<u>16,997</u>	8
9	SNF/PED					9
10	ICF	<u>35,196</u>	<u>14,533</u>		<u>49,729</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,196</u>	<u>14,533</u>	<u>16,997</u>	<u>66,726</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.39%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Note : Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/9/84

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

YES ☐Date New ConstructionNO ☒

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

YES ☒NO ☐If YES, enter number
of beds certified 224 and days of care provided 14,639Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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	398,318	37,136	6,807	442,261		442,261		442,261			1
2	Food Purchase		364,807		364,807		364,807	(17,388)	347,419			2
3	Housekeeping	382,011	43,688		425,699		425,699	419	426,118			3
4	Laundry	69,164	24,834		93,998		93,998		93,998			4
5	Heat and Other Utilities			249,964	249,964		249,964	8,263	258,227			5
6	Maintenance	34,202		167,326	201,528		201,528	94,179	295,707			6
7	Other (specify):* Mgmt Co.-Allocated I							12,536	12,536			7
8	TOTAL General Services	883,695	470,465	424,097	1,778,257		1,778,257	98,009	1,876,266			8
	B. Health Care and Programs											
9	Medical Director			80,550	80,550		80,550		80,550			9
10	Nursing and Medical Records	4,977,451	296,002	227,887	5,501,340		5,501,340	44,879	5,546,219			10
10a	Therapy											10a
11	Activities	260,672	24,538	16,003	301,213		301,213		301,213			11
12	Social Services	123,177		4,997	128,174		128,174		128,174			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co.-Allocated I							6,432	6,432			15
16	TOTAL Health Care and Programs	5,361,300	320,540	329,437	6,011,277		6,011,277	51,311	6,062,588			16
	C. General Administration											
17	Administrative	153,607		1,633,456	1,787,063		1,787,063	(1,591,479)	195,584			17
18	Directors Fees											18
19	Professional Services			260,252	260,252		260,252	16,382	276,634			19
20	Dues, Fees, Subscriptions & Promotions			49,412	49,412		49,412	17,280	66,692			20
21	Clerical & General Office Expenses	242,946	33,078	51,203	327,227		327,227	688,389	1,015,616			21
22	Employee Benefits & Payroll Taxes			1,069,277	1,069,277		1,069,277	17,213	1,086,490			22
23	Inservice Training & Education			9,650	9,650		9,650	1,106	10,756			23
24	Travel and Seminar							3,284	3,284			24
25	Other Admin. Staff Transportation			467	467		467	20,921	21,388			25
26	Insurance-Prop.Liab.Malpractice			389,198	389,198		389,198	4,537	393,735			26
27	Other (specify):* Mgmt Co.-Allocated I							110,920	110,920			27
28	TOTAL General Administration	396,553	33,078	3,462,915	3,892,546		3,892,546	(711,447)	3,181,099			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,641,548	824,083	4,216,449	11,682,080		11,682,080	(562,127)	11,119,953			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			251,738	251,738		251,738	376,598	628,336			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,955	45,955		45,955	(1,751)	44,204			32
33	Real Estate Taxes							205,580	205,580			33
34	Rent-Facility & Grounds			1,650,587	1,650,587		1,650,587	(1,646,055)	4,532			34
35	Rent-Equipment & Vehicles			79,902	79,902		79,902	3,912	83,814			35
36	Other (specify):*											36
37	TOTAL Ownership			2,028,182	2,028,182		2,028,182	(1,061,716)	966,466			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		589,967	1,763,107	2,353,074		2,353,074		2,353,074			39
40	Barber and Beauty Shops			27,577	27,577		27,577		27,577			40
41	Coffee and Gift Shops			2,061	2,061		2,061		2,061			41
42	Provider Participation Fee			438,682	438,682		438,682		438,682			42
43	Other (specify):* Non-Allowable Co	132,002		168,490	300,492		300,492	(300,492)				43
44	TOTAL Special Cost Centers	132,002	589,967	2,399,917	3,121,886		3,121,886	(300,492)	2,821,394			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,773,550	1,414,050	8,644,548	16,832,148		16,832,148	(1,924,335)	14,907,813			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(175)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,911)	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	(193)	30		9
10	Interest and Other Investment Income	(94,494)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9,285)	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	(6,752)	43		18
19	Entertainment				19
20	Contributions	(555)	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	(21,052)	43		24
25	Fund Raising, Advertising and Promotional	(51,734)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax	(19,209)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(206,596)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (416,956)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,507,379)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,507,379)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,924,335)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lexington HCC-Lombard

ID# 0028860

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Diagnostics managed care	\$ (4,505)	43	1
2	Labs - Part A	(7,717)	43	2
3	X-Rays - Part A	(48,097)	43	3
4	Marketing Salary	(132,002)	21	4
5	Trust Fees	(505)	43	5
6	Collections	(488)	19	6
7	Out of period legal	(10,432)	19	7
8	Misc Income	(1,210)	21	8
9	Dues & Subscriptions marketing	(617)	20	9
10	Education & Seminar Marketing	(1,563)	43	10
11	Reclass LHI under 2,500 to R&M	6,065	6	11
12	Development Expense	(5,525)	43	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	(206,596)		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	34	Rental Expense	\$ 1,650,587	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	\$	(1,650,587)	1
2	V	30	Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	316,012	316,012	2
3	V	32	Interest Expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	72,475	72,475	3
4	V	33	Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	198,587	198,587	4
5	V	43	State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	14,415	14,415	5
6	V	43	Trust fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	505	505	6
7	V	19	Professional Fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	200	200	7
8	V								8
9	V								9
10	V								10
11	V				**The owners of Lexington Health Care Center of Lombard, Inc. own				11
12	V				100% of Lexington Health Care Systems of Lombard Limited Partnership.				12
13	V								13
14	Total			\$ 1,650,587			\$ 602,194	\$ * (1,048,393)	14

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

Facility Name & ID Number Lexington HCC-Lombard# 0028860Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 419	\$ 419 15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,000	7,000 16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	310	310 17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	952	952 18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	78,894	78,894 19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	8,808	8,808 20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	412	412 21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	12,536	12,536 22
23	V	10 Medical consultant		Royal Management Corp.	**	4,398	4,398 23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	40,481	40,481 24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	6,432	6,432 25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	41,977	41,977 26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	19,778	19,778 27
28	V	19 Professional fees		Royal Management Corp.	**	7,324	7,324 28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,343	1,343 29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	16,554	16,554 30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	656,076	656,076 31
32	V	21 Bank charges		Royal Management Corp.	**	3,632	3,632 32
33	V	21 Office supplies & printing		Royal Management Corp.	**	11,556	11,556 33
34	V	21 Postage		Royal Management Corp.	**	4,681	4,681 34
35	V	21 Telephone		Royal Management Corp.	**	13,655	13,655 35
36	V	23 Inservice Training		Royal Management Corp.	**	1,106	1,106 36
37	V						
38	V	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.					
39	Total		\$			\$ 938,324	\$ * 938,324 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	24	Travel & seminar	\$	Royal Management Corp.	**	\$ 3,284	\$ 3,284	15
16	V	25	Auto expense		Royal Management Corp.	**	20,921	20,921	16
17	V	26	Insurance general		Royal Management Corp.	**	4,537	4,537	17
18	V	27	Management allocation - employee benefits		Royal Management Corp.	**	110,920	110,920	18
19	V	30	Depreciation		Royal Management Corp.	**	60,779	60,779	19
20	V	32	Interest		Royal Management Corp.	**	18,539	18,539	20
21	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,729	1,729	21
22	V	33	Property taxes		Royal Management Corp.	**	6,993	6,993	22
23	V	34	Rent expense		Royal Management Corp.	**	4,532	4,532	23
24	V	35	Equipment rental		Royal Management Corp.	**	1,849	1,849	24
25	V	17	Management fees	1,633,456	Royal Management Corp.	**		(1,633,456)	25
26	V	35	Auto Lease		Royal Management Corp.	**	2,063	2,063	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total			\$ 1,633,456			\$ 236,146	\$ * (1,397,310)	39

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

Facility Name & ID Number

Lexington HCC-Lombard

0028860

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	33.33%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingtondale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas	33.33%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem	33.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Vesta Mgmt	Lombard	Mgmt. Company	3
4			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Group, LLC			4
5			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Lexington Square	Lombard	Independent and	5
6			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Life Care of		Assisted Living	6
7			Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Lombard, LLC		Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Lexington Square	Elmhurst	Independent	8
9			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Life Care of		Living Facility	9
10					Elmhurst, LLC			10
11					Lexington Health	Lombard	Real Estate	11
12					Care Systems of		Property	12
13					Lombard Ltd. Pts			13
14					Royal Management	Lombard	Mgmt Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance Company	16
17					Services, LLC			17
18					Samvest of	Lombard	Lessor	18
19					Lombard II			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 HCC-Lombard # 0028860 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 11,691	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,563	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	10,365	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,772	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,586	L17, C7	5
6		Member									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 41,977		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 HCC-Lombard# 0028860

Report Period Beginning:

01/01/2012Ending: 2/31/2012

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 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	725,412	10	\$ 3,707	\$	81,984	\$ 419	1
2	5	Utilities - gas & electric	Bed Days	725,412	10	61,939		81,984	7,000	2
3	5	Utilities - water & sewer	Bed Days	725,412	10	2,741		81,984	310	3
4	5	Utilities - maintenance office	Bed Days	725,412	10	8,424		81,984	952	4
5	6	Management allocation - salaries	Bed Days	725,412	10	698,068	698,068	81,984	78,894	5
6	6	Repairs & maintenance	Bed Days	725,412	10	77,933		81,984	8,808	6
7	6	Scavenger & exterminating	Bed Days	725,412	10	3,642		81,984	412	7
8	7	Management allocation - employee	Bed Days	725,412	10	110,922		81,984	12,536	8
9	10	Medical consultant	Bed Days	725,412	10	38,914		81,984	4,398	9
10	10	Management allocation - salaries	Bed Days	725,412	10	358,188	358,188	81,984	40,481	10
11	15	Management allocation - employee	Bed Days	725,412	10	56,916		81,984	6,432	11
12	17	Management allocation - salaries	Bed Days	725,412	10	371,421	371,421	81,984	41,977	12
13	19	Computer consultant & supplies	Bed Days	725,412	10	174,999		81,984	19,778	13
14	19	Professional fees	Bed Days	725,412	10	64,806		81,984	7,324	14
15	20	Dues & subscriptions	Bed Days	725,412	10	11,884		81,984	1,343	15
16	20	Advertising - help wanted	Bed Days	725,412	10	146,469		81,984	16,554	16
17	21	Management allocation - salaries	Bed Days	725,412	10	5,805,098	5,805,098	81,984	656,076	17
18	21	Bank charges	Bed Days	725,412	10	32,134		81,984	3,632	18
19	21	Office supplies & printing	Bed Days	725,412	10	102,249		81,984	11,556	19
20	21	Postage	Bed Days	725,412	10	41,415		81,984	4,681	20
21	21	Telephone	Bed Days	725,412	10	120,819		81,984	13,655	21
22	23	Inservice Training	Bed Days	725,412	10	9,785		81,984	1,106	22
23										23
24										24
25	TOTALS					\$ 8,302,473	\$ 7,232,775		\$ 938,324	25

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	24	Travel and Seminar	Bed Days	725,412	10	\$ 29,058	\$	81,984	\$ 3,284	1
2	25	Auto expense	Bed Days	725,412	10	185,111		81,984	20,921	2
3	26	Insurance general	Bed Days	725,412	10	40,142		81,984	4,537	3
4	27	Management allocation - employee	Bed Days	725,412	10	981,440		81,984	110,920	4
5	30	Depreciation	Bed Days	725,412	10	537,783		81,984	60,779	5
6	32	Interest	Bed Days	725,412	10	164,037		81,984	18,539	6
7	32	Amortization of mortgage costs	Bed Days	725,412	10	15,301		81,984	1,729	7
8	33	Property taxes	Bed Days	725,412	10	61,875		81,984	6,993	8
9	34	Rent expense	Bed Days	725,412	10	40,101		81,984	4,532	9
10	35	Equipment rental	Bed Days	725,412	10	16,356		81,984	1,849	10
11	35	Auto Lease	Bed Days	725,412	10	18,252		81,984	2,063	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					\$ 2,089,456	\$		\$ 236,146	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							\$		\$			\$	1	
2													2	
3													3	
4													4	
5							Interest on financing insurance premium					1,586	5	
	Working Capital													
6	Bank of America		X	Line of Credit	Varies	4/6/02	2,500,000	1,390,000	6/30/13	Prime/Libor	28,151		6	
7	Shareholder Loan	X		Capital Improvements	Varies	7/16/08	499,000	499,000	Demand	Prime	16,218		7	
8	Shareholder Loan	X		Working Capital	Varies	4/30/08	2,230,000	2,230,000	Demand	Prime	72,475		8	
9	TOTAL Facility Related						\$ 5,229,000	\$ 4,119,000			\$ 118,430		9	
	B. Non-Facility Related*													
10								Interest Income Offset			(5,801)		10	
11								Offset of Shareholder Interest			(88,693)		11	
12													12	
13								Allocation of Management Costs			20,268		13	
14	TOTAL Non-Facility Related						\$	\$			\$ (74,226)		14	
15	TOTALS (line 9+line14)						\$ 5,229,000	\$ 4,119,000			\$ 44,204		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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	163,200	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.)		2011		\$	178,187	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	14,987	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	183,600	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.		6,993																					
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.				\$	205,580	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:	2007	146,240	8	<table border="1"> <tr> <td></td> <td colspan="2">FOR BHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2011</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>				FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
	2008	142,577	9																							
	2009	146,768	10																							
	2010	140,430	11																							
	2011	178,187	12																							
See attached real estate accrual sheet																										

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Lexington HCC-Lombard

COUNTY
Dupage

FACILITY IDPH LICENSE NUMBER
0028860

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 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	06-19-307-002		\$ 178,187.00	\$ 178,187.00
2.	Royal Management Corp. (Samvest of Lombard II)		\$ 230,165.98	\$ 6,993.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 408,352.98	\$ 185,180.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

A. Square Feet: 78,770

B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square feet

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	30,000	1984	\$ 616,761	1
2	Management Company Allocation			22,023	2
3	TOTALS	30,000		\$ 638,784	3

Facility Name & ID Number Lexington HCC-Lombard

0028860

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	215		1984	1984	\$ 3,661,472	\$	35	\$ 104,614	\$ 104,614	\$ 2,953,149
5	9		1995	1995	284,156	8,119	35	8,119		133,959
6										
7										
8										
	Improvement Type**									
9	Building Improvements		1990		96,219		10			96,218
10	Leasehold Improvements Additions		1995		71,493		10			71,493
11	Building Improvements		1994		20,200		10			20,200
12	Building Improvements		1995		14,535	415	35	415		7,266
13	Building Improvements - dishwasher hood		1996		2,748		10			2,748
14	Building Improvements - outside painting		1996		11,308		10			11,308
15	Building Improvements - dining room		1996		3,752		10			3,752
16	Leasehold Improvements		1992		16,299	466	35	466		9,549
17	Leasehold Improvements		1994		21,836		10			21,836
18	Leasehold Improvements - 2nd floor		1996		19,319		10			18,353
19	Leasehold Improvements - bathroom rehab		1996		9,216		10			8,909
20	Leasehold Improvements - fan coil repairs		1996		6,669	191	35	191		3,115
21	Land Improvements		1993		2,985		15			2,985
22	Land Improvements		1995		4,596		15			4,595
23	Capitalized Repairs		1986		1,730		10			1,730
24	Building Improvements - basement		1996		18,993		10			18,993
25	Leasehold Improvements - Corner Guards		1997		520		10			520
26	Leasehold Improvements - Corridor flooring		1997		10,380		10			10,380
27	BI: Kitchen Rehab		1998		2,494		10			2,494
28	Wiring for MDS project		1998		3,365		10			3,365
29	Install Fire Sprinklers in Mechanical Rms		1998		4,600	131	35	131		1,904
30	Tile for Lobby		1998		20,530		10			20,530
31	Walk in Freezers/Coolers		1998		3,183	91	35	91		1,319
32	Fire Wall Repairs		1998		12,411	355	35	355		5,144
33	Underground storage tank		1998		2,613		10			2,613
34	Repave parking lot		1999		7,625	508	15	508		6,353
35	Lounge Floor Tile		1999		2,963		10			2,963
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 HCC-Lombard

0028860

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	Rewire Building	1999	\$ 9,083	\$ 260	35	\$ 260	\$	\$ 3,506	37
38	Heat exchanger for water heater	1999	1,660		5			1,660	38
39	Compressor and tank for freezer	1999	2,924		5			2,924	39
40	Plumbing Improvements	2000	2,833		10			2,833	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		786	41
42	Water heater repairs	2000	3,831		5			3,831	42
43	Automatic door	2000	4,556	130	35	130		1,626	43
44	Install sprinklers	2001	6,082		10			6,082	44
45	Infrared curtains for elevator	2001	4,500		10			4,500	45
46	Elevator upgrade	2002	3,006		5			3,006	46
47	Condensor	2002	2,679		5			2,679	47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		14,452	48
49	Plumbing loop repairs	2003	6,125	613	10	613		5,566	49
50	Fire alarm panel/call system	2003	8,495	425	20	425		4,213	50
51	Facility Rehab - Painting	2003	6,872	687	10	687		6,344	51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		13,412	52
53	Nurse call system	2003	49,451	2,473	20	2,473		22,461	53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		2,758	54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		157,240	55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		138,162	56
57	Floor Tile	2003	58,720	2,936	20	2,936		29,360	57
58	Carpeting/cove base	2003	29,518	2,952	10	2,952		29,519	58
59	Water heater	2004	9,209	921	10	921		7,521	59
60	Kitchen sewer and dishroom	2004	31,233	1,562	20	1,562		12,625	60
61	Landscaping	2005	3,255	163	20	163		1,208	61
62	HVAC	2005	8,028	401	20	401		2,875	62
63	Kitchen sewer, dishroom and ceiling	2005	22,924	1,146	20	1,146		8,691	63
64	Lobby and reception redecorating - painting/wallpaper	2005	37,999	1,900	20	1,900		14,567	64
65	Rehab therapy room - electrical, carpet, tile	2005	66,393	3,320	20	3,320		25,452	65
66	Rehab 1st floor therapy room - electrical, carpet, tile	2005	39,341	1,967	20	1,967		15,080	66
67	Wallpaper, tile, electrical for transitional unit	2005	22,946	1,147	20	1,147		8,890	67
68	Window treatments	2005	8,053	403	20	403		3,055	68
69	Tile, flooring, and wallpaper	2005	57,699	2,885	20	2,885		21,878	69
70	TOTAL (lines 4 thru 69)		\$ 5,504,063	\$ 69,442		\$ 174,056	\$ 104,614	\$ 4,026,505	70

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

Facility Name & ID Number Lexington HCC-Lombard

0028860

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,504,063	\$ 69,442		\$ 174,056	\$ 104,614	\$ 4,026,505	1
2	Countertops	2005	845		5			845	2
3	Curtains and blinders	2005	4,672		5			4,672	3
4	Mini scroll	2005	527		5			527	4
5	Medical Records Storage/Office Room	2006	5,901	148	40	148		912	5
6	Office Remodel	2006	5,537	138	40	138		828	6
7	Piping	2006	4,511	301	15	301		1,906	7
8	HVAC	2006	7,985	200	40	200		1,200	8
9	Emergency A/C	2006	9,385	235	40	235		1,410	9
10	Adm Office-HVAC	2006	6,421	161	40	161		1,032	10
11	Sink installation	2006	2,561	64	40	64		432	11
12	Land Improvements Patio	2006	23,736	1,582	15	1,582		10,020	12
13	Brick Pavers	2007	8,500	567	15	567		3,213	13
14	Landscaping	2007	16,420	821	20	821		4,447	14
15	Parking Lot	2007	13,219	661	20	661		3,580	15
16	Roof	2007	9,800	490	20	490		2,818	16
17	HVAC	2007	8,197	410	20	410		2,255	17
18	LHI-Emergency A/C	2007	11,126	556	20	556		2,873	18
19	LHI-Plumbing & Sprinkler	2007	6,799	680	10	680		3,570	19
20	Automatic Doors is Common Areas	2007	20,874	1,044	20	1,044		5,655	20
21	Tike System & Foundation	2007	4,500	225	20	225		1,144	21
22	Exterior of Building Painting	2007	16,600	830	20	830		4,358	22
23	Landscaping	2008	21,600	1,440	15	1,440		6,840	23
24	Parking Lot	2008	9,625	481	20	481		2,205	24
25	Roof Repair	2008	11,001	550	20	550		2,383	25
26	HVAC	2008	20,164	1,102	20	1,102		4,953	26
27	Sink and Toliet	2008	4,000	400	10	400		1,867	27
28	Elevator Upgrades	2008	171,955	4,299	40	4,299		18,271	28
29	Metal Doors	2008	3,907	195	20	195		927	29
30	Basement Renovation	2008	25,195	1,260	20	1,260		5,880	30
31	Trash Compactor	2008	11,590	580	20	580		2,610	31
32	Painting Gazebo	2008	4,450	223	20	223		984	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,975,666	\$ 89,085		\$ 193,699	\$ 104,614	\$ 4,131,122	34

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

Facility Name & ID Number Lexington HCC-Lombard

0028860

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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		\$ 5,975,666	\$ 89,085		\$ 193,699	\$ 104,614	\$ 4,131,122	1
2	2nd floor remodel-Electric, flooring,painting	2008	561,165		27	20,406	20,406	83,325	2
3	Kitchen Upgrade-Carpentry, painting, plumbing	2008	18,364		27	668	668	2,728	3
4	1st floor remodel-painting, electrical, flooring,plumbing	2008	547,836		27	19,921	19,921	97,945	4
5	Irrigation System	2009	14,235	949	15	949		3,242	5
6	Landscaping Enhancements	2009	22,005	1,467	15	1,467		5,135	6
7	Roof	2009	139,578	6,979	20	6,979		23,845	7
8	Fan Coil	2009	5,607	280	20	280		1,051	8
9	Quick Connectors	2009	5,300	265	20	265		972	9
10	Room Convector	2009	4,962	248	20	248		806	10
11	Nurse Call System	2009	35,509	1,291	27	1,291		4,088	11
12	Electrical key pad	2009	5,995	218	27	218		745	12
13	PT Room Countertops	2009	4,050	147	27	147		454	13
14	2nd floor remodel-Electric, flooring,painting	2009	2,935	107	27	107		410	14
15	Patio Pergola	2009	10,849	542	20	542		1,717	15
16	Landscaping/Retaining wall	2010	4,741	316	15	316		790	16
17	Ejector Pump	2010	6,983	466	15	466		1,164	17
18	Parking lot repair/signs	2010	8,970	727	15	727		1,830	18
19	Repair Roof	2010	24,000	1,200	20	1,200		2,500	19
20	Key pad entrance	2010	3,085	308	10	308		848	20
21	Canopy	2010	2,567	257	10	257		663	21
22	Exhaust HVAC	2010	4,003	146	27	146		316	22
23	Drainline	2010	4,130	151	27	151		314	23
24	Pantry carpentry,electrical,plumbing	2010	7,566	276	27	276		667	24
25	Paint over bed lights	2010	6,319	231	27	231		615	25
26	Library/Lounge carpentry,painting,signs	2010	8,441	308	27	308		719	26
27	Second floor doors	2010	3,144	314	10	314		864	27
28	Med Room carpentry,plumbing	2010	7,678	280	27	280		677	28
29	Patio Pergola	2010	11,695	2,339	5	2,339		5,263	29
30	Stamped concrete	2010	15,862	1,057	15	1,057		2,819	30
31	Office carpentry,flooring,electrical,painting,plumbing,signs	2010	64,446	5,409	27	5,409		10,818	31
32	3rd floor remodel-carpentry,plumbing,electrical,painting	2010	753,399		27	60,085	60,085	155,219	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,291,085	\$ 115,363		\$ 321,057	\$ 205,694	\$ 4,543,671	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,291,085	\$ 115,363		\$ 321,057	\$ 205,694	\$ 4,543,671	1
2									2
3	Office Remodel - carpentry,plumbing,electrical,painting	2011	11,187	407	27	407		678	3
4	Front Entrance remodel of kitchen doors	2011	3,584	130	27	130		130	4
5	Remodel Shower Room - Carpentry, Flooring, Electrical,	2011	53,886	1,959	27	1,959		2,449	5
6	-Plumbing, Showers, Millwork & Painting								6
7	Boiler Coll HVAC	2011	3,175	115	27	115		173	7
8	Roof Top Unit HVAC	2011	40,890	1,487	27	1,487		1,859	8
9	Fire Dampers HVAC	2011	67,012	2,437	27	2,437		2,640	9
10	Remodel Laundry Room - Electrical, Painting and Flooring	2011	9,814	357	27	357		506	10
11	Replace Doors on 1st Floor	2011	57,237	2,081	27	2,081		2,254	11
12	Replace doors on 2nd Floor	2011	39,952	1,453	27	1,453		1,937	12
13	Doctors office-keys, painting, flooring	2012	5,484	83	27	83		83	13
14	Generator Exhaust	2012	21,590	523	27	523		523	14
15	Sprinklers in building - Front Canopy & Lobby Area	2012	11,558	70	27	70		70	15
16	Replace sanitary pipe	2012	5,800	123	27	123		123	16
17	Replace lights, mirrors in 1st floor resident rooms	2012	10,962	199	27	199		199	17
18	Replacement faucets in 1st floor resident rooms	2012	6,410	97	27	97		97	18
19	Reconcile to book			194			(194)		19
20									20
21	Building-management company	2002	304,761		40	9,244	9,244	98,963	21
22	HVAC, electrical, security system-management company	2003	2,677		30	681	681	1,744	22
23	Key card system-management company	2004	421		20	21	21	177	23
24	VAV TX controls-management compnay	2005	128		20	7	7	50	24
25	Building Improvements-management company	2006	93		20	6	6	38	25
26	Building Improvements-management company	2008	14,769		20	790	790	3,995	26
27	Building Improvements-management company	2009	2,757		20	52	52	515	27
28	Building Improvements-management company	2010	2,687		20	113	113	453	28
29	Building Improvements-management company	2011	1,896		20	90	90	131	29
30	Building Improvements-management company	2012	6,551		20	3	3	151	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,976,366	\$ 127,078		\$ 343,585	\$ 216,507	\$ 4,663,609	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	\$1,416,465	\$107,468	\$217,787	\$110,319	5	\$1,007,875	71
72	Current Year Purchases	122,880	17,192	17,192		5	17,192	72
73	Fully Depreciated Assets	116,581				5	116,581	73
74	Allocated from Mgmt. Co.	536,042		44,735	44,735	5	309,474	74
75	TOTALS	\$2,191,968	\$124,660	\$279,714	\$155,054		\$1,451,122	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.			52,317		5,037	5,037		41,650	79
80	TOTALS			\$52,317	\$	\$5,037	\$5,037		\$41,650	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)	\$11,859,435	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$251,738	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$628,336	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$376,598	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,156,381	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				4,532			6
7	TOTAL				\$ 4,532			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?
16. Rental Amount for movable equipment: \$ 81,751 Description: Copier-\$10,204;Mail Sys-\$129;Printer-\$1,358;Oxygen-\$45,933;Med Equip-\$22,278;Mgmt. Co.-\$1,849
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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			2,063	20
21	TOTAL		\$	\$ 2,063	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 EndingAnnual Rent

12. /2013\$

13. /2014\$

14. /2015\$

* 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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	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	\$	13,122	\$ 840,774	\$	13,122	\$ 840,774	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		5,589	208,249		5,589	208,249	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2)(3)	hrs		14,730	712,189	4,178	14,730	716,367	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				585,789		585,789	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Dentist /Hearing Aid	39(3)				1,895			1,895	13
14	TOTAL			\$	33,441	\$ 1,763,107	\$ 589,967	33,441	\$ 2,353,074	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.

This report must be completed even if financial statements are attached.				
		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 691,180	\$ 1,637,782	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 393,055)	3,867,643	3,867,643	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,502	138,502	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,697,325	\$ 5,643,927	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		638,784	13
14	Buildings, at Historical Cost		3,945,628	14
15	Leasehold Improvements, at Historical Cost	2,891,025	5,030,738	15
16	Equipment, at Historical Cost	931,131	2,244,285	16
17	Accumulated Depreciation (book methods)	(1,633,445)	(6,156,381)	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 (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,188,711	\$ 5,703,054	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,886,036	\$ 11,346,981	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 666,995	\$ 666,995	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,390,000	1,390,000	29
30	Accrued Salaries Payable	352,384	352,384	30
31	Accrued Taxes Payable (excluding real estate taxes)	105,866	105,866	31
32	Accrued Real Estate Taxes(Sch.IX-B)		183,600	32
33	Accrued Interest Payable		6,155	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	926,574	764,371	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,441,819	\$ 3,469,371	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	499,000	2,729,000	39
40	Mortgage Payable			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)	\$ 499,000	\$ 2,729,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,940,819	\$ 6,198,371	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,945,217	\$ 5,148,610	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,886,036	\$ 11,346,981	48

*(See instructions.)

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660
1/1/12-12/31/12

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other current liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
DUE TO MERIT HOSPICE	25,000	25,000
RENT RECEIVABLE	162,203	
401K WITHHOLDING	1,060	1,060
ACCRUED EXPENSES	61,702	61,702
ACCRUED ROYAL / VESTA MGMT FEES	(3,132)	(3,132)
ACCRUED INSURANCE	138,722	138,722
DUE TO PATIENT TRUST FUND	4,584	4,584
ADVANCE - BIWEEKLY PART A PAYM	(10,576)	(10,576)
UNCOLLECTIBLE PART A CO PVTS	(36,450)	(36,450)
DEFERRED INCOME	402,836	402,836
DUE TO - ROYAL OPERATIONS	38,751	38,751
DUE TO/FROM REPUBLIC CONSTRUCTION	1,511	1,511
DUE TO CHICAGO RIDGE	749	749
DUE TO STREAMWOOD	7,413	7,413
DUE TO/FROM SQUARE LOMBARD	1,090	1,090
PROFESSIONAL LIABILITIES CLAIMS	131,111	131,111
	<u>926,574</u>	<u>764,371</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,560,587	1
2	Restatements (describe):		2
3	Post closing adjustment	(42,864)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,517,723	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	967,494	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	(540,000)	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)	\$ 427,494	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)	\$ 2,945,217	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington HCC-Lombard# 0028860Report Period Beginning: 01/01/2012Ending: 12/31/2012**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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 19,353,097	1
2	Discounts and Allowances for all Levels	(8,235,345)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,117,752	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,823,155	6
7	Oxygen	5,356	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,828,511	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,194	12
13	Barber and Beauty Care	34,620	13
14	Non-Patient Meals	175	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	555,669	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	267,184	19
20	Radiology and X-Ray		20
21	Other Medical Services	175,262	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,036,104	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,801	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,801	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income and Recovery of write off	1,210	28
28a	Bed Hold Early Discharge	810,264	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 811,474	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,799,642	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,778,257	31
32	Health Care	6,011,277	32
33	General Administration	3,892,546	33
	B. Capital Expense		
34	Ownership	2,028,182	34
	C. Ancillary Expense		
35	Special Cost Centers	2,683,204	35
36	Provider Participation Fee	438,682	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,832,148	40
41	Income before Income Taxes (line 30 minus line 40)**	967,494	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 967,494	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,628,298	44
45	Private Pay - Net Inpatient Revenue	3,052,854	45
46	Medicare - Net Inpatient Revenue	2,637,962	46
47	Other-(specify) <u>Managed Care</u>	798,638	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,117,752	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 tax payer.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,007	2,383	\$ 133,813	\$ 56.15	1
2	Assistant Director of Nursing	32,667	38,773	1,059,428	27.32	2
3	Registered Nurses	33,190	40,969	1,279,751	31.24	3
4	Licensed Practical Nurses	27,157	33,560	858,661	25.59	4
5	CNAs & Orderlies	111,193	133,906	1,607,034	12.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,445	16,485	201,507	12.22	10
11	Social Service Workers	6,625	7,625	123,177	16.15	11
12	Dietician	1,612	1,837	43,266	23.55	12
13	Food Service Supervisor	1,599	1,917	38,121	19.89	13
14	Head Cook	1,703	1,917	45,713	23.85	14
15	Cook Helpers/Assistants	10,448	12,244	125,715	10.27	15
16	Dishwashers	13,995	16,034	145,503	9.07	16
17	Maintenance Workers	1,837	2,068	34,202	16.54	17
18	Housekeepers	33,863	40,631	382,011	9.40	18
19	Laundry	5,759	7,030	69,164	9.84	19
20	Administrator	1,650	2,275	153,607	67.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,606	12,805	242,946	18.97	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	2,045	2,435	38,764	15.92	31
32	Other Health Care Memory Care	2,978	3,566	59,165	16.59	32
33	Other(specify) Marketing	3,829	4,254	132,002	31.03	33
34	TOTAL (lines 1 - 33)	317,208	382,714	\$ 6,773,550 *	\$ 17.70	34

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	Monthly	\$ 6,807	1(3)	35
36	Medical Director	Monthly	80,550	9(3)	36
37	Medical Records Consultant	Monthly	880	10(3)	37
38	Nurse Consultant	Monthly	126,811	10(3)	38
39	Pharmacist Consultant	Monthly	13,298	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	5,456	11(3)	44
45	Social Service Consultant	Monthly	4,869	12(3)	45
46	Other(specify) Joint commission	Monthly	24,317	12(3)	46
47	Pulmonary	Monthly	62,581	10(3)	47
48	Medical Consultant	Monthly	4,398	10(7)	48
49	TOTAL (lines 35 - 48)		\$ 329,967		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Lexington HCC-Lombard

0028860

Report Period Beginning:

01/01/2012

Page 21

Ending:

12/31/2012

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	
Lenette Clark	Administrator	0	\$ 101,146	Workers' Compensation Insurance	\$ 165,367	IDPH License Fee	\$	
Quinn Corcoran	Administrator	0	52,461	Unemployment Compensation Insurance	102,026	Advertising: Employee Recruitment	35,969	
				FICA Taxes	499,124	Health Care Worker Background Check		
				Employee Health Insurance	232,969	(Indicate # of checks performed 163)	1,950	
				Employee Meals	17,213	Patient Background Checks	684 8,208	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fess	2,028	
				401K	20,280	Miscellaneous Dues & Subscriptions	884	
				Other Employee Benefits	49,511	AANAC Membership Dues	373	
						Management Company Allocation	17,897	
						Marketing dues	(617)	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 153,607						\$ 66,692		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount	\$ 1,086,490				
Management Fees-Royal Operating			\$ 1,123,615					
Management Fees-Vesta Mgmt.			509,841					
Eliminated in Column 7								
TOTAL (agree to Schedule V, line 17, col. 3) (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	
Grabowski Law Center, LLC	Collections		\$ 488					
Cassiday Schade, LLP	Legal		58,519	N/A				
Pension Administrators, Inc.	Pension Administration		1,103					
McGladrey LLP	Accounting		33,834					
Much Shelist	Legal		6,370					
Personnel Planners	U/C Consulting		1,965					
Secretary of State	Banking		125					
McCracken & Frank	Legal		351					
Duane Morris	Legal		170					
RealMed	WC Consulting		(13)					
Serpico, Petrosino & DiPiero	Legal		250					
See Schedule 21C			157,090					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 260,252				\$				

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660
1/1/12-12/31/12
Section XIX.

Schedule 21C

C. Professional Fees

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
American Finan / Vocollect	Computer Consulting	73,787
Ability Network	Computer Consulting	1,605
Americorp Financial	Computer Consulting	5,552
EFAX Corporate	Computer Consulting	1,091
Ehealth Data Solutions	Computer Consulting	3,000
Elton Designs	Computer Consulting	260
Facility Wizard	Computer Consulting	358
Genesis Technology	Computer Consulting	412
Health MedX	Computer Consulting	15,033
Information Controls	Computer Consulting	1,176
Kronos	Computer Consulting	1,392
Lintech LLC	Computer Consulting	4,223
Microsoft Licensing	Computer Consulting	6,312
MY Innerview	Computer Consulting	6,335
National Datacare	Computer Consulting	1,092
On Shift	Computer Consulting	8,016
Oracle	Computer Consulting	8,927
Paragon Clinical	Computer Consulting	1,300
Relias Learning	Computer Consulting	3,864
Silver Chair Learning Systems	Computer Consulting	4,277
Soft choice Corporation	Computer Consulting	128
Telemedicine Solutions	Computer Consulting	7,200
Top Notch	Computer Consulting	109
Touchpoint	Computer Consulting	136
Trisys	Computer Consulting	140
TYMPANI	Computer Consulting	1,237
Virtual Rabbit	Computer Consulting	10
XO Communications	Computer Consulting	118
		<u>157,090</u>

Total Schedule V, line 19, column 3

260,252

Less: Collections

(488)

Out of period legal

(10,432)

Lexington Health Care Systems of Lombard Partnerships

Secretary of State

200

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660
1/1/12-12/31/12
Section XIX.

Allocated from Management Co.

Much Shelist	Legal	628
Duane Morris	Legal	41
Cassiday Schade	Legal	2
McGladrey LLP	Accounting	1,499
Illinois Secretary of State	Filing Fees	35
Gilson Labus & Silverman	KEP	420
Tam Kaiden	Investigative Services	53
Bank of America Leasing	UCC Search & Filing	22
Versight Inc.	Annual Report-Health Ins	124
Personnel Planners	U/C Consultant	22
LaSalle Network	Recruiting/Finance	1,587
Pension Administrators, Inc.	401K Administration	306
Gene Whitehorn	Medicaid Reimb Specialist	1,213
Christine Toolan	Social Service Consulting	19
M Werner Consulting	Financial Consultant	1,063
Computer Services	Computer Consulting	19,778

Allocated from Samvest of Lombard II	Accounting	290
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Total Schedule V, line 19, column 8	<u>276,634</u>
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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?

6 Years
- (6)

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

\$

61,467

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.

\$

438,682

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.

\$

17,213

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

175
- (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.