

		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: 0042739 Facility Name: Lexington of Chicago Ridge Address: 10300 Southwest Highway Chicago Ridge 60415 County: Cook Telephone Number: (708) 425-1100 Fax #: (708) 425-0779 HFS ID Number: Date of Initial License for Current Owners: 5/27/91 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Amanda Springborn Telephone Number: (314) 925-3838 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) 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
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Facility Name & ID Number Lexington of Chicago Ridge# 0042739 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>203</u>	Skilled (SNF)	<u>203</u>	<u>74,298</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>203</u>	TOTALS	<u>203</u>	<u>74,298</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>23,627</u>	<u>23,627</u>	8
9	SNF/PED					9
10	ICF	<u>34,695</u>	<u>6,421</u>		<u>41,116</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,695</u>	<u>6,421</u>	<u>23,627</u>	<u>64,743</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.14%

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 6/4/91

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 203 and days of care provided 13,588Medicare 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.

	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	413,737	36,552	13,353	463,642		463,642		463,642		1
2	Food Purchase		371,281		371,281		371,281	(18,978)	352,303		2
3	Housekeeping	411,639	49,407		461,046		461,046	380	461,426		3
4	Laundry	66,643	32,093		98,736		98,736		98,736		4
5	Heat and Other Utilities			213,651	213,651		213,651	7,488	221,139		5
6	Maintenance	44,037		219,584	263,621		263,621	87,560	351,181		6
7	Other (specify):* Mgmt Co.-Allocated I							11,361	11,361		7
8	TOTAL General Services	936,056	489,333	446,588	1,871,977		1,871,977	87,811	1,959,788		8
	B. Health Care and Programs										
9	Medical Director			95,988	95,988		95,988		95,988		9
10	Nursing and Medical Records	5,252,659	467,762	286,177	6,006,598		6,006,598	40,672	6,047,270		10
10a	Therapy										10a
11	Activities	252,524	29,394	8,125	290,043		290,043		290,043		11
12	Social Services	207,501		5,086	212,587		212,587		212,587		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co.-Allocated I							5,829	5,829		15
16	TOTAL Health Care and Programs	5,712,684	497,156	395,376	6,605,216		6,605,216	46,501	6,651,717		16
	C. General Administration										
17	Administrative	164,570		1,673,305	1,837,875		1,837,875	(1,635,263)	202,612		17
18	Directors Fees										18
19	Professional Services			274,107	274,107		274,107	8,982	283,089		19
20	Dues, Fees, Subscriptions & Promotions			29,329	29,329		29,329	15,602	44,931		20
21	Clerical & General Office Expenses	188,331	49,611	53,866	291,808		291,808	624,625	916,433		21
22	Employee Benefits & Payroll Taxes			1,211,129	1,211,129		1,211,129	18,898	1,230,027		22
23	Inservice Training & Education			11,279	11,279		11,279	1,002	12,281		23
24	Travel and Seminar			325	325		325	2,651	2,976		24
25	Other Admin. Staff Transportation			2,022	2,022		2,022	18,959	20,981		25
26	Insurance-Prop.Liab.Malpractice			576,351	576,351		576,351	4,111	580,462		26
27	Other (specify):* Mgmt Co.-Allocated I							100,521	100,521		27
28	TOTAL General Administration	352,901	49,611	3,831,713	4,234,225		4,234,225	(839,912)	3,394,313		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,001,641	1,036,100	4,673,677	12,711,418		12,711,418	(705,600)	12,005,818		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			213,856	213,856		213,856	371,349	585,205			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,492	29,492		29,492	412,839	442,331			32
33	Real Estate Taxes							682,629	682,629			33
34	Rent-Facility & Grounds			1,996,293	1,996,293		1,996,293	(1,992,186)	4,107			34
35	Rent-Equipment & Vehicles			88,427	88,427		88,427	3,544	91,971			35
36	Other (specify):*											36
37	TOTAL Ownership			2,328,068	2,328,068		2,328,068	(521,825)	1,806,243			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,075,444	2,267,774	3,343,218		3,343,218		3,343,218			39
40	Barber and Beauty Shops			23,954	23,954		23,954		23,954			40
41	Coffee and Gift Shops			7,256	7,256		7,256		7,256			41
42	Provider Participation Fee			423,157	423,157		423,157		423,157			42
43	Other (specify):* Non-Allowable Co	130,992		240,038	371,030		371,030	(371,030)				43
44	TOTAL Special Cost Centers	130,992	1,075,444	2,962,179	4,168,615		4,168,615	(371,030)	3,797,585			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,132,633	2,111,544	9,963,924	19,208,101		19,208,101	(1,598,455)	17,609,646			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	(80)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,569)	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	(156)	30		9
10	Interest and Other Investment Income	(2,808)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,684)	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	(1)	43		18
19	Entertainment				19
20	Contributions	(4,855)	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	(26,579)	43		24
25	Fund Raising, Advertising and Promotional	(51,369)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax	777	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(182,305)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (285,629)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,312,826)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,312,826)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,598,455)		37

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

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

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

Lexington of Chicago Ridge

ID# 0042739

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Trust Fees	\$ (75)	43	1
2	Labs - Part A	(38,561)	43	2
3	X-Rays - Part A	(41,248)	43	3
4	Diagnostics Managed Care	(22,799)	43	4
5	Misc Income	(324)	21	5
6	Collection Fees	(5,697)	19	6
7	Out of period legal	(10,083)	19	7
8	Reclass LHI under 2500	7,708	6	8
9	Valet Service	(32,244)	43	9
10	Marketing Salary	(130,992)	43	10
11	Travel and Seminar marketing	(325)	24	11
12	Dues & subscriptions marketing	(617)	20	12
13	Unrealized loss on FMV swap	97,858	43	13
14	Development Expense	(4,906)	43	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	(182,305)		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 Chicago Ridge Limited Partnership	**	\$ 200	\$ 200	1
2	V	30	Depreciation		Sambell of Chicago Ridge Limited Partnership	**	316,424	316,424	2
3	V	32	Interest expense		Sambell of Chicago Ridge Limited Partnership	**	395,991	395,991	3
4	V	32	Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	1,288	1,288	4
5	V	33	Property tax		Sambell of Chicago Ridge Limited Partnership	**	676,292	676,292	5
6	V	34	Rental expense	1,996,293	Sambell of Chicago Ridge Limited Partnership	**		(1,996,293)	6
7	V	43	Trust fees		Sambell of Chicago Ridge Limited Partnership	**	75	75	7
8	V	43	Unrealized loss on FMV swap	97,858	Sambell of Chicago Ridge Limited Partnership	**		(97,858)	8
9	V								9
10	V								10
11	V				** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%				11
12	V				of Sambell of Chicago Ridge Limited Partnership				12
13	V								13
14	Total			\$ 2,094,151			\$ 1,390,270	\$ * (703,881)	14

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

Facility Name & ID Number Lexington of Chicago Ridge# 0042739Report 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.	**	\$ 380	\$ 380 15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,344	6,344 16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	281	281 17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	863	863 18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	71,497	71,497 19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	7,982	7,982 20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	373	373 21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	11,361	11,361 22
23	V	10 Medical consultant		Royal Management Corp.	**	3,986	3,986 23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	36,686	36,686 24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	5,829	5,829 25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	38,042	38,042 26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	17,924	17,924 27
28	V	19 Professional fees		Royal Management Corp.	**	6,638	6,638 28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,217	1,217 29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	15,002	15,002 30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	594,569	594,569 31
32	V	21 Bank charges		Royal Management Corp.	**	3,291	3,291 32
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,473	10,473 33
34	V	21 Postage		Royal Management Corp.	**	4,242	4,242 34
35	V	21 Telephone		Royal Management Corp.	**	12,374	12,374 35
36	V	23 Inservice Training		Royal Management Corp.	**	1,002	1,002 36
37	V	24 Travel & seminar		Royal Management Corp.	**	2,976	2,976 37
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.					
39	Total		\$			\$ 853,332	\$ * 853,332 39

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

Facility Name & ID Number	Lexington of Chicago Ridge
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0042739

Report 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	25	Auto expense	\$	Royal Management Corp.	**	\$ 18,959	\$ 18,959	15
16	V	26	Insurance general		Royal Management Corp.	**	4,111	4,111	16
17	V	27	Management allocation - employee benefits		Royal Management Corp.	**	100,521	100,521	17
18	V	30	Depreciation		Royal Management Corp.	**	55,081	55,081	18
19	V	32	Interest		Royal Management Corp.	**	16,801	16,801	19
20	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,567	1,567	20
21	V	33	Property taxes		Royal Management Corp.	**	6,337	6,337	21
22	V	34	Rent expense		Royal Management Corp.	**	4,107	4,107	22
23	V	35	Equipment rental		Royal Management Corp.	**	1,675	1,675	23
24	V	17	Management fees	1,673,305	Royal Management Corp.	**		(1,673,305)	24
25	V	35	Auto Lease		Royal Management Corp.	**	1,869	1,869	25
26	V								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 Chicago Ridge, Inc. own 100% of Royal Management Corp.						38
39	Total			\$ 1,673,305			\$ 211,028	\$ * (1,462,277)	39

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

Facility Name & ID Number

Lexington of Chicago Ridge

0042739

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 Discretionary Trust	22.33%	Lexington HC Ctr. of Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive Living	1
2	John Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	of Algonquin, LLC		Facility	2
3	Cynthia Thiem Discretionary Trust	22.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Vesta Management	Lombard	Mgmt. Company	3
4	Jeffrey J. Bell Revocable Trust	8.25%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Group LLC			4
5	Lawrence W. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Sambell of	Chicago Ridge	Real Estate	5
6	David S. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Chicago Ridge		Property	6
7	Jeffrey J. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Ltd. Ptsp.			7
8	Lawrence W. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Royal Management	Lombard	Mgmt. Company	8
9	David S. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Corporation			9
10					Lexington Financial	Lombard	Finance Company	10
11					Services II, LLC			11
12					Lexington Square	Lombard	Independent and	12
13					Life Care of		Assisted Living	13
14					Lombard, LLC			14
15					Lexington Square	Elmhurst	Independent	15
16					Life Care of		Living Facility	16
17					Elmhurst, LLC			17
18					Samvest of	Lombard	Lessor	18
19					Lombard II, LLC			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 of Chicago Ridge # 0042739 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	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 10,596	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,760	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,393	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,043	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,250	L17, C7	5
6		Member			Certain individuals work in excess of 40 hours per week						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 38,042		13

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

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

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

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	\$	74,298	\$ 380	1
2	5	Utilities - gas & electric	Bed Days	725,412	10	61,939		74,298	6,344	2
3	5	Utilities - water & sewer	Bed Days	725,412	10	2,741		74,298	281	3
4	5	Utilities - maintenance office	Bed Days	725,412	10	8,424		74,298	863	4
5	6	Management allocation - salaries	Bed Days	725,412	10	698,068	698,068	74,298	71,497	5
6	6	Repairs & maintenance	Bed Days	725,412	10	77,933		74,298	7,982	6
7	6	Scavenger & exterminating	Bed Days	725,412	10	3,642		74,298	373	7
8	7	Management allocation - employee	Bed Days	725,412	10	110,922		74,298	11,361	8
9	10	Medical consultant	Bed Days	725,412	10	38,914		74,298	3,986	9
10	10	Management allocation - salaries	Bed Days	725,412	10	358,188	358,188	74,298	36,686	10
11	15	Management allocation - employee	Bed Days	725,412	10	56,916		74,298	5,829	11
12	17	Management allocation - salaries	Bed Days	725,412	10	371,421	371,421	74,298	38,042	12
13	19	Computer consultant & supplies	Bed Days	725,412	10	174,999		74,298	17,924	13
14	19	Professional fees	Bed Days	725,412	10	64,806		74,298	6,638	14
15	20	Dues & subscriptions	Bed Days	725,412	10	11,884		74,298	1,217	15
16	20	Advertising - help wanted	Bed Days	725,412	10	146,469		74,298	15,002	16
17	21	Management allocation - salaries	Bed Days	725,412	10	5,805,098	5,805,098	74,298	594,569	17
18	21	Bank charges	Bed Days	725,412	10	32,134		74,298	3,291	18
19	21	Office supplies & printing	Bed Days	725,412	10	102,249		74,298	10,473	19
20	21	Postage	Bed Days	725,412	10	41,415		74,298	4,242	20
21	21	Telephone	Bed Days	725,412	10	120,819		74,298	12,374	21
22	23	Inservice Training	Bed Days	725,412	10	9,785		74,298	1,002	22
23	24	Travel and Seminar	Bed Days	725,412	10	29,058		74,298	2,976	23
24	25	Auto expense	Bed Days	725,412	10	185,111		74,298	18,959	24
25	TOTALS					\$ 8,516,642	\$ 7,232,775		\$ 872,291	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 II, L.L.C.	X		Mortgage	Varies	4/30/07		6,908,000		6,188,682	5/1/17	0.0625	395,991	2	
3														3	
4														4	
5							Interest on financing insurance premium					1,666	5		
	Working Capital														
6	JP Morgan Chase		X	Line of Credit	Varies	6/29/12		5,600,000		1,250,000	6/29/13	Libor +1	27,826	6	
7														7	
8														8	
9	TOTAL Facility Related						\$	12,508,000	\$	7,438,682			\$	425,483	9
	B. Non-Facility Related*														
10									Amortization of loan cost				1,288	10	
11									Interest Income offset				(2,808)	11	
12									Allocate from Home Office				18,368	12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$	16,848	14
15	TOTALS (line 9+line14)						\$	12,508,000	\$	7,438,682			\$	442,331	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.		\$	504,000	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011		\$	571,149	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	67,149	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	589,200	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.			6,337																					
				\$	22,342	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 \$ 2,399 For 2002 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(2,399)	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	682,629	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:		2007	555,313	8	<table><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	663,869	9																						
		2009	486,131	10																						
		2010	488,567	11																						
		2011	571,149	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 of Chicago Ridge

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0042739

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)
	<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>24-18-200-030-0000</u>	<u>Land & Building</u>	\$ <u>551,305.73</u>	\$ <u>551,305.73</u>
2.	<u>24-07-311-012-0000</u>	<u>Land & Building</u>	\$ <u>19,843.01</u>	\$ <u>19,843.01</u>
3.	<u>Royal Management Corp(Samvest of Lombard II)</u>		\$ <u>230,165.98</u>	\$ <u>6,337.00</u>
4.	<u>05-01-202-019</u>	<u>Land & Building</u>	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>801,314.72</u></u>	\$ <u><u>577,485.74</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 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 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).

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	31,000	1989	\$ 505,000	1
2	Management Company Allocation			22,023	2
3	TOTALS	31,000		\$ 527,023	3

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	203		1991	1991	\$ 5,143,342	\$	35	\$ 146,951	\$ 146,951	\$ 3,171,729	4	
5			1995	1995	97,352	2,781	35	2,781		48,674	5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Leasehold Improvements			1993	2,694	77	35	77		1,502	9	
10	Leasehold Improvements			1994	6,581	188	35	188		3,479	10	
11	Dishwasher hood			1996	2,480		10			2,480	11	
12	Lobby repairs			1996	8,698		10			8,698	12	
13	Basement rehab			1997	24,477		10			24,477	13	
14	Wiring			1998	3,429		10			3,429	14	
15	Handrails			1998	895	60	15	60		867	15	
16	Resurface & restripe parking lot			1998	4,450		10			4,451	16	
17	Fire wall			1998	2,169	62	35	62		899	17	
18	Foyer floor tile			1999	32,379		10			32,379	18	
19	Wallpapering / painting / decorating			1999	8,833		10			8,832	19	
20	Rebuild garage area			1999	1,762	50	35	50		661	20	
21	Roof repairs			2000	6,240		10			6,240	21	
22	Electrical wiring			2000	3,986	114	35	114		1,424	22	
23	Electrical wiring			2000	2,536	72	35	72		904	23	
24	Kitchen rehab			2000	6,623	221	35	221		2,761	24	
25	Automatic doors			2000	1,300		10			1,300	25	
26	Elevator eye sensors			2000	4,500	300	15	300		3,750	26	
27	Resurface & restripe parking lot			2001	3,319		10			3,319	27	
28	Door releases			2001	5,200		10			5,200	28	
29	Carpeting			2001	10,022		10			10,022	29	
30	Roof repairs			2002	25,600	1,280	20	1,280		13,867	30	
31	Elevator upgrade			2002	9,865	413	10	413		9,865	31	
32	Painting/decorating/carpet/wallpaper			2003	38,165	1,908	20	1,908		19,081	32	
33	Rehab/new office			2003	26,733	1,337	20	1,337		13,368	33	
34	Facility rehab - construction costs, painting & decorating			2003	257,174	12,859	20	12,859		122,159	34	
35	Facility rehab - electrical			2003	12,840	642	20	642		6,099	35	
36	Facility rehab - carpeting			2003	7,800	780	10	780		7,410	36	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Chicago Ridge

0042739

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Facility rehab - floor tile	2003	\$ 3,548	\$ 177	20	\$ 177	\$	\$ 1,683	37
38									38
39	Kickplates/Door protectors	2004	4,095	410	10	410		3,552	39
40	Kitchen Fire Protection Upgrade	2004	1,427	143	10	143		1,238	40
41	Parking Lot - Paving and Sealcoating	2005	4,375	219	20	219		1,605	41
42	Kitchen Rehab	2005	19,228	961	20	961		6,888	42
43	Lobby/Lounge Reception Area	2005	36,503	1,825	20	1,825		13,840	43
44	Sidewalk - Raise and Support	2005	1,330	67	20	67		485	44
45	Lower Level Therapy Rehab	2005	52,525	2,626	20	2,626		19,258	45
46	Transitional Unit	2005	1,020	51	20	51		361	46
47	Basement Renovation	2005	3,754	188	20	188		1,347	47
48	Landscaping Enhancement	2006	6,463	431	15	431		2,694	48
49	Lhi-Hvac	2006	4,333	217	20	217		1,320	49
50	Rehab Common Areas	2006	7,661	383	20	383		2,490	50
51	Modular Units attached to wall	2006	10,316	516	20	516		3,268	51
52	Cubical Curtains	2006	1,578	316	5	316		1,894	52
53	Landscaping	2007	5,000	333	15	333		1,804	53
54	Parking lot	2007	35,969		20	1,819	1,819	9,095	54
55	HVAC	2007	4,580	229	20	229		1,298	55
56	Emergency A/C	2007	30,293	1,515	20	1,515		8,080	56
57	Portable A/C	2007	3,768	188	20	188		1,019	57
58	Employee Lunch Room	2007	3,671	184	20	184		951	58
59	Painting	2007	16,150	808	20	808		4,309	59
60	1st floor remodel-carpentry, flooring, plumbing, electrical fixtures-	2007	641,616		40	16,225	16,225	81,125	60
61	painting,								61
62	Create first floor therapy	2007	185	9	20	9		54	62
63	Landscaping	2008	19,600	1,307	15	1,307		5,772	63
64	Parking Lot-paving,sealcoating and repairs	2008	44,050	2,203	20	2,203		9,363	64
65	HVAC Sport Coolers	2008	3,790	95	40	95		380	65
66	Plumbing & Sprinkler Shower room	2008	9,668	483	20	483		1,932	66
67	Common areas-doors and locks	2008	3,162	158	20	158		764	67
68	Basement Renovation	2008	7,569	189	40	189		914	68
69	2nd Floor Remodel-Carpentry, Flooring, Electrical, painting	2008	578,270		27	21,028	21,028	85,864	69
70	TOTAL (lines 4 thru 69)		\$ 7,326,941	\$ 39,375		\$ 225,398	\$ 186,023	\$ 3,813,973	70

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

Facility Name & ID Number Lexington of Chicago Ridge

0042739

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		\$ 7,326,941	\$ 39,375		\$ 225,398	\$ 186,023	\$ 3,813,973	1
2	Land improvements	2009	15,180	1,012	15	1,012		3,289	2
3	Landscaping	2009	3,693	246	15	246		841	3
4	Chiller	2009	178,462	8,923	20	8,923		31,974	4
5	Quick connectors/spot cooler	2009	10,244	512	20	512		1,869	5
6	Plumbing & Sprinkler	2009	6,172	154	40	154		501	6
7	Chiller Fence	2009	5,350	268	20	268		804	7
8	Land improvements-patio pergola	2009	7,930	397	20	397		1,323	8
9	Land improvements patio fence	2009	14,308	715	20	715		2,205	9
10	3rd floor remodel-Carpentry,flooring,electrical, painting,sprinkler system	2009	670,689		27	24,389	24,389	75,199	10
11									11
12	Landscaping Enhancements	2010	4,560	304	15	304		659	12
13	Office carpentry,flooring,electrical,painting,plumbing,signs	2010	82,988	10,435	27	10,435		20,870	13
14	Tree removal	2010	12,094	806	15	806		1,881	14
15	Seal Crack Filing and Striping	2010	3,000	200	15	200		467	15
16	Parking lot signage,posts and lamps	2010	30,501	1,113	27	1,113		2,226	16
17	HVAC Quick connects	2010	4,043	147	27	147		307	17
18	Pantries-Tile,shelves	2010	2,855	104	27	104		234	18
19	Director of Nursing office painting	2010	8,090	295	27	295		590	19
20	1st floor rehab-cabinets,library lounge-art,flooring	2010	4,725	172	27	172		385	20
21	2nd floor rehab-painting,flooring	2010	61,521	2,244	27	2,244		4,488	21
22									22
23	Payroll Office Remodel - Electrical	2011	5,439	198	27	198		330	23
24	Payroll Office Remodel - Doors & Millwork	2011	10,336	376	27	376		533	24
25	Holding Tank	2011	16,400	596	27	596		844	25
26	Bulk Pipe - Removal of vent lines	2011	4,380	159	27	159		186	26
27	Remodel Laundry Room - Electrical, Painting & Flooring	2011	7,222	263	27	263		329	27
28	2nd Floor Doors	2011	23,290	847	27	847		1,129	28
29	2nd Floor Remodeling - Carpentry (Drywall, finish/trim)	2011	17,949		27	653	653	1,306	29
30	Exterior Painting	2011	3,000		27	109	109	145	30
31	Fire Dampers	2011	20,441		27	743	743	805	31
32	Boiler	2011	9,800		27	356	356	594	32
33	Parking Lot - seal and stripe	2011	4,300			156	156	195	33
34	TOTAL (lines 1 thru 33)		\$ 8,575,903	\$ 69,861		\$ 282,290	\$ 212,429	\$ 3,970,481	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 12B, Carried Forward		\$ 8,575,903	\$ 69,861		\$ 282,290	\$ 212,429	\$ 3,970,481	1
2	Building Wiring-EMR	2012	13,566		27	164	164	164	2
3									3
4									4
5									5
6									6
7	Reconcile to book depreciation			154			(154)		7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17	Land improvements - management company	2002	304,761		40	8,377	8,377	98,963	17
18	HVAC, electrical, security system - management company	2003	2,677		30	617	617	1,744	18
19	Key card system - management company	2004	421		20	19	19	177	19
20	VAV TX controls - management company	2005	128		20	6	6	50	20
21	Interior Signs- management company	2006	93		5	6	6	38	21
22	Building - management company	2008	14,769		5	716	716	3,995	22
23	Building - management company	2009	2,757		15	47	47	515	23
24	Building - management company	2010	2,687		15	103	103	453	24
25	Building - management company	2011	1,896		15	82	82	131	25
26	Building - management company	2012	6,551		15	2	2	151	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,926,209	\$ 70,015		\$ 292,429	\$ 222,414	\$ 4,076,862	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	\$1,480,272	\$136,815	\$240,644	\$103,829	5	\$967,498	71
72	Current Year Purchases	57,100	7,026	7,026		5	7,026	72
73	Fully Depreciated Assets	74,434					74,434	73
74	Allocated from Mgmt. Co.	536,042		40,542	40,542	5	309,474	74
75	TOTALS	\$2,147,848	\$143,841	\$288,212	\$144,371		\$1,358,432	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		4,564	4,564	5	41,650	79
80	TOTALS			\$52,317	\$	\$4,564	\$4,564		\$41,650	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$11,653,397	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$213,856	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$585,205	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$371,349	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,476,944	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				4,107			6
7	TOTAL				\$ 4,107			7

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2013 \$
13. /2014 \$
14. /2015 \$

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: \$ 90,102
- Description: Copier-\$8,604;Postage-\$181;Printer-\$2,021;Med Eq-\$39,902;Oxygen-\$37,720;Alloc. Mgmt Co.-\$1675
- (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			1,869	20
21	TOTAL		\$	\$ 1,869	21

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

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

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.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	23,210	\$ 576,035	\$	23,210	\$ 576,035	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		5,939	171,394		5,939	171,394	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		19,487	1,510,766		19,487	1,510,766	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				1,075,444		1,075,444	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)					7,668		7,668	12
13	Other (specify): Dentist	39(3)					1,911		1,911	13
14	TOTAL			\$	48,636	\$ 2,258,195	\$ 1,085,023	48,636	\$ 3,343,218	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
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	\$ 357,499	\$ 434,143	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 176,761)	6,384,165	6,384,165	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,972	63,972	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)	38,068	38,068	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,845,694	\$ 6,922,338	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		527,023	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	1,456,658	3,782,867	15
16	Equipment, at Historical Cost	992,916	2,200,165	16
17	Accumulated Depreciation (book methods)	(1,125,043)	(5,476,944)	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): Mortgage cost net		25,216	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,324,531	\$ 6,201,669	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,170,225	\$ 13,124,007	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 940,421	\$ 940,421	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,250,000	1,250,000	29
30	Accrued Salaries Payable	413,369	413,369	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,848	11,848	31
32	Accrued Real Estate Taxes(Sch.IX-B)		589,200	32
33	Accrued Interest Payable		32,353	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Schedule 17A	4,352,574	3,972,324	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,968,212	\$ 7,209,515	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,188,682	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)	\$	\$ 6,188,682	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,968,212	\$ 13,398,197	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,202,013	\$ (274,190)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,170,225	\$ 13,124,007	48

*(See instructions.)

Schedule 17A
XV. Balance Sheet

C. Current Liabilities
36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
LHCC ACCRUED RENT	1,457,394	
LHCC DUE TO MERIT HOSPICE	50,000	50,000
LHCC PA AUDIT SETTLEMENT	84,560	84,560
LHCC DUE FROM REMODELING	95,885	
LHCC DUE TO/FROM REPUBLIC CONSTRUCTION	4,527	4,527
LHCC 401K WITHHOLDING	3,711	3,711
LHCC ACCRUED EXPENSES	86,853	86,853
LHCC ACCRUED RESIDENT TAX	97,869	97,869
LHCC ACCRUED ROYAY/VESTA MGMT. FEES	513,047	513,047
LHCC ACCRUED INSURANCE	138,769	138,769
LHCC DUE TO PATIENT TRUST FUND	8,353	8,353
LHCC ADVANCE - BIWEEKLY PART A PAYM	(21,845)	(21,845)
LHCC UNCOLLECTIBLE PART A CO PVTS	(77,795)	(77,795)
LHCC DUE TO - ROYAL OPERATIONS	39,290	39,290
LHCC PROFESSIONAL LIABILITIES CLAIMS	1,871,956	1,871,956
LHCC SAMBEL INTEREST RATE SWAP LIABILITY		1,173,029
	<u>4,352,574</u>	<u>3,972,324</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,604,657	1
2	Restatements (describe):		2
3	Post closing adjustment	(254,485)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,350,172	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,148,159)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,148,159)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,202,013	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Chicago Ridge# 0042739Report 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	\$ 19,818,920	1
2	Discounts and Allowances for all Levels	(6,996,802)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,822,118	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,106,744	6
7	Oxygen	182	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,106,926	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	3,468	12
13	Barber and Beauty Care	30,244	13
14	Non-Patient Meals	80	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	522,158	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	278,095	19
20	Radiology and X-Ray		20
21	Other Medical Services	293,244	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,127,289	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,808	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,808	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income/Recovery of write off</u>	801	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 801	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,059,942	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,871,977	31
32	Health Care	6,605,216	32
33	General Administration	4,234,225	33
	B. Capital Expense		
34	Ownership	2,328,068	34
	C. Ancillary Expense		
35	Special Cost Centers	3,745,458	35
36	Provider Participation Fee	423,157	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,208,101	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,148,159)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,148,159)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,737,247	44
45	Private Pay - Net Inpatient Revenue	1,550,727	45
46	Medicare - Net Inpatient Revenue	2,177,285	46
47	Other-(specify) <u>Managed Care</u>	4,356,859	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,822,118	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	1,958	2,348	\$ 153,731	\$ 65.47	1
2	Assistant Director of Nursing	40,233	49,217	1,321,105	26.84	2
3	Registered Nurses	16,994	20,714	661,359	31.93	3
4	Licensed Practical Nurses	50,035	59,137	1,502,883	25.41	4
5	CNAs & Orderlies	115,753	136,131	1,544,981	11.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,108	14,221	164,070	11.54	10
11	Social Service Workers	10,366	12,311	207,501	16.85	11
12	Dietician	4,010	4,584	90,701	19.79	12
13	Food Service Supervisor	1,460	1,774	37,930	21.38	13
14	Head Cook	1,546	1,740	29,541	16.98	14
15	Cook Helpers/Assistants	8,883	10,821	113,182	10.46	15
16	Dishwashers	14,295	16,457	142,383	8.65	16
17	Maintenance Workers	2,010	2,362	44,037	18.64	17
18	Housekeepers	33,465	40,803	411,639	10.09	18
19	Laundry	5,351	6,588	66,643	10.12	19
20	Administrator	1,635	2,302	164,570	71.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,240	8,774	188,331	21.46	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	3,429	4,294	68,601	15.98	31
32	Other Health Care <u>Memory Care</u>	3,558	4,261	88,453	20.76	32
33	Other(specify) <u>Marketing</u>	4,830	5,366	130,992	24.41	33
34	TOTAL (lines 1 - 33)	338,159	404,205	\$ 7,132,633 *	\$ 17.65	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	\$ 8,549	1(3)	35
36	Medical Director	Monthly	95,988	9(3)	36
37	Medical Records Consultant	Monthly	1,128	10(3)	37
38	Nurse Consultant	Monthly	168,265	10(3)	38
39	Pharmacist Consultant	Monthly	13,149	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	5,446	11(3)	44
45	Social Service Consultant	Monthly	4,869	12(3)	45
46	Other(specify) <u>Psychosocial</u>	Monthly	79	12(3)	46
47	<u>Medical Consultant</u>	Monthly	3,986	10(7)	47
48	<u>Pulmonary Exchange</u>	Monthly	103,635	10(3)	48
49	TOTAL (lines 35 - 48)		\$ 405,094		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Nancy McDonald	Administrator	0	\$ 164,570
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 164,570
B. Administrative - Other			
Description			Amount
Management Fees-Royal Operating		\$	1,132,703
Management Fees-Vesta Mgmt.			540,602
Management Fees (Eliminated in Column 7)			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$	1,673,305
C. Professional Services			
Vendor/Payee	Type		Amount
Grabowski Law Center	Collections	\$	5,697
Cassiday Schade	Legal		75,988
McGladrey & Pullen	Accounting		34,657
Personnel Planners	U/C Consulting		1,565
IL Secretary of State	Accounting		141
Serpico, Petrosino & Dipiero	Legal		7,717
Much Shelist	Legal		6,370
North Heron Ins	Insurance		31,113
Pension Administrators	Pension Administration		1,076
RealMed	WC Consulting		13
See Schedule 21C			109,770
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 274,107
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	143,793
Unemployment Compensation Insurance			170,932
FICA Taxes			520,723
Employee Health Insurance			284,700
Employee Meals			18,898
Illinois Municipal Retirement Fund (IMRF)*			
401K			26,864
Other Employee Benefits			64,117
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,230,027
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,990
Advertising: Employee Recruitment			9,969
Health Care Worker Background Check (Indicate # of checks performed)	140		1,674
Patient Background Checks	419		5,023
Miscellaneous Licenses & Fees			9,026
Miscellaneous Dues & Subscriptions			1,647
Less: Marketing			(617)
Management Company Allocation			16,219
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 44,931
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			
Management Company Allocation			2,976
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	2,976

*** Attach copy of IMRF notifications**

****See instructions.**

Lexington Health Care Center of Chicago Ridge
12/31/2012
Section XIX.

C. Professional Fees

Schedule 21C

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Keller	Lobbyist	16,966
McCracken & Frank	Legal	520
Duane Morris	Legal	5,505
Scott & Krause	Legal	6,495
Ability Network & Bank of Americ	Computer Consulting	1,549
Efax Corporate	Computer Consulting	1,091
E-Health Data Solutions	Computer Consulting	2,400
Elton Designs Inc	Computer Consulting	260
E-mail security	Computer Consulting	405
Facility Wizard Software	Computer Consulting	358
Health Medx	Computer Consulting	15,183
Information Control	Computer Consulting	1,538
Kronos	Computer Consulting	1,392
Lintech L LC	Computer Consulting	4,213
Microsoft Licensing	Computer Consulting	7,488
MY Innerview	Computer Consulting	6,335
National Datacare	Computer Consulting	2,597
On Shift	Computer Consulting	8,016
Oracle	Computer Consulting	8,927
Paragon Clinical	Computer Consulting	1,200
Real Med Corp	Computer Consulting	134
Relias Learning	Computer Consulting	3,864
SilverChair Learning Systems	Computer Consulting	3,324
Softchoice	Computer Consulting	816
Telemedicine Solutions	Computer Consulting	7,200
Top Notch	Computer Consulting	109
Toshiba Business Solutions	Computer Consulting	422
Trisys	Computer Consulting	140
Tympani	Computer Consulting	1,195
Vision Share, Inc.	Computer Consulting	10
XO Communications	Computer Consulting	118

	<u>109,770</u>
Schedule V, line 19 column 3	<u><u>274,107</u></u>

To disallow collection fees	(5,697)
Out of period legal	(10,083)

Legal allocated from Real Estate Secretary of State	200
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<u>Samvest of Lombard</u> Accounting	264
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Allocated from Mgmt Co.

Much Shelist	Legal	569
Duane Morris	Legal	38
Cassiday Schade	Legal	2
McGladrey LLP	Accounting	1,358
Illinois Secretary of State	Filing Fees	32
Gilson Labus & Silverman	KEP	380
Tam Kaiden	Investigative Services	48
Bank of America Leasing	UCC Search & Filing	20
Versight Inc.	Annual Report-Health Ins	112
Personnel Planners	U/C Consultant	20
LaSalle Network	Recruiting/Finance	1,438
Pension Administrators, Inc.	401K Administration	277
Gene Whitehorn	Medicaid Reimb Specialist	1,099
Christine Toolan	Social Service Consulting	18
M Werner Consulting	Financial Consultant	963
Computer Services	Computer Consulting	17,924
		<u>24,298</u>
		<u>283,089</u>
Schedule V, line 19, column 8		<u><u>283,089</u></u>

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? <u>No</u> (2) Are there any dues to nursing home associations included on the cost report? <u>No</u> If YES, give association name and amount. <u>N/A</u> (3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u> (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u> (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>5 Years</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>61,393</u> Line <u>10(2)</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u> (9) Are you presently operating under a sublease agreement? YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u> (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>423,157</u> 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? <u>No</u> 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? <u>Yes</u> (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? <u>No</u> 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. \$ <u>18,898</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>80</u> (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>0</u> d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained.</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>N/A</u> (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? <u>Yes</u> (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? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.
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