FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0037317

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

Address: 420 W. Butterfield Road (Number) Elmhurst (City) 60126 (Zip Code)

County: Dupage

Telephone Number: (630) 832-2300 **Fax #** (630) 832-7043

HFS ID Number:

Date of Initial License for Current Owners: 11/12/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
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 01/01/2011 to 12/31/2011 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) SEE ACCOUNTANTS' PREPERATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	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	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			20,790	20,790	8
9	SNF/PED					9
10	ICF	20,768	4,831		25,599	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,768	4,831	20,790	46,389	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.65%

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? Yes

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/12/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 11,780

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, I # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	343,649	27,717	11,448	382,814		382,814		382,814			1
2	Food Purchase		260,021		260,021		260,021	(15,423)	244,598			2
3	Housekeeping	294,478	28,718		323,196		323,196	265	323,461			3
4	Laundry	48,125	16,439		64,564		64,564		64,564			4
5	Heat and Other Utilities			214,953	214,953		214,953	7,249	222,202			5
6	Maintenance	41,486		94,027	135,513		135,513	59,660	195,173			6
7	Other (specify):* Mgmt Co. Alloc. Bene							6,537	6,537			7
8	**TOTAL General Services**	727,738	332,895	320,428	1,381,061		1,381,061	58,288	1,439,349			8
	B. Health Care and Programs											
9	Medical Director			71,363	71,363		71,363		71,363			9
10	Nursing and Medical Records	3,557,339	294,726	117,823	3,969,888		3,969,888	44,822	4,014,710			10
10a	Therapy			1,241,847	1,241,847		1,241,847		1,241,847			10a
11	Activities	186,270	22,581	8,695	217,546		217,546		217,546			11
12	Social Services	124,662		7,104	131,766		131,766		131,766			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co. Alloc. Bene							6,199	6,199			15
16	**TOTAL Health Care and Programs**	3,868,271	317,307	1,446,832	5,632,410		5,632,410	51,021	5,683,431			16
	C. General Administration											
17	Administrative	121,386		1,122,580	1,243,966		1,243,966	(1,103,157)	140,809			17
18	Directors Fees											18
19	Professional Services			185,078	185,078		185,078	12,291	197,369			19
20	Dues, Fees, Subscriptions & Promotions			27,826	27,826		27,826	4,998	32,824			20
21	Clerical & General Office Expenses	158,488	28,958	31,120	218,566		218,566	431,833	650,399			21
22	Employee Benefits & Payroll Taxes			796,340	796,340		796,340	13,739	810,079			22
23	Inservice Training & Education			17,903	17,903		17,903	1,156	19,059			23
24	Travel and Seminar			1,953	1,953		1,953	38	1,991			24
25	Other Admin. Staff Transportation			2,075	2,075		2,075	14,023	16,098			25
26	Insurance-Prop.Liab.Malpractice			292,459	292,459		292,459	4,847	297,306			26
27	Other (specify):* Mgmt Co. Alloc. Bene							62,293	62,293			27
28	**TOTAL General Administration**	279,874	28,958	2,477,334	2,786,166		2,786,166	(557,939)	2,228,227			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,875,883	679,160	4,244,594	9,799,637		9,799,637	(448,630)	9,351,007			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. #0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			154,691	154,691		154,691	314,799	469,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,529	3,529		3,529	625,662	629,191			32
33	Real Estate Taxes							75,152	75,152			33
34	Rent-Facility & Grounds			1,006,787	1,006,787		1,006,787	(1,003,848)	2,939			34
35	Rent-Equipment & Vehicles			52,900	52,900		52,900	2,371	55,271			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,217,907	1,217,907		1,217,907	14,136	1,232,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		362,472	1,500	363,972		363,972		363,972			39
40	Barber and Beauty Shops			23,320	23,320		23,320		23,320			40
41	Coffee and Gift Shops			2,243	2,243		2,243		2,243			41
42	Provider Participation Fee			182,481	182,481		182,481		182,481			42
43	Other (specify):* **Non-Allow Costs**	102,291		113,872	216,163		216,163	(216,163)				43
44	**TOTAL Special Cost Centers**	102,291	362,472	323,416	788,179		788,179	(216,163)	572,016			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,978,174	1,041,632	5,785,917	11,805,723		11,805,723	(650,657)	11,155,066			45

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,684)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,965)	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	1,235	30		9
10	Interest and Other Investment Income	(439)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,687)	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	(1,062)	43		18
19	Entertainment				19
20	Contributions	(1,350)	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	(18,822)	43		24
25	Fund Raising, Advertising and Promotional	(50,411)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,850)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	920,080			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 830,045		$	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)	(1,480,702)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,480,702)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (650,657)		37

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

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

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

Lexington Health Care Center of Elmhurst, Inc.

ID# 0037317

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (645)	43	1
2	Labs-Part A	(3,852)	43	2
3	X-Rays-Part A	(20,228)	43	3
4	Trust Fees	(185)	43	4
5	Dues & Subscriptions Marketing	(263)	20	5
6	Collection fees	(4,855)	19	6
7	Reclass assets to Repairs & Maintenance	10,934	6	7
8	Education & Seminar Marketing	(1,953)	24	8
9	Loss on FMV swap	1,043,418	43	9
10	Marketing Salary	(102,291)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	920,080		49

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 supplemental page 6		See supplemental page 6		See supplemental page 6		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,006,787	Sambell of Elmhurst II Limited Partnership	**	$	$ (1,006,787)	1
2	V	19	Professional Fees		Sambell of Elmhurst II Limited Partnership	**	200	200	2
3	V	21	Office Supplies		Sambell of Elmhurst II Limited Partnership	**	42	42	3
4	V	30	Depreciation		Sambell of Elmhurst II Limited Partnership	**	279,670	279,670	4
5	V	32	Interest expense		Sambell of Elmhurst II Limited Partnership	**	611,165	611,165	5
6	V	32	Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	3,405	3,405	6
7	V	33	Property taxes		Sambell of Elmhurst II Limited Partnership	**	70,787	70,787	7
8	V	43	Unrealized loss on FMV swap	1,043,418	Sambell of Elmhurst II Limited Partnership	**		(1,043,418)	8
9	V	43	Trust fees		Sambell of Elmhurst II Limited Partnership	**	185	185	9
10	V								10
11	V								11
12	V				** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				12
13	V				of Sambell of Elmhust II Limited Partnership				13
14	Total			$ 2,050,205			$ 965,454	$ * (1,084,751)	14

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 265	$ 265	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	6,308	6,308	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	144	144	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	797	797	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	44,421	44,421	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	4,064	4,064	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	241	241	21
22	V	6	Security service		Royal Management Corp.	**			22
23	V	7	Management allocation - employee benefits		Royal Management Corp.	**	6,537	6,537	23
24	V	10	Medical consultant		Royal Management Corp.	**	2,699	2,699	24
25	V	10	Management allocation - salaries		Royal Management Corp.	**	42,123	42,123	25
26	V	15	Management allocation - employee benefits		Royal Management Corp.	**	6,199	6,199	26
27	V	17	Management allocation - salaries		Royal Management Corp.	**	19,423	19,423	27
28	V	19	Computer consultant & supplies		Royal Management Corp.	**	12,307	12,307	28
29	V	19	Professional fees		Royal Management Corp.	**	4,639	4,639	29
30	V	20	Dues & subscriptions		Royal Management Corp.	**	952	952	30
31	V	23	Inservice Training		Royal Management Corp.	**	1,156	1,156	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	4,309	4,309	32
33	V	21	Management allocation - salaries		Royal Management Corp.	**	403,859	403,859	33
34	V	21	Bank charges		Royal Management Corp.	**	7,726	7,726	34
35	V	21	Office supplies & printing		Royal Management Corp.	**	8,944	8,944	35
36	V	21	Postage		Royal Management Corp.	**	2,894	2,894	36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.						38
39	Total			$			$ 580,007	$ * 580,007	39

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Telephone	$	Royal Management Corp.	**	$ 8,368	$ 8,368	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,991	1,991	16
17	V	25	Auto expense		Royal Management Corp.	**	14,023	14,023	17
18	V	26	Insurance general		Royal Management Corp.	**	4,847	4,847	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	62,293	62,293	19
20	V	30	Depreciation		Royal Management Corp.	**	33,894	33,894	20
21	V	32	Interest		Royal Management Corp.	**	11,505	11,505	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	26	26	22
23	V	33	Property taxes		Royal Management Corp.	**	4,365	4,365	23
24	V	34	Rent expense		Royal Management Corp.	**	2,939	2,939	24
25	V	35	Equipment rental		Royal Management Corp.	**	848	848	25
26	V	17	Management fees	1,122,580	Royal Management Corp.	**		(1,122,580)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,523	1,523	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		** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.						37
38	V								38
39	Total			$ 1,122,580			$ 146,622	$ * (975,958)	39

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	16.66%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	16.67%	Lexington HC Ctr. of Lombard, Inc.	Lombard	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	16.67%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Vesta Management	Lombard	Mgmt. Co.	3
4	David S. Bell Revocable Trust	12.50%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Group LLC			4
5	Jeffrey J. Bell Revocable Trust	12.50%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Sambell of	Elmhurst	Real Estate	5
6	Lawrence W. Bell Revocable Trust	12.50%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Elmhurst Ltd. Ptsp.		Property	6
7	David S. Bell 2001 Trust	4.16%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Royal Management	Lombard	Management	7
8	Jeffrey J. Bell 2001 Trust	4.17%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Corporation		Company	8
9	Lawrence W. Bell 2001 Trust	4.17%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Lexington Financial	Lombard	Finance Company	9
10			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Services II, LLC			10
11					Lexington Square	Lombard	Independent	11
12					Life Care of		and Assisted	12
13					Lombard, LLC		Living	13
14					Lexington Square	Elmhurst	Independent	14
15					Life Care of		Living Facility	15
16					Elmhurst, LLC			16
17					Samvest of Lombard	Lombard	Lessor	17
18					II, LLC			18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington Health Care Center of Elmhurst, # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/Officer	Administrative	16.66	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 7,123	L 17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	16.67	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,009	L 17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	16.67	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,290	L 17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,424	L 21, C7	4
5											5
6											6
7				Certain Individuals work in excess of 40 hours per week.							7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,846		13

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

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	722,420	10	$ 3,612	$	52,925	$ 265	1
2	5	Utilities - gas & electric	Bed Days	722,420	10	86,099		52,925	6,308	2
3	5	Utilities - water & sewer	Bed Days	722,420	10	1,961		52,925	144	3
4	5	Utilities - maintenance office	Bed Days	722,420	10	10,885		52,925	797	4
5	6	Management allocation - salaries	Bed Days	722,420	10	606,344	606,344	52,925	44,421	5
6	6	Repairs & maintenance	Bed Days	722,420	10	55,471		52,925	4,064	6
7	6	Scavenger & exterminating	Bed Days	722,420	10	3,293		52,925	241	7
8	6	Security service	Bed Days	722,420	10			52,925	0	8
9	7	Management allocation - employee	Bed Days	722,420	10	89,234		52,925	6,537	9
10	10	Medical consultant	Bed Days	722,420	10	36,843		52,925	2,699	10
11	10	Management allocation - salaries	Bed Days	722,420	10	574,970	574,970	52,925	42,123	11
12	15	Management allocation - employee	Bed Days	722,420	10	84,616		52,925	6,199	12
13	17	Management allocation - salaries	Bed Days	722,420	10	265,116	265,116	52,925	19,423	13
14	19	Computer consultant & supplies	Bed Days	722,420	10	167,987		52,925	12,307	14
15	19	Professional fees	Bed Days	722,420	10	63,319		52,925	4,639	15
16	20	Dues & subscriptions	Bed Days	722,420	10	13,000		52,925	952	16
17	23	Inservice Training	Bed Days	722,420	10	15,778		52,925	1,156	17
18	20	Advertising - help wanted	Bed Days	722,420	10	58,818		52,925	4,309	18
19	21	Management allocation - salaries	Bed Days	722,420	10	5,512,623	5,512,623	52,925	403,859	19
20	21	Bank charges	Bed Days	722,420	10	105,454		52,925	7,726	20
21	21	Office supplies & printing	Bed Days	722,420	10	122,091		52,925	8,944	21
22	21	Postage	Bed Days	722,420	10	39,500		52,925	2,894	22
23	21	Telephone	Bed Days	722,420	10	114,221		52,925	8,368	23
24	24	Travel and Seminar	Bed Days	722,420	10	27,173		52,925	1,991	24
25	TOTALS					$ 8,058,408	$ 6,959,053		$ 590,366	25

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Ave.
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	25	Auto expense	Bed Days	722,420	10	$ 191,407	$	52,925	$ 14,023	1
2	26	Insurance general	Bed Days	722,420	10	66,156		52,925	4,847	2
3	27	Management allocation - employee	Bed Days	722,420	10	850,290		52,925	62,293	3
4	30	Depreciation	Bed Days	722,420	10	462,650		52,925	33,894	4
5	32	Interest	Bed Days	722,420	10	157,045		52,925	11,505	5
6	32	Amortization of mortgage costs	Bed Days	722,420	10	354		52,925	26	6
7	33	Property taxes	Bed Days	722,420	10	59,576		52,925	4,365	7
8	34	Rent expense	Bed Days	722,420	10	40,122		52,925	2,939	8
9	35	Equipment rental	Bed Days	722,420	10	11,581		52,925	848	9
10	35	Auto Lease	Bed Days	722,420	10	20,791		52,925	1,523	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,859,972	$		$ 136,263	25

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Ir # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial Services	X		Mortgage	Varies	4/30/07	$ 5,391,000	$ 4,240,844	5/1/17	0.0625	$ 611,165	1
2	II, L.L.C											2
3												3
4												4
5							Interest on financing insurance premium				798	5
	Working Capital											
6	JP Morgan Chase		X	Line of Credit	Various	4/30/07	800,000	510,000	6/30/12	Libor + 2.25%	2,731	6
7												7
8												8
9	TOTAL Facility Related						$ 6,191,000	$ 4,750,844			$ 614,694	9
	B. Non-Facility Related*											
10								Interest Income Offset			(439)	10
11								Amortization of Loan Cost			3,405	11
12								Allocated from Home Office			11,531	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 14,497	14
15	TOTALS (line 9+line14)						$ 6,191,000	$ 4,750,844			$ 629,191	15

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

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

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 63,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010	$ 68,387	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,787	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,000	4
	Allocated from Mgmt Co.	4,365	
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.		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 75,152	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	60,570	8
2007	64,015	9
2008	62,753	10
2009	68,355	11
2010	68,387	12

Accrual Calculation: See attached schedule

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0037317

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-14-317-008	Land & Building	$ 68,387.44	$ 68,387.44
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land & Building	$ 229,415.60	$ 4,365.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 297,803.04	$ 72,752.44

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

Lexington Square Life Care of Elmhurst, Inc.: Retirement Community: 342 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization:
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	55,000	1991	$ 1,277,670	1
2	Allocated from management company			14,755	2
3	TOTALS	55,000		$ 1,292,425	3

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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	133		1991	1991	$ 4,110,586	$	35	$ 117,445	$ 117,445	$ 2,361,675	4
5	12		1995	1995	73,302	2,095	35	2,095		34,887	5
6			2001	2001							6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1992	693	20	35	20		382	9
10	Land Improvement			1995	7,500		15			7,500	10
11	Fan Coil Units			1996	4,904	140	35	140		2,171	11
12	Patio			1996	2,322	155	15	155		2,245	12
13	Basement rehab			1997	17,151		10			17,151	13
14	Baseboards			1997	3,129		10			3,129	14
15	Wiring			1998	3,090		10			3,090	15
16	Lobby Tile			1999	19,354		10			19,354	16
17	Patio			1999	4,196	280	15	280		3,358	17
18	Automatic Door			2000	1,300		10			1,300	18
19	Wallpaper			2000	6,853		10			6,853	19
20	Patio			2000	1,242	83	15	83		953	20
21	Storage closet for HVAC			2000	3,745	250	15	250		2,872	21
22	Fire pump system			2001	4,140	20	10	207	187	4,140	22
23	Door releases			2001	4,420	221	10	221		4,420	23
24	Infrared curtains for elevators			2001	3,000	150	10	150		3,000	24
25	Parking lot			2002	2,532	253	10	253		2,532	25
26	Kitchen tile and plumbing			2002	9,661	966	10	966		9,339	26
27	Elevator upgrade			2002	2,596		5			2,596	27
28	Facility Rehab-Painting/wallpaper/carpeting			2003	175,251	17,525	10	17,525		156,265	28
29	Facility Rehab-Floor tile/room upgrade			2003	38,140	1,907	20	1,907		17,004	29
30	Facility Rehab-Carpeting			2003	7,861	786	10	786		6,943	30
31	Parking lot			2004	2,000		5			2,000	31
32	Roof			2004	15,000	750	20	750		5,563	32
33	Landscaping			2005	5,396	270	20	270		1,754	33
34	Paint for building			2005	9,000	900	10	900		5,625	34
35	Roof			2005	14,300	715	20	715		4,409	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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	HVAC upgrade	2005	$ 3,230	$ 162	20	$ 162	$	$ 1,079	37
38	Sprinkler system	2005	1,060	53	20	53		331	38
39	Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		9,545	39
40	Window treatment	2005	1,932	193	10	193		1,287	40
41	Cubicle curtains	2005	820		5			820	41
42	Countertop	2005	845		5			845	42
43	HVAC	2006	3,793	190	20	190		965	43
44	Automatic Door Lock	2006	2,784	139	20	139		695	44
45	Storeroom Door Lock	2006	1,904	95	20	95		491	45
46	Service Door	2006	2,545	127	20	127		635	46
47	Landscaping Enhancement-Patio	2006	2,340	156	15	156		845	47
48	PT Therapy Room	2006	570	14	40	14		70	48
49									49
50									50
51									51
52	Transitional Unit	2007	1,864	93	20	93		442	52
53	Employee Lunch Room	2007	2,827	141	20	141		635	53
54	PT Room Rehab	2007	58,628	2,941	20	2,941		12,549	54
55	Landscaping-brick pavers	2008	43,813	2,921	15	2,921		9,493	55
56	Parking Lot	2008	31,700	1,585	20	1,585		5,680	56
57	Roof Repairs	2008	4,200	280	15	280		1,027	57
58	HVAC-New Chillers	2008	118,557	5,928	20	5,928		19,760	58
59	Emergency A/C	2008	5,706	285	20	285		950	59
60	Building Addition	2008			27				60
61	Kitchen Upgrade	2008	7,214		27	262	262	830	61
62	2nd Floor Remodel-painting,flooring, electrical	2008	561,274		27	20,410	20,410	64,632	62
63	Foundation Stabilization	2008	66,195		27	2,407	2,407	7,622	63
64	Irrigation System	2009	15,485	1,032	15	1,032		2,408	64
65	Landscaping Enhancements	2009	26,798	1,787	15	1,787		4,318	65
66	Patio Fence	2009	9,319	466	20	466		1,204	66
67	Chiller	2009	82,310	4,115	20	4,115		11,317	67
68	Plumbing	2009	4,280	214	20	214		428	68
69	2nd floor remodel-MDS office,HR office,Nursing call system	2009	6,853	250	27	250		510	69
70	TOTAL (lines 4 thru 69)		$ 5,649,111	$ 52,033		$ 192,744	$ 140,711	$ 2,853,923	70

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 5,649,111	$ 52,033		$ 192,744	$ 140,711	$ 2,853,923	1
2	Patio Pergola	2009	12,814	641	20	641		1,496	2
3	Tub Room carpentry,flooring,electrical	2009	5,828	212	27	212		424	3
4	2nd Floor remodel-Carpentry,doors,flooring,electrical	2009	455,801		7	16,575	16,575	45,581	4
5	painting,sprikler system								5
6	Landscaping	2010	3,314	221	15	221		276	6
7	Physician office remodel-carpentry,tiling	2010	6,450	235	27	235		255	7
8	Front Entrance-door and drain tile	2010	4,418	216	27	216		263	8
9	Nurse pull cord station	2010	3,256	118	27	118		118	9
10	Remodel Pantry-shelves	2010	7,146	260	27	260		260	10
11	Director of Nursing office painting	2010	5,539	201	27	201		201	11
12	Cooridor remodel-flag poll,tiling	2010	13,777	550	27	550		614	12
13	Library/Lounge remodel-art,carpentry,electrical	2010	11,870	432	27	432		432	13
14	Steel frame remodel	2010	6,740	245	27	245		368	14
15	2nd Floor remodel-Carpentry,doors,flooring,electrical	2010	17,168	624	27	624		1,248	15
16	Tub Room carpentry,plumbing	2010	11,731	427	27	427		783	16
17	Pergola	2010	8,180	1,636	5	1,636		2,181	17
18	Stamped concrete	2010	17,260	628	27	628		837	18
19	Landscaping	2011	4,443	99	15	99		99	19
20	Offices-doors, locks, keys	2011	66,131	1,403	27	1,403		1,403	20
21	Seal and stripe parking lot	2011	3,500	32	27	32		32	21
22	Laundry room-electrical, painting	2011	6,412	117	27	117		117	22
23	Floor install	2011	10,158	308	27	308		308	23
24	2nd floor doors	2011	9,654	322	27	322		322	24
25									25
26									26
27	Reconcile to book depreciation			644			(644)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,340,701	$ 61,604		$ 218,246	$ 156,642	$ 2,911,541	34

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 6,340,701	$ 61,604		$ 218,246	$ 156,642	$ 2,911,541	1
2									2
3									3
4									4
5									5
6									6
7	Land improvements - management company	2002	204,186		15	5,994	5,994	60,230	7
8	Building - management company	2002			40				8
9	HVAC, electrical, security system - management company	2003	1,793		30	343	343	1,044	9
10	Key card system - management company	2004	282		20	14	14	105	10
11	VAV TX controls - management company	2005	86		20	4	4	29	11
12	Interior Signs- management company	2006	62		5	4	4	22	12
13	Building - management company	2008	9,894		5	512	512	2,045	13
14	Building - management company	2009	1,847		15	34	34	245	14
15	Building - management company	2010	1,800		15	73	73	186	15
16	Building - management company	2011	1,271		15	28	28	28	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,561,922	$ 61,604		$ 225,252	$ 163,648	$ 2,975,475	34

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 1,224,417	$ 85,036	$ 209,299	$ 124,263	5	$ 696,402	71
72	Current Year Purchases	89,114	8,051	8,051		5	8,051	72
73	Fully Depreciated Assets	38,029					38,029	73
74	Alloc. From Mgmt Co.	237,865		23,518	23,518	5	185,451	74
75	TOTALS	$ 1,589,425	$ 93,087	$ 240,868	$ 147,781		$ 927,933	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	Alloc. From Mgmt Co.			33,462		3,370	3,370		25,926	77
78										78
79										79
80	TOTALS			$ 33,462	$	$ 3,370	$ 3,370		$ 25,926	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)	$ 9,477,234	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 154,691	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 469,490	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 314,799	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,929,334	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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? 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 Mgmt Co.				2,939			6
7	TOTAL				$ 2,939 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 53,748 Description: Copier-$8,305;Mailing System-$120;Med Equip-$20,022;Oxygen-$24,453; Mgmt Co. Allocation-$848
(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	Allocated from Mgmt Co.			1,523	18
19					19
20					20
21	TOTAL		$	$ 1,523	21

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

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	10A(3)	hrs	$	11,178	$ 467,493	$	11,178	$ 467,493	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,202	192,920		4,202	192,920	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,179	581,434		11,179	581,434	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				362,472		362,472	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)					1,500		1,500	12
13	Other (specify):									13
14	TOTAL			$	26,559	$ 1,241,847	$ 363,972	26,559	$ 1,605,819	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.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 800,965	$ 807,838	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 390,069)	2,345,108	2,345,108	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,041	55,041	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	35,830	4,599	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,236,944	$ 3,212,586	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,319	6,319	12
13	Land		1,292,425	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	1,142,243	2,451,336	15
16	Equipment, at Historical Cost	650,396	1,622,887	16
17	Accumulated Depreciation (book methods)	(770,717)	(3,929,334)	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 Net Cost		70,076	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,028,241	$ 5,624,295	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,265,185	$ 8,836,881	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 530,990	$ 530,990	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	510,000	510,000	29
30	Accrued Salaries Payable	325,313	325,313	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,589	1,589	31
32	Accrued Real Estate Taxes(Sch.IX-B)		66,000	32
33	Accrued Interest Payable		40,207	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	429,416	1,408,231	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,797,308	$ 2,882,330	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,240,844	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)**	$	$ 4,240,844	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,797,308	$ 7,123,174	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,467,877	$ 1,713,707	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,265,185	$ 8,836,881	48

***(See instructions.)**

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/11-12/31/11

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Interest Rate Swap Liability		992,759
Due to Republic Construction of Illinois, Inc	6,849	6,849
Due to LHCC Elmhurst		
Accrued Expenses	17,922	17,922
Accrued Royl Mgmt Fees/Vesta Fees	30,382	30,382
Accrued Rent	13,944	-
Accrued Insurance	121,046	121,046
Due to Patient Trust Fund	6,150	6,150
Deferered Income	118,926	118,926
Due to Royal Operations	38,436	38,436
Advance-Bi-weekly Part A Payments	(24,928)	(24,928)
Uncollectible Part A Co. Pvts.	(12,770)	(12,770)
Due to Chicago Ridge	10,366	10,366
Accrued Resident Tax	103,093	103,093
	429,416	1,408,231

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,264,105	1	
2	Restatements (describe):		2	
3	**Post closing adjustment**	(88,270)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,175,835	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,271,224	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	(979,182)	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)**	$ 292,042	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,467,877	24	*

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,827,655	1
2	Discounts and Allowances for all Levels	(4,818,147)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,009,508	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,310,457	6
7	Oxygen	39,516	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,349,973	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	1,027	12
13	Barber and Beauty Care	25,365	13
14	Non-Patient Meals	1,684	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	354,176	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	106,968	19
20	Radiology and X-Ray		20
21	Other Medical Services	226,530	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 715,750	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,251	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,251	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	465	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 465	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,076,947	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,381,061	31
32	Health Care	5,632,410	32
33	General Administration	2,786,166	33
	B. Capital Expense		
34	Ownership	1,217,907	34
	C. Ancillary Expense		
35	Special Cost Centers	605,698	35
36	Provider Participation Fee	182,481	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,805,723	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,271,224	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,271,224	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This is a cash basis tax payer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,579	1,929	$ 99,061	$ 51.35	1
2	Assistant Director of Nursing	26,478	32,130	880,336	27.40	2
3	Registered Nurses	21,043	24,709	754,802	30.55	3
4	Licensed Practical Nurses	21,019	24,808	622,757	25.10	4
5	CNAs & Orderlies	78,406	90,738	1,061,530	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,339	8,531	105,703	12.39	8
9	Activity Director					9
10	Activity Assistants	11,808	13,839	186,270	13.46	10
11	Social Service Workers	5,902	6,764	124,662	18.43	11
12	Dietician	3	4	61	15.25	12
13	Food Service Supervisor	1,862	2,189	44,156	20.17	13
14	Head Cook	1,885	2,189	32,501	14.85	14
15	Cook Helpers/Assistants	11,377	13,278	133,687	10.07	15
16	Dishwashers	12,882	14,898	133,244	8.94	16
17	Maintenance Workers	1,796	2,229	41,486	18.61	17
18	Housekeepers	27,857	31,485	294,478	9.35	18
19	Laundry	4,506	5,372	48,125	8.96	19
20	Administrator	1,805	2,802	121,386	43.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,935	14,456	158,488	10.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,704	2,071	33,150	16.01	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,950	1,950	102,291	52.46	33
34	TOTAL (lines 1 - 33)	250,136	296,371	$ 4,978,174 *	$ 16.80	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,424	1(3)	35
36	Medical Director	Number	71,363	9(3)	36
37	Medical Records Consultant	27	1,574	10(3)	37
38	Nurse Consultant	Monthly	44,711	10(3)	38
39	Pharmacist Consultant	Monthly	7,902	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	4,865	11(3)	44
45	Social Service Consultant	Monthly	4,992	12(3)	45
46	Other(specify) Psychosocial	44	2,112	12(3)	46
47	Pulmonary	Monthly	63,636	10(3)	47
48	Medical Consultant	Monthly	2,699	10(7)	48
49	TOTAL (lines 35 - 48)	71	$ 215,278		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Pfeiffer III	Administrator	0%	$ 121,386
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 121,386

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 689,532
Management Fees-Vesta Mgmt.	390,712
Royal Capital MGMT Fees	42,336
Removed in column 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,122,580
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center, LLC	Collections	$ 4,855
Cassidy Schade, LLP	Legal	33,993
McGladrey & Pullen, LLP	Accounting	26,914
Much Shelist	Legal	34,395
Personnel Planners	U/C Consulting	1,940
Polsinelli Shughart	Legal	8,909
RSM McGladrey	Accounting	5,039
Secretary of State	Filing Fees	100
Pension Administrators	Pension Administration	673
See Schedule 21C		68,261
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 185,078

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,147
Unemployment Compensation Insurance	107,801
FICA Taxes	369,098
Employee Health Insurance	161,799
Employee Meals	13,739
Illinois Municipal Retirement Fund (IMRF)*	
401K	16,873
Other Employee Benefits	36,586
Uniform Allowance	4,186
Tuition Reimbursement	850
TOTAL (agree to Schedule V, line 22, col.8)	$ 810,079

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	16,737
Health Care Worker Background Check	
(Indicate # of checks performed 344)	4,128
Patient Background Checks 127	1,527
Miscellaneous Licenses & Fees	1,850
Miscellaneous Subscriptions & Dues	1,331
Allocated from Mgmt Co.	5,261
Less: Chamber of commerce dues	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,824

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from Mgmt Co.	1,991
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,991

**See instructions.

Lexington Health Care Center of Elmhurst
1/1/11-12/31/11
Section XIX

Schedule 21C

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Computer Consulting	768.26
ACE-Action Computer	Computer Consulting	884.58
Avtech	Computer Consulting	271.94
BSKLIVE INC. (Staffknex)	Computer Consulting	1,204.80
Efax Corporate	Computer Consulting	2,105.27
E-Health Data Solutions	Computer Consulting	2,400.00
Elton Designs Inc	Computer Consulting	2,201.67
Facility Wizard Software	Computer Consulting	358.00
Information Control	Computer Consulting	1,119.00
Kronos	Computer Consulting	1,400.00
Lintech L LC	Computer Consulting	5,048.87
Microsoft Licensing	Computer Consulting	7,071.92
MNJ Technologies Direct	Computer Consulting	4,185.00
MY Innerview	Computer Consulting	1,848.00
National Datacare	Computer Consulting	1,333.10
Paragon Clinical	Computer Consulting	1,000.00
Question Pro	Computer Consulting	66.70
On Shift	Computer Consulting	3,967.60
Real Med Corp	Workers Compensation	37.50
Right Now Technologies	Computer Consulting	8,927.40
SilverChair Learning Systems	Computer Consulting	8,610.00
Softchoice	Computer Consulting	4,654.58
Survey Analytics	Computer Consulting	300.00
System Design	Computer Consulting	44.10
Telemedicine Solutions	Computer Consulting	7,200.00
Tympani	Computer Consulting	114.95
Vision Share, Inc.	Computer Consulting	84.51
XO Communications	Computer Consulting	1,052.90
		68,261
Schedule V, line 19, column 3		185,078
Collection Fees		(4,855)
Out of period legal		
Allocated from Sambell of Elmhurst		
Secretary of State		200
Allocated from Samvest of Lombard II		
Legal		164
Accounting		178
		342
Allocated from Mgmt Co.		
McGladrey & Pullen LLP	Accounting	1,045
Much Shelist	Legal	277
LaSalle Network	Recruiting/Finance	1,283
Gilson Labus & Silverman	Accounting	142
Laner Muchin	Legal	12

Katten Muchin	Legal	307
Pension Administrators	401K Administration	198
Illinois Secretary of State	Filing Fees	29
Gene Whitehorn	Medicaid Reim Specialist	764
Seyfarth Shaw	Legal	210
Christine Toolan	Social Service Consulting	5
M Werner Consulting	Financial Consulting	3
Susan Parker	Social Service Consulting	22
Computer Service	Computer Services	12,307
		16,604

Schedule V, line 19, column 8	197,369

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lexington Health Care Center of Elmhurst, Inc. # 0037317 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. $ **45,860** Line **10**

(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. $ **182,481**
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. $ **13,739** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,684**

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

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

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