

		FOR BHF USE					

LL1

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: 0038083

Facility Name: Lexington of LaGrange

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "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) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

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

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

Facility Name & ID Number Lexington of LaGrange# 0038083 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</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>120</u>	TOTALS	<u>120</u>	<u>43,920</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>25,843</u>	<u>25,843</u>	8
9	SNF/PED					9
10	ICF	<u>5,143</u>	<u>3,589</u>		<u>8,732</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,143</u>	<u>3,589</u>	<u>25,843</u>	<u>34,575</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.72%

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 7/31/92

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 120 and days of care provided 21,534Medicare 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	329,771	19,089	2,681	351,541		351,541		351,541			1
2	Food Purchase		197,056		197,056		197,056	(13,924)	183,132			2
3	Housekeeping	259,877	29,091		288,968		288,968	224	289,192			3
4	Laundry	58,975	12,593		71,568		71,568		71,568			4
5	Heat and Other Utilities			183,474	183,474		183,474	4,426	187,900			5
6	Maintenance	39,343		109,567	148,910		148,910	47,203	196,113			6
7	Other (specify):* Alloc. Mgmt Co. Bene							6,716	6,716			7
8	TOTAL General Services	687,966	257,829	295,722	1,241,517		1,241,517	44,645	1,286,162			8
	B. Health Care and Programs											
9	Medical Director			76,000	76,000		76,000		76,000			9
10	Nursing and Medical Records	4,041,343	343,413	364,228	4,748,984		4,748,984	24,042	4,773,026			10
10a	Therapy											10a
11	Activities	77,557	17,466	16,744	111,767		111,767		111,767			11
12	Social Services	166,770		5,007	171,777		171,777		171,777			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Mgmt Co. Bene							3,446	3,446			15
16	TOTAL Health Care and Programs	4,285,670	360,879	461,979	5,108,528		5,108,528	27,488	5,136,016			16
	C. General Administration											
17	Administrative	122,824		1,107,996	1,230,820		1,230,820	(1,085,508)	145,312			17
18	Directors Fees											18
19	Professional Services			176,977	176,977		176,977	7,021	183,998			19
20	Dues, Fees, Subscriptions & Promotions			47,828	47,828		47,828	8,971	56,799			20
21	Clerical & General Office Expenses	190,199	32,952	43,865	267,016		267,016	369,046	636,062			21
22	Employee Benefits & Payroll Taxes			860,275	860,275		860,275	11,116	871,391			22
23	Inservice Training & Education			10,643	10,643		10,643	592	11,235			23
24	Travel and Seminar			1,294	1,294		1,294	465	1,759			24
25	Other Admin. Staff Transportation			1,024	1,024		1,024	11,208	12,232			25
26	Insurance-Prop.Liab.Malpractice			274,578	274,578		274,578	2,430	277,008			26
27	Other (specify):* Alloc. Mgmt Co. Bene							59,421	59,421			27
28	TOTAL General Administration	313,023	32,952	2,524,480	2,870,455		2,870,455	(615,238)	2,255,217			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,286,659	651,660	3,282,181	9,220,500		9,220,500	(543,105)	8,677,395			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			124,949	124,949		124,949	324,154	449,103			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,976	5,976		5,976	355,847	361,823			32
33	Real Estate Taxes							401,840	401,840			33
34	Rent-Facility & Grounds			1,166,094	1,166,094		1,166,094	(1,163,666)	2,428			34
35	Rent-Equipment & Vehicles			98,886	98,886		98,886	2,095	100,981			35
36	Other (specify):*											36
37	TOTAL Ownership			1,395,905	1,395,905		1,395,905	(79,730)	1,316,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		903,309	2,498,786	3,402,095		3,402,095		3,402,095			39
40	Barber and Beauty Shops			20,390	20,390		20,390		20,390			40
41	Coffee and Gift Shops			520	520		520		520			41
42	Provider Participation Fee			143,141	143,141		143,141		143,141			42
43	Other (specify):* Non-Allowable Co	119,354		191,680	311,034		311,034	(311,034)				43
44	TOTAL Special Cost Centers	119,354	903,309	2,854,517	3,877,180		3,877,180	(311,034)	3,566,146			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,406,013	1,554,969	7,532,603	14,493,585		14,493,585	(933,869)	13,559,716			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	(2,808)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,783)	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	115	30		9
10	Interest and Other Investment Income	(1,548)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,256)	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	(21)	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	(14,636)	43		24
25	Fund Raising, Advertising and Promotional	(57,131)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax	(4,965)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(147,447)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (240,035)		\$	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)	(693,834)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (693,834)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (933,869)		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 of LaGrange

	ID#	0038083
Report Period Beginning:		01/01/2012
Ending:		12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Reclass Repairs & Maintenance	\$	6	1
2	Labs-Part A	(15,688)	43	2
3	X-Rays-Part A	(44,584)	43	3
4	Diagnostics Managed Care	(8,054)	43	4
5	Trust Fees	(75)	43	5
6	Collections	(4,242)	19	6
7	Out of Period legal	(3,456)	19	7
8	Marketing Salary	(119,354)	43	8
9	Education & Seminar marketing	(1,294)	24	9
10	Unrealized loss on FMV swap	85,306	43	10
11	Valet Services	(32,244)	43	11
12	Miscellaneous Income	(382)	21	12
13	Dues & Subscriptions Marketing	(617)	20	13
14	Development Expenses	(2,763)	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	(147,447)		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.

[illegible]

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

☒	X	YES	☐	NO
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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 LaGrange Limited Partnership	**	\$ 200	\$ 200	1	
2	V	30	Depreciation		Sambell of LaGrange Limited Partnership	**	291,479	291,479	2	
3	V	32	Interest Expense		Sambell of LaGrange Limited Partnership	**	345,198	345,198	3	
4	V	32	Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	1,339	1,339	4	
5	V	33	Property Taxes		Sambell of LaGrange Limited Partnership	**	398,094	398,094	5	
6	V	34	Rental Expense	1,166,094	Sambell of LaGrange Limited Partnership	**		(1,166,094)	6	
7	V	43	Trust Fees		Sambell of LaGrange Limited Partnership	**	75	75	7	
8	V	21	Office Supplies		Sambell of LaGrange Limited Partnership	**			8	
9	V	43	Unrealized loss on FMV swap	85,306	Sambell of LaGrange Limited Partnership	**		(85,306)	9	
10	V								10	
11	V								11	
12	V				** The owners of Lexington Health Care Center of La Grange, Inc. owns 100%				12	
13	V				of Sambell of LaGrange Limited Partnership.				13	
14	Total			\$ 1,251,400				\$ 1,036,385	\$ * (215,015)	14

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

VII. RELATED PARTIES (continued)

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

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

1		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.	**	\$ 224	\$ 224	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3,750	3,750	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	166	166	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	510	510	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	42,264	42,264	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	4,718	4,718	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	221	221	21
22	V	6	Security service		Royal Management Corp.	**			22
23	V	7	Management allocation - employee benefits		Royal Management Corp.	**	6,716	6,716	23
24	V	10	Medical consultant		Royal Management Corp.	**	2,356	2,356	24
25	V	10	Management allocation - salaries		Royal Management Corp.	**	21,686	21,686	25
26	V	15	Management allocation - employee benefits		Royal Management Corp.	**	3,446	3,446	26
27	V	17	Management allocation - salaries		Royal Management Corp.	**	22,488	22,488	27
28	V	19	Computer consultant & supplies		Royal Management Corp.	**	10,595	10,595	28
29	V	19	Professional fees		Royal Management Corp.	**	3,924	3,924	29
30	V	20	Dues & subscriptions		Royal Management Corp.	**	720	720	30
31	V	23	Inservice Training		Royal Management Corp.	**	592	592	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	8,868	8,868	32
33	V	21	Management allocation - salaries		Royal Management Corp.	**	351,469	351,469	33
34	V	21	Bank charges		Royal Management Corp.	**	1,946	1,946	34
35	V	21	Office supplies & printing		Royal Management Corp.	**	6,191	6,191	35
36	V	21	Postage		Royal Management Corp.	**	2,507	2,507	36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			\$			\$ 495,357	\$ * 495,357	39

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

Facility Name & ID Number	Lexington of LaGrange	#	0038083	Report Period Beginning:	01/01/2012	Ending:	12/31/2012
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VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Telephone	\$	Royal Management Corp.	**	\$ 7,315	\$ 7,315	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,759	1,759	16
17	V	25	Auto expense		Royal Management Corp.	**	11,208	11,208	17
18	V	26	Insurance general		Royal Management Corp.	**	2,430	2,430	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	59,421	59,421	19
20	V	30	Depreciation		Royal Management Corp.	**	32,560	32,560	20
21	V	32	Interest		Royal Management Corp.	**	9,932	9,932	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	926	926	22
23	V	33	Property taxes		Royal Management Corp.	**	3,746	3,746	23
24	V	34	Rent expense		Royal Management Corp.	**	2,428	2,428	24
25	V	35	Equipment rental		Royal Management Corp.	**	990	990	25
26	V	17	Management fees	1,107,996	Royal Management Corp.	**		(1,107,996)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,105	1,105	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		**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						36
37	V								37
38	V								38
39	Total			\$ 1,107,996			\$ 133,820	\$ * (974,176)	39

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

Facility Name & ID Number

Lexington of LaGrange

0038083

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	1
2	John Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingtondale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	22.34%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Vesta Mgmt.	Lombard	Mgmt. Company	3
4	Jeffrey J. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Group LLC			4
5	Lawrence W. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Sambell of	LaGrange	Real Estate	5
6	David S. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	LaGrange		Property	6
7	David S. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Ltd. Ptsp.			7
8	Jeffrey J. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Royal Mgmt.	Lombard	Mgmt. Company	8
9	Lawrence W. 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	12
13					Life Care of		and Assisted	13
14					Lombard, LLC		Living	14
15					Lexington Square	Elmhurst	Independent	15
16					Life Care of		Living Facility	16
17					Elmhurst, LLC			17
18					Samvest of Lombard	Lombard	Lessor	18
19					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 LaGrange # 0038083 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	\$ 6,263	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,587	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,553	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,164	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,921	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	\$ 22,488		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 LaGrange# 0038083

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 Available	725,412	10	\$ 3,707	\$	43,920	\$ 224	1
2	5	Utilities - gas & electric	Bed Days Available	725,412	10	61,939		43,920	3,750	2
3	5	Utilities - water & sewer	Bed Days Available	725,412	10	2,741		43,920	166	3
4	5	Utilities - maintenance office	Bed Days Available	725,412	10	8,424		43,920	510	4
5	6	Management allocation - salaries	Bed Days Available	725,412	10	698,068		43,920	42,264	5
6	6	Repairs & maintenance	Bed Days Available	725,412	10	77,933		43,920	4,718	6
7	6	Scavenger & exterminating	Bed Days Available	725,412	10	3,642		43,920	221	7
8	6	Security service	Bed Days Available	725,412	10			43,920	0	8
9	7	Management allocation - employee	Bed Days Available	725,412	10	110,922		43,920	6,716	9
10	10	Medical consultant	Bed Days Available	725,412	10	38,914		43,920	2,356	10
11	10	Management allocation - salaries	Bed Days Available	725,412	10	358,188		43,920	21,686	11
12	15	Management allocation - employee	Bed Days Available	725,412	10	56,916		43,920	3,446	12
13	17	Management allocation - salaries	Bed Days Available	725,412	10	371,421		43,920	22,488	13
14	19	Computer consultant & supplies	Bed Days Available	725,412	10	174,999		43,920	10,595	14
15	19	Professional fees	Bed Days Available	725,412	10	64,806		43,920	3,924	15
16	20	Dues & subscriptions	Bed Days Available	725,412	10	11,884		43,920	720	16
17	23	Inservice Training	Bed Days Available	725,412	10	9,785		43,920	592	17
18	20	Advertising - help wanted	Bed Days Available	725,412	10	146,469		43,920	8,868	18
19	21	Management allocation - salaries	Bed Days Available	725,412	10	5,805,098		43,920	351,469	19
20	21	Bank charges	Bed Days Available	725,412	10	32,134		43,920	1,946	20
21	21	Office supplies & printing	Bed Days Available	725,412	10	102,249		43,920	6,191	21
22	21	Postage	Bed Days Available	725,412	10	41,415		43,920	2,507	22
23	21	Telephone	Bed Days Available	725,412	10	120,819		43,920	7,315	23
24	24	Travel and Seminar	Bed Days Available	725,412	10	29,058		43,920	1,759	24
25	TOTALS					\$ 8,331,531	\$		\$ 504,431	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	Sevices II, LLC	X		Mortgage	Varies	4/30/07		5,991,000	5,385,022	5/1/17		0.0625	345,198	2	
3														3	
4														4	
5							Interest on financing insurance premium					707	5		
	Working Capital														
6	JP Morgan Chase		X	Line of Credit	Various	6/29/12		5,600,000	270,000	6/29/13		Libor +2.25%	5,269	6	
7														7	
8														8	
9	TOTAL Facility Related						\$	11,591,000	\$	5,655,022			\$	351,174	9
	B. Non-Facility Related*														
10									Amortization of Loan Cost				1,339	10	
11									Interest Income offset				(1,548)	11	
12														12	
13									Allocated from Mgmt. Co.				10,858	13	
14	TOTAL Non-Facility Related						\$		\$			\$	10,649	14	
15	TOTALS (line 9+line14)						\$	11,591,000	\$	5,655,022			\$	361,823	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																								
1. Real Estate Tax accrual used on 2011 report.				\$	252,000	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		\$	331,522	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	79,522	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	342,000	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		Allocated from Mgmt. Co.			3,746																					
				\$	11,942	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 \$ 35,370 For 2009 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(35,370)	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	401,840	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:		2007	226,830	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	219,332	9																						
		2009	241,653	10																						
		2010	244,173	11																						
		2011	331,522	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 LaGrange

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0038083

CONTACT PERSON REGARDING THIS REPORT
Karen Gillis

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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.	18-08-207-017-0000	Land & Building	\$ 185,002.01	\$ 185,002.01
2.	18-08-207-018-0000	Land & Building	\$ 146,519.53	\$ 146,519.53
3.	Royal Management Corp. (Samvest of Lombard II)		\$ 230,165.98	\$ 3,746.00
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 561,687.52	\$ 335,267.54

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:

50,072

B. General Construction Type:

Exterior

Concrete Block

Frame

Steel

Number of Stories

2

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	40,000	1991	\$ 500,000	1
2	Management Company Allocation			10,717	2
3	TOTALS	40,000		\$ 510,717	3

Facility Name & ID Number Lexington of LaGrange

0038083

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1992	1992	\$ 2,661,448	\$	35	\$ 76,041	\$ 76,041	\$ 1,558,846	4
5			1995	1995	79,363		10			79,363	5
6			2005	2005	2,321,014		21	110,524	110,524	828,932	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1992	1,152		20	28	28	1,152	9
10	Building Improvements			1992	2,714		31			2,714	10
11	Building Improvements			1993	2,901		35	83	83	1,658	11
12	Leasehold Improvements			1994	6,402		10			6,402	12
13	Leasehold Improvements - Corner Guards			1996	2,195		10			2,122	13
14	Wiring			1998	3,378		10			3,378	14
15	Resurface & Restripe Parking Lot			1998	3,753		10			3,753	15
16	Lobby Tile			1998	19,488		10			19,488	16
17	Resurface & Restripe Parking Lot			2000	1,997		10			1,998	17
18	Automatic Door			2000	1,300		10			1,300	18
19	Kitchen Rehab			2001	1,441		10			1,441	19
20	Infrared curtains for elevator			2001	3,000		10			3,000	20
21	Dining room, resident rooms, and corridors renovation			2002	150,083	7,505	20	7,505		75,671	21
22	Elevator upgrade			2002	5,398	179	10	179		5,398	22
23	Air conditioner compressor			2003	9,218	922	10	922		8,681	23
24	Sidewalk and fencing			2005	46,701	2,335	20	2,335		16,734	24
25	HVAC			2005	8,141	407	20	407		2,883	25
26	Wiring			2005	4,506	225	20	225		1,632	26
27	Lobby, lounge and reception renovations			2005	24,362	1,218	20	1,218		8,932	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors			2005	326,862		20	16,343	16,343	114,401	28
29	Wallcoverings			2005	10,822		5			10,822	29
30	Medical records room rehab			2006	19,739	987	20	987		5,922	30
31	Activity/PT Room Rehab			2006	1,158	58	20	58		348	31
32	Land scape enhancement			2006	8,726	582	15	582		3,686	32
33	Roof			2006	29,700	1,980	15	1,980		12,540	33
34	HVAC			2006	3,254	163	20	163		1,032	34
35	Plumbing and sprinkler system			2006	20,725	1,036	20	1,036		7,253	35
36	Laundry Combustion Air			2006	16,814	841	20	841		5,676	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 LaGrange

0038083

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	Lobby/Lounge/Reception rehab	2006	\$ 14,033	\$ 1,403	10	\$ 1,403	\$	\$ 9,120	37
38	Cubicle curtains/drapery	2006	6,955	177	5	177		7,132	38
39	Cabinets/counters for 2nd FI library	2006	2,665	267	10	267		1,668	39
40	TCU rehab	2006	2,402	120	20	120		730	40
41	First floor remodel	2006	212,084		20	10,604	10,604	63,624	41
42	Kitchen rehab	2006	8,165	408	20	408		2,653	42
43	Bath fixtures-2nd foor	2006	2,076	208	10	208		1,421	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		1,057	44
45	Landscaping	2007	3,862	257	15	257		1,435	45
46	HVAC	2007	58,326	2,916	20	2,916		15,795	46
47	Common Areas Remodel	2007	2,059	206	10	206		1,150	47
48	First Floor Remodel	2007	6,517		20	326	326	1,873	48
49	Garage	2007	16,487	824	20	824		4,189	49
50	Land Improvements	2008	3,745	250	15	250		1,021	50
51	Parking lot-paving	2008	8,720	436	20	436		1,926	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		560	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	16,260	16,260	78,590	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		11,803	55
56	Irrigation System	2009	16,740	1,116	15	1,116		3,627	56
57	Landscaping	2009	10,321	688	15	688		2,236	57
58	Parking lot repairs	2009	3,500	175	20	175		627	58
59	HVAC Chiller	2009	2,594	130	20	130		444	59
60	Patio Pergola	2009	6,760	338	20	338		1,296	60
61	Stamped Concrete	2009	16,658	833	20	833		2,777	61
62	Fence	2009	4,084	204	20	204		629	62
63	Patio Wall	2009	8,212	411	20	411		1,336	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		972	64
65									65
66	Brick Panel Replacement	2010	16,578	603	27	603		1,608	66
67	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	17,565	641	27	641		1,282	67
68	Landscaping Enhancements	2010	15,258	1,017	15	1,017		2,543	68
69	Drain tile,sewer concrete	2010	3,221	214	15	214		474	69
70	TOTAL (lines 4 thru 69)		\$ 6,882,020	\$ 36,689		\$ 266,898	\$ 230,209	\$ 3,022,756	70

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

Facility Name & ID Number Lexington of LaGrange

0038083

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 12A, Carried Forward		\$ 6,882,020	\$ 36,689		\$ 266,898	\$ 230,209	\$ 3,022,756	1
2	Retaining wall	2010	15,736	1,049	15	1,049		2,098	2
3	Canopy Installation	2010	4,466	163	27	163		353	3
4	Dining Room HVAC	2010	4,169	152	27	152		380	4
5	Pantry carpentry,flooring,plumbing	2010	2,911	106	27	106		247	5
6	Director of Nursing office painting	2010	4,245	155	27	155		310	6
7	Remodel Library/Lounge-art,painting,flooring	2010	6,477	236	27	236		472	7
8	2nd floor doors	2010	3,046	111	27	111		305	8
9	Office changes-carpentry, painting, flooring	2011	2,487	90	27	90		143	9
10	Fence	2011	2,750	183	15	183		214	10
11	Mulch and stone	2011	2,662	177	15	177		207	11
12	Laundry Room-Tile, Painting	2011	7,311	266	27	266		355	12
13	Locker Room - Installation of 6 tier box lockers	2011	2,573	94	27	94		149	13
14	Place beds back into service - Carpentry, Flooring, Electrical,	2011	117,350	4,267	27	4,267		6,756	14
15	-Painting and Plumbing								15
16									16
17									17
18	Electrical wiring for EMR	2012	13,699	42	27	42		42	18
19									19
20									20
21									21
22									22
23									23
24	Reconcile book depreciation			(135)			135		24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,071,902	\$ 43,645		\$ 273,989	\$ 230,344	\$ 3,034,787	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		\$ 7,071,902	\$ 43,645		\$ 273,989	\$ 230,344	\$ 3,034,787	1
2	Building - management company	2002	148,299		40	4,952	4,952	48,157	2
3	HVAC, electrical, security system - management company	2003	1,303		30	365	365	849	3
4	Key card system - management company	2004	205		20	11	11	86	4
5	VAV TX controls - management company	2005	62		20	3	3	24	5
6	Interior Signs-management company	2006	45		5	3	3	19	6
7	Building - management company	2008	7,186		5	423	423	1,944	7
8	Building - management company	2009	1,341		15	28	28	251	8
9	Building - management company	2010	1,307		15	61	61	221	9
10	Building - management company	2011	923		15	48	48	64	10
11	Building - management company	2012	3,188		15	1	1	73	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,235,761	\$ 43,645		\$ 279,884	\$ 236,239	\$ 3,086,475	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	\$ 795,932	\$ 76,933	\$ 138,183	\$ 61,250	5	\$ 593,394	71
72	Current Year Purchases	35,477	4,371	4,371		5	4,371	72
73	Fully Depreciated Assets	203,098				5	203,098	73
74	Allocated from Mgmt. Co.	260,842		23,967	23,967	5	150,592	74
75	TOTALS	\$ 1,295,349	\$ 81,304	\$ 166,521	\$ 85,217		\$ 951,455	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.			25,458		2,698	2,698		20,267	79
80	TOTALS			\$ 25,458	\$	2,698	\$ 2,698		\$ 20,267	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)	\$ 9,067,285	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,949	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 449,103	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 324,154	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,058,197	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: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				2,428			6
7	TOTAL				\$ 2,428			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 99,876 Description: Copier-\$9,943, Mailing System-\$XX231,Printer-\$1,523; Medical Equip.-\$41,540, Oxygen Equip.-\$45,649, Mg
(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			1,105	20
21	TOTAL		\$	\$ 1,105	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/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.)

		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	\$	23,435	\$ 1,285,826	\$	23,435	\$ 1,285,826	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,954	109,920		3,954	109,920	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		22,391	1,093,810		22,391	1,093,810	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				903,309		903,309	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				9,054			9,054	12
13	Other (specify): Dentist	39(3)				174			174	13
14	TOTAL			\$	49,780	\$ 2,498,784	\$ 903,309	49,780	\$ 3,402,093	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	\$ 684,938	\$ 927,338	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (165,034))	2,923,757	2,923,757	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	134,447	134,447	6
7	Other Prepaid Expenses	1,158	1,158	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,744,300	\$ 3,986,700	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		510,717	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	1,069,321	4,574,313	15
16	Equipment, at Historical Cost	619,897	1,320,807	16
17	Accumulated Depreciation (book methods)	(761,721)	(4,058,197)	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		26,213	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 934,549	\$ 5,042,353	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,678,849	\$ 9,029,053	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 834,573	\$ 834,573	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	270,000	270,000	29
30	Accrued Salaries Payable	328,528	328,528	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,519	1,519	31
32	Accrued Real Estate Taxes(Sch.IX-B)		342,000	32
33	Accrued Interest Payable		28,203	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,381,476	2,116,940	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,816,096	\$ 3,921,763	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,385,022	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)	\$	\$ 5,385,022	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,816,096	\$ 9,306,785	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,862,753	\$ (277,732)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,678,849	\$ 9,029,053	48

*(See instructions.)

Schedule 17A

XV. Balance Sheet

36. Other Current Liabilities

Description	Operating	After Consolidation
Due from Lexington Fin Serv	21	21
Accrued Expenses	96,449	96,449
Accrued Resident Tax	33,472	33,472
Accrued Royl/Vesta Mgmt	8,843	8,843
Accrued Rent	287,104	
Accrued Insurance	60,086	60,086
Due to Patient Trust Fund	273	273
Due to Chicago Ridge	172	172
Due to Royal Operating	40,168	40,168
Due to Republic Construction of Illinois, Inc	(1,770)	(1,770)
Advance bi-weekly part A payments	(12,524)	(12,524)
Uncollectible part A Co. Pvts	(58,502)	(58,502)
Prepaid Insurance	18,264	18,264
Professional Liabilities Claims	909,420	909,420
Interest Rate Swap Liability		1,022,568
	1,381,476	2,116,940

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,227,793	1
2	Restatements (describe):		2
3	Post closing adjustment	(46,985)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,180,808	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	59,945	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(378,000)	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)	\$ (318,055)	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)	\$ 1,862,753	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of LaGrange# 0038083Report 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	\$ 13,141,292	1
2	Discounts and Allowances for all Levels	(6,821,283)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,320,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,662,312	6
7	Oxygen	83,396	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,745,708	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	472	12
13	Barber and Beauty Care	26,663	13
14	Non-Patient Meals	2,808	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	843,600	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	295,272	19
20	Radiology and X-Ray		20
21	Other Medical Services	317,068	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,485,883	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,548	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,548	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Recovery of write off</u>	382	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 382	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,553,530	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,241,517	31
32	Health Care	5,108,528	32
33	General Administration	2,870,455	33
	B. Capital Expense		
34	Ownership	1,395,905	34
	C. Ancillary Expense		
35	Special Cost Centers	3,734,039	35
36	Provider Participation Fee	143,141	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,493,585	40
41	Income before Income Taxes (line 30 minus line 40)**	59,945	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 59,945	43

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 775,559	44
45	Private Pay - Net Inpatient Revenue	847,431	45
46	Medicare - Net Inpatient Revenue	3,032,051	46
47	Other-(specify) <u>Managed Care</u>	1,664,968	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,320,009	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	1,345	1,689	\$ 100,230	\$ 59.34	1
2	Assistant Director of Nursing	34,790	42,088	1,192,768	28.34	2
3	Registered Nurses	25,435	32,917	978,997	29.74	3
4	Licensed Practical Nurses	22,062	27,978	764,327	27.32	4
5	CNAs & Orderlies	34,518	79,862	961,957	12.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,892	5,996	77,557	12.93	10
11	Social Service Workers	7,337	8,445	166,770	19.75	11
12	Dietician	2,260	2,603	52,611	20.21	12
13	Food Service Supervisor	1,285	1,759	42,220	24.00	13
14	Head Cook	1,664	1,937	28,783	14.86	14
15	Cook Helpers/Assistants	9,240	11,139	113,503	10.19	15
16	Dishwashers	9,080	10,860	92,654	8.53	16
17	Maintenance Workers	1,885	2,240	39,343	17.56	17
18	Housekeepers	21,622	26,442	259,877	9.83	18
19	Laundry	5,158	6,352	58,975	9.28	19
20	Administrator	1,301	1,818	122,824	67.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,412	11,058	190,199	17.20	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	2,212	2,728	43,064	15.79	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	3,937	4,374	119,354	27.29	33
34	TOTAL (lines 1 - 33)	198,435	282,285	\$ 5,406,013 *	\$ 19.15	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 792	1(3)	35
36	Medical Director	Monthly	76,000	9(3)	36
37	Medical Records Consultant	26	1,164	10(3)	37
38	Nurse Consultant	Monthly	184,540	10(3)	38
39	Pharmacist Consultant	Monthly	6,961	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	108	5,834	11(3)	44
45	Social Service Consultant	96	5,007	12(3)	45
46	Other(specify)				46
47	<u>Pulmonary</u>	Monthly	86,549	10(3)	47
48	<u>Medical Consultant</u>	Monthly	2,356	10(7)	48
49	TOTAL (lines 35 - 48)	230	\$ 369,203		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	656	\$ 42,698	10(3)	50
51	Licensed Practical Nurses	1,042	42,316	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,698	\$ 85,014		53

STATE OF ILLINOIS

0038083

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Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Facility Name & ID Number

Lexington of LaGrange

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Renee Mills	Administrator	0	\$ 10,404
Eliana Casella	Administrator	0	112,420
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 122,824

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	\$ 671,657
Management Fees-Vesta Mgmt.	436,339
(Eliminated on page 3,C7,L17)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 1,107,996

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center LLC	Collections	\$ 4,242
Cassiday Schade	Legal	23,319
Duane Morris	Legal	6,410
Scott & Krause	Legal	6,495
Secretary of State	Filing Fees	135
McGladrey & Pullen	Accounting	32,429
Pension Administrators	401K Administration	676
Personnel Planners	U/C Consulting	2,390
Real Med	Workers Compensation	25
Much Shelist	Legal	6,994
McCracken & Frank	Legal	350
See Schedule 21C		93,512
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 176,977

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 102,717
Unemployment Compensation Insurance	109,666
FICA Taxes	393,439
Employee Health Insurance	181,398
Employee Meals	11,116
Illinois Municipal Retirement Fund (IMRF)*	
401K	12,827
Other Employee Benefits	46,637
Unifrom Expense	1,389
Tuition	12,202
TOTAL (agree to Schedule V, line 22, col.8)	\$ 871,391

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	\$ 35
Advertising: Employee Recruitment	32,975
Health Care Worker Background Check (Indicate # of checks performed 232)	2,786
Patient Background Checks 775	9,295
Miscellaneous Licenses & Fees	578
Miscellaneous Dues & Subscriptions	2,159
Less: Dues & Subscriptions marketing	(617)
Management Company Allocation	9,588
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 56,799

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Management Company Allocation	1,759
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,759

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Lexington Health Care Center of LaGrange
1/1/12-12/31/12
 Section XIX.

C. Professional Fees

Schedule 21C

Vendor/Payee	Type	Amount
Serpico,Petrosino & Dipiero, LTD	Legal	19,878
Vrdolyak Law Group	Legal	192
ABILITY NETWORK INC	Computer Consulting	1,982
CURASPAN HEALTH GROUP	Computer Consulting	2,750
EFAX CORP	Computer Consulting	1,199
E-HEALTH DATA SOLUTIONS	Computer Consulting	2,400
ELTON DESIGNS INC	Computer Consulting	260
FACILITY WIZARD SOFTWARE	Computer Consulting	358
HEALTHMEDX 6956	Computer Consulting	8,975
INFORMATION CONTROLS	Computer Consulting	1,246
KRONOS	Computer Consulting	1,392
LINTECH	Computer Consulting	4,391
MICROSOFT LEASE	Computer Consulting	6,932
MY INNERVIEW	Computer Consulting	6,335
NATL DATACARE	Computer Consulting	697
ON SHIFT	Computer Consulting	8,144
ORACLE	Computer Consulting	8,927
PARAGON	Computer Consulting	1,200
REALMED	Computer Consulting	71
RELIAS	Computer Consulting	3,864
SILVERCHAIR LEARNING SYSTEM	Computer Consulting	3,864
SOFTCHOICE	Computer Consulting	96
TELEMEDICINE	Computer Consulting	7,200
TRSYS INC	Computer Consulting	140
TYMPANI	Computer Consulting	782
VIRTUAL RABBBIT	Computer Consulting	10
XO COMMUNICATIONS	Computer Consulting	227
Secretary of State	Filing Fees	
Serpico, Petrosino & Dipiero, LTD	Legal	

		<u>93,512</u>
Total Schedule V, line 19, column 3		176,977
Less collection fees		(4,242)
Out of period legal		(3,456)
Allocated from Sambell of LaGrange James Samatas		200
Samvest of Lombard II Accounting		<u>156</u>
		<u>156</u>
Allocated from Mgmt Co.		
Much Shelist	Legal	336
Duane Morris	Legal	22
Cassiday Schade	Legal	1
McGladrey LLP	Accounting	803
Illinois Secretary of State	Filing Fees	19
Gilson Labus & Silverman	KEP	225
Tam Kaiden	Investigative Services	28
Bank of America Leasing	UCC Search & Filing	12
Versight Inc.	Annual Report-Health Ins	66
Personnel Planners	U/C Consultant	12
LaSalle Network	Recruiting/Finance	851
Pension Administrators, Inc.	401K Administration	164
Gene Whitehorn	Medicaid Reimb Specialist	650
Christine Toolan	Social Service Consulting	10
M Werner Consulting	Financial Consultant	569
Computer Services	Computer Consulting	<u>10,595</u>
		<u>14,363</u>
Total Schedule V, line 19 column 8		<u>183,998</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?

No
- (2) Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

N/A
- (3) Did the nursing home make political contributions or payments to a political action organization?

No

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

N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 29,240

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.

\$ 143,141

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.

\$ 11,116

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ (2,808)
- (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.

\$ 0

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

Adequate records have been maintained.

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.