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: 0036095

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

Address: 675 South Roselle Road (Number) Schaumburg (City) 60193 (Zip Code)

County: Cook

Telephone Number: (847) 351-5500 **Fax #** (847) 352-8592

HFS ID Number:

Date of Initial License for Current Owners: 3/3/90

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' PREPARATION 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 Schaumburg, Inc. # 0036095 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	214	Skilled (SNF)	214	78,110	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	214	TOTALS	214	78,110	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			20,427	20,427	8
9	SNF/PED					9
10	ICF	42,519	5,234	115	47,868	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,519	5,234	20,542	68,295	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.43%

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 04/01/90

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 214 and days of care provided 14,798

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 Schaumbur # 0036095 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	386,000	44,666	29,507	460,173		460,173		460,173			1
2	Food Purchase		385,969		385,969		385,969	(18,385)	367,584			2
3	Housekeeping	379,902	40,720		420,622		420,622	391	421,013			3
4	Laundry	77,188	23,763		100,951		100,951		100,951			4
5	Heat and Other Utilities			257,016	257,016		257,016	10,698	267,714			5
6	Maintenance	39,412		226,678	266,090		266,090	76,430	342,520			6
7	Other (specify):* Mgmt Co. - Allocated							9,648	9,648			7
8	TOTAL General Services	882,502	495,118	513,201	1,890,821		1,890,821	78,782	1,969,603			8
	B. Health Care and Programs											
9	Medical Director			71,938	71,938		71,938		71,938			9
10	Nursing and Medical Records	5,090,051	454,874	73,498	5,618,423		5,618,423	66,151	5,684,574			10
10a	Therapy			1,384,893	1,384,893		1,384,893		1,384,893			10a
11	Activities	257,581	29,701	15,245	302,527		302,527		302,527			11
12	Social Services	152,447		6,720	159,167		159,167		159,167			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co. - Allocated							9,149	9,149			15
16	TOTAL Health Care and Programs	5,500,079	484,575	1,552,294	7,536,948		7,536,948	75,300	7,612,248			16
	C. General Administration											
17	Administrative	134,276		1,605,127	1,739,403		1,739,403	(1,576,462)	162,941			17
18	Directors Fees											18
19	Professional Services			257,402	257,402		257,402	10,554	267,956			19
20	Dues, Fees, Subscriptions & Promotions			33,309	33,309		33,309	7,766	41,075			20
21	Clerical & General Office Expenses	229,075	36,340	44,509	309,924		309,924	636,646	946,570			21
22	Employee Benefits & Payroll Taxes			1,023,413	1,023,413		1,023,413	18,385	1,041,798			22
23	Inservice Training & Education			15,245	15,245		15,245	1,706	16,951			23
24	Travel and Seminar			3,563	3,563		3,563	(625)	2,938			24
25	Other Admin. Staff Transportation			1,586	1,586		1,586	20,695	22,281			25
26	Insurance-Prop.Liab.Malpractice			430,912	430,912		430,912	7,153	438,065			26
27	Other (specify):* Mgmt Co. - Allocated							91,936	91,936			27
28	TOTAL General Administration	363,351	36,340	3,415,066	3,814,757		3,814,757	(782,246)	3,032,511			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,745,932	1,016,033	5,480,561	13,242,526		13,242,526	(628,164)	12,614,362			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 Schaumburg, Inc. #0036095 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			223,202	223,202		223,202	367,591	590,793			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,593	7,593		7,593	469,095	476,688			32
33	Real Estate Taxes							449,460	449,460			33
34	Rent-Facility & Grounds			1,835,020	1,835,020		1,835,020	(1,830,682)	4,338			34
35	Rent-Equipment & Vehicles			105,308	105,308		105,308	3,500	108,808			35
36	Other (specify):*											36
37	TOTAL Ownership			2,171,123	2,171,123		2,171,123	(541,036)	1,630,087			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		700,264	16,160	716,424		716,424		716,424			39
40	Barber and Beauty Shops			20,322	20,322		20,322		20,322			40
41	Coffee and Gift Shops			6,621	6,621		6,621		6,621			41
42	Provider Participation Fee			280,145	280,145		280,145		280,145			42
43	Other (specify):* Non-Allow Costs	124,234		144,432	268,666		268,666	(268,666)				43
44	TOTAL Special Cost Centers	124,234	700,264	467,680	1,292,178		1,292,178	(268,666)	1,023,512			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,870,166	1,716,297	8,119,364	16,705,827		16,705,827	(1,437,866)	15,267,961			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 Schaumburg, Inc. # 0036095 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				4
5	Telephone, TV & Radio in Resident Rooms	(5,805)	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	(471)	30		9
10	Interest and Other Investment Income	(706)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10,471)	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	(1,657)	43		18
19	Entertainment				19
20	Contributions	(2,000)	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	(33,449)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,879)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(670,910)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (727,348)		$	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)	(710,518)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (710,518)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,437,866)		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

STATE OF ILLINOIS

Lexington Health Care Center of Schaumburg, Inc.

ID# 0036095

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (40,058)	43	1
2	Labs-Part A	(10,262)	43	2
3	X-Rays-Part A	(37,366)	43	3
4	Reclsas to LHI to R&M	4,516	6	4
5	Trust Fees	(50)	43	5
6	Out of period legal	(4,395)	19	6
7	Collections	(10,260)	19	7
8	Marketing Salary	(124,234)	21	8
9	Diagnostics Managed Care	(443,115)	43	9
10	Unrealized loss on FMV swap	(1,505)	43	10
11	Miscellaneous Income Offset	(618)	21	11
12	Travel & Seminar Marketing	(3,563)	24	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**	(670,910)		49

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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	19	Professional Fees	$	Sambell of Schaumburg Limited Partnership	**	$ 200	$ 200	1
2	V	30	Depreciation		Sambell of Schaumburg Limited Partnership	**	318,039	318,039	2
3	V	32	Amortization of mortgage costs		Sambell of Schaumburg Limited Partnership	**	2,717	2,717	3
4	V	32	Interest expense		Sambell of Schaumburg Limited Partnership	**	450,066	450,066	4
5	V	33	Property taxes		Sambell of Schaumburg Limited Partnership	**	443,018	443,018	5
6	V	34	Rental expense	1,835,020	Sambell of Schaumburg Limited Partnership	**		(1,835,020)	6
7	V	43	State replacement tax		Sambell of Schaumburg Limited Partnership	**	20	20	7
8	V	43	Trust fees		Sambell of Schaumburg Limited Partnership	**	50	50	8
9	V	43	Unrealized loss FMV swap		Sambell of Schaumburg Limited Partnership	**	443,115	443,115	9
10	V		** The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Sambell of Schaumburg Ltd. Ptsp.						10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,835,020			$ 1,657,225	$ * (177,795)	14

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

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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.	**	$ 391	$ 391	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	9,309	9,309	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	212	212	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	1,177	1,177	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	65,560	65,560	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	5,998	5,998	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	356	356	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	9,648	9,648	22
23	V	10	Medical consultant		Royal Management Corp.	**	3,984	3,984	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	62,167	62,167	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	9,149	9,149	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	28,665	28,665	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	18,163	18,163	27
28	V	19	Professional fees		Royal Management Corp.	**	6,846	6,846	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,406	1,406	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	6,360	6,360	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	596,040	596,040	31
32	V	21	Bank charges		Royal Management Corp.	**	11,402	11,402	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	13,201	13,201	33
34	V	21	Postage		Royal Management Corp.	**	4,271	4,271	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 854,305	$ * 854,305	39

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

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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.	**	$ 12,350	$ 12,350	15
16	V	24	Travel & seminar		Royal Management Corp.	**	2,938	2,938	16
17	V	25	Auto expense		Royal Management Corp.	**	20,695	20,695	17
18	V	26	Insurance general		Royal Management Corp.	**	7,153	7,153	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	91,936	91,936	19
20	V	30	Depreciation		Royal Management Corp.	**	50,023	50,023	20
21	V	32	Interest		Royal Management Corp.	**	16,980	16,980	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	38	38	22
23	V	33	Property taxes		Royal Management Corp.	**	6,442	6,442	23
24	V	34	Rent expense		Royal Management Corp.	**	4,338	4,338	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,252	1,252	25
26	V	17	Management fees	1,605,127	Royal Management Corp.	**		(1,605,127)	26
27	V	35	Auto Lease Expense		Royal Management Corp.	**	2,248	2,248	27
28	V	23	Inservice Training		Royal Management Corp.	**	1,706	1,706	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,605,127			$ 218,099	$ * (1,387,028)	39

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

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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	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.	Bloomingdale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	22.34%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Lexington Square	Lombard	Independent	3
4	Jeffrey J. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Life Care of		and Assisted	4
5	Lawrence W. Bell Revocable Trust	8.25%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Lombard, LLC		Living Facility	5
6	David S. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lexington Square	Elmhurst	Independent	6
7	David S. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Life Care of		Living Facility	7
8	Jeffrey J. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Elmhurst, LLC			8
9	Lawrence W. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Vesta Management	Lombard	Management	9
10					Group, LLC		Company	10
11					Sambell of	Schaumburg	Real Estate	11
12					Schaumburg		Property	12
13					Ltd. Ptsp.			13
14					Royal Management	Lombard	Management	14
15					Corporation		Company	15
16					Lexington Financial	Lombard	Finance	16
17					Services, LLC		Company	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 Health Care Center of Schaumbu # 0036095 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	22.33%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 10,512	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,869	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,284	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,053	L21, C7	4
5											5
6											6
7											7
8		Certain individuals work in excess of 40 hours per week.									8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,718		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 Schaumburg, Inc. # 0036095 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	$	78,110	$ 391	1
2	5	Utilities - gas & electric	Bed Days	722,420	10	86,099		78,110	9,309	2
3	5	Utilities - water & sewer	Bed Days	722,420	10	1,961		78,110	212	3
4	5	Utilities - maintenance office	Bed Days	722,420	10	10,885		78,110	1,177	4
5	6	Management allocation - salaries	Bed Days	722,420	10	606,344	606,344	78,110	65,560	5
6	6	Repairs & maintenance	Bed Days	722,420	10	55,471		78,110	5,998	6
7	6	Scavenger & exterminating	Bed Days	722,420	10	3,293		78,110	356	7
8	7	Management allocation - employee	Bed Days	722,420	10	89,234		78,110	9,648	8
9	10	Medical consultant	Bed Days	722,420	10	36,843		78,110	3,984	9
10	10	Management allocation - salaries	Bed Days	722,420	10	574,970	574,970	78,110	62,167	10
11	15	Management allocation - employee	Bed Days	722,420	10	84,616		78,110	9,149	11
12	17	Management allocation - salaries	Bed Days	722,420	10	265,116	265,116	78,110	28,665	12
13	19	Computer consultant & supplies	Bed Days	722,420	10	167,987		78,110	18,163	13
14	19	Professional fees	Bed Days	722,420	10	63,319		78,110	6,846	14
15	20	Dues & subscriptions	Bed Days	722,420	10	13,000		78,110	1,406	15
16	20	Advertising - help wanted	Bed Days	722,420	10	58,818		78,110	6,360	16
17	21	Management allocation - salaries	Bed Days	722,420	10	5,512,623	5,512,623	78,110	596,040	17
18	21	Bank charges	Bed Days	722,420	10	105,454		78,110	11,402	18
19	21	Office supplies & printing	Bed Days	722,420	10	122,091		78,110	13,201	19
20	21	Postage	Bed Days	722,420	10	39,500		78,110	4,271	20
21	21	Telephone	Bed Days	722,420	10	114,221		78,110	12,350	21
22	24	Travel and Seminar	Bed Days	722,420	10	27,173		78,110	2,938	22
23										23
24										24
25	TOTALS					$ 8,042,630	$ 6,959,053		$ 869,593	25

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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	25	Auto expense	Bed Days	722,420	10	$ 191,407	$	78,110	$ 20,695	1
2	26	Insurance general	Bed Days	722,420	10	66,156		78,110	7,153	2
3	27	Management allocation - employee	Bed Days	722,420	10	850,290		78,110	91,936	3
4	30	Depreciation	Bed Days	722,420	10	462,650		78,110	50,023	4
5	32	Interest	Bed Days	722,420	10	157,045		78,110	16,980	5
6	32	Amortization of mortgage costs	Bed Days	722,420	10	354		78,110	38	6
7	33	Property taxes	Bed Days	722,420	10	59,576		78,110	6,442	7
8	34	Rent expense	Bed Days	722,420	10	40,122		78,110	4,338	8
9	35	Equipment rental	Bed Days	722,420	10	11,581		78,110	1,252	9
10	35	Auto Lease	Bed Days	722,420	10	20,791		78,110	2,248	10
11	23	Inservice Training	Bed Days	722,420	10	15,778		78,110	1,706	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,875,750	$		$ 202,811	25

Facility Name & ID Number Lexington Health Care Center of Schaumburg # 0036095 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						$	$			$	1
2	Services LL	X		Mortgage	Varies	5/22/08	7,982,000	7,392,507	01/01/2033	Variable	450,066	2
3												3
4												4
5							Interest on financing insurance premium				1,154	5
	Working Capital											
6	Bank of America		X	Working Capital	Varies	5/31/06	2,000,000	1,370,000	6/30/12	Prime/Libor	6,439	6
7												7
8												8
9	TOTAL Facility Related						$ 9,982,000	$ 8,762,507			$ 457,659	9
	B. Non-Facility Related*											
10							Amortization of loan cost				2,717	10
11							Interest Income offset				(706)	11
12							Allocate from Home Office				17,018	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 19,029	14
15	TOTALS (line 9+line14)						$ 9,982,000	$ 8,762,507			$ 476,688	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 Schaumburg, Inc. # 0036095 **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.**		$ 368,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010	$ 383,165	2
3. Under or (over) accrual (line 2 minus line 1).		$ 14,765	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 394,800	4
	Allocated from Mgmt. Co.	6,442	
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.**		$ 50,095	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** $ 16,641 **For** 2008 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (16,641)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 449,460	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	390,989	8
	2007	415,099	9
	2008	425,860	10
	2009	357,470	11
	2010	383,165	12

See attached accrual worksheet.

	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 Schaumburg, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036095

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.	07-27-201-039-000	Land & Building	$ 383,164.63	$ 383,164.63
2.	Royal Management Corp. (Samvest of		$	$
3.	Lombard II)	Land & Building	$ 229,415.60	$ 6,442.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 612,580.23	$ 389,606.63

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 Schaumburg, Inc. # 0036095 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,541 B. General Construction Type: Exterior Concrete 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).

N/A

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	230,000	1988	$ 211,532	1
2	Allocated from Management Company			22,035	2
3	TOTALS	230,000		$ 233,567	3

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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	214		1990	1990	$ 6,091,126	$	35	$ 174,032	$ 174,032	$ 3,782,376	4
5			1995	1995	146,217	4,178	35	4,178		64,754	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1991	3,521		10			3,491	9
10	Building improvements			1992	860	25	35	25		481	10
11	Land improvements			1992	5,764		20	288	288	5,618	11
12	Land improvements			1992	5,000		20	250	250	4,625	12
13	Fan coil units in offices			1996	5,149	147	35	147		2,280	13
14	Basement rehab			1997	14,697		10			14,697	14
15	Brick			1997	1,500	43	35	43		618	15
16	Dining room rehab			1997	6,422		10			6,422	16
17	Parking lot repave and restripe			1998	2,777		10			2,777	17
18	Wiring			1998	3,667		10			3,667	18
19	Retile 2nd and 3rd floor corridors			1998	10,100		10			10,100	19
20	Plumbing for HVAC			1998	2,263		5			2,263	20
21	Lobby-floor tile			1999	7,478		10			7,478	21
22	Wallpaper-labor			1999	9,705		10			9,705	22
23	New patio			1999	19,039	1,269	15	1,269		15,547	23
24	New pay phone/wiring			1999	2,975		10			2,976	24
25	Roof repairs			2000	9,625		10			9,625	25
26	Water heater			2000	6,688		10			6,688	26
27	Automatic door			2000	1,300		10			1,300	27
28	Rehab project - paint resident rooms, carpet hallways, and tile			2000	52,760		10			52,760	28
29	Water heater and storage tanks			2001	12,102		10			12,102	29
30	Garbage area			2001	4,788	239	20	239		4,788	30
31											31
32											32
33											33
34											34
35											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 Schaumburg, Inc. # 0036095 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	Roof	2002	$ 25,600	$ 2,560	10	$ 2,560	$	$ 23,893	37
38	Facility rehab - paint resident rooms, carpet hallways, and tile	2002	327,253	16,363	20	16,363		170,001	38
39	Elevator electronic curtain	2002	4,500	450	10	450		4,275	39
40	Elevator upgrade	2002	5,471	547	10	547		5,197	40
41	Painting and decorating	2003	13,477	1,348	10	1,348		10,783	41
42	Electrical improvements	2003	844	42	20	42		340	42
43	Repave parking lot	2004	28,840	721	40	721		5,347	43
44	Dining room remodel - paint	2004	11,387	569	20	569		4,364	44
45	Landscaping	2005	593	30	20	30		192	45
46	HVAC upgrade	2005	17,734	887	20	887		5,395	46
47	Generator upgrade	2005	19,650	983	20	983		6,880	47
48	Window replacement	2005	3,899	195	20	195		1,235	48
49	Flooring replacement	2005	1,483	74	20	74		469	49
50	Lobby, lounge and reception rehab	2005	27,180	1,359	20	1,359		8,154	50
51	Therapy room rehab	2005	35,135	1,757	20	1,757		10,833	51
52	Create first floor therapy room	2005	32,045	1,602	20	1,602		10,948	52
53	Create transitional care unit	2005	29,170	1,458	20	1,458		8,871	53
54	Basement renovation	2005	5,996	300	20	300		1,800	54
55	Countertops	2005	845		5			845	55
56	Interior signs	2005	4,412		5			4,412	56
57	Window treatments	2005	912		5			912	57
58	Wall covering	2005	439		5			439	58
59	Panel Brick Replacement	2006	17,387	869	20	869		4,490	59
60	Landscaping Enhancement	2006	7,608	507	15	507		2,662	60
61	HVAC	2006	12,232	612	20	612		3,111	61
62	Sink	2006	2,331	117	20	117		662	62
63	TCU Units	2006	16,379	819	20	819		4,300	63
64	Employee lunch room rehab	2006	8,127	406	20	406		2,234	64
65	Dining room rehab	2006	2,357	118	20	118		649	65
66	Basement renovation	2006	9,465	473	20	473		2,523	66
67	Oxygen room rehab	2006	2,664	133	20	133		710	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,100,938	$ 41,200		$ 215,770	$ 174,570	$ 4,334,064	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 Schaumburg, Inc. # 0036095 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		$ 7,100,938	$ 41,200		$ 215,770	$ 174,570	$ 4,334,064	1
2	Replace Sidewalk	2007	14,625	731	20	731		3,229	2
3	Landscaping	2007	15,700	785	20	785		3,336	3
4	Emergency A/C	2007	15,545	777	20	777		3,561	4
5	1st Floor Remodel - Carpentry, Flooring, Plumbing, Paint	2007	676,072		40	16,902	16,902	73,242	5
6	Bathroom Faucets	2007	12,358	618	20	618		2,523	6
7	Landscaping	2008	10,000	667	15	667		2,445	7
8	Roofing	2008	11,950	598	20	598		1,993	8
9	HVAC-Air tank	2008	2,671	67	40	67		229	9
10	HVAC-Spot Cooler	2008	3,790	95	40	95		285	10
11	Electrical-Fire panel upgrade	2008	71,077	1,777	40	1,777		6,516	11
12	Electrical-Replace Gasket	2008	6,125	613	10	613		2,145	12
13	2nd floor remodel-carpentry, painting, plumbing,electrical	2008	558,949		27	20,325	20,325	64,363	13
14	Panel Brick Replacement	2009	184,595	9,230	20	9,230		18,460	14
15	Land Improvements	2009	12,400	620	20	620		1,550	15
16	Parking Lot	2009	4,600	230	20	230		575	16
17	Front Entrace Improvements	2009	28,660	717	40	717		1,673	17
18	HVAC Quick Connectors	2009	5,591	140	40	140		338	18
19	HVAC Spot Cooler	2009	4,254	106	40	106		256	19
20	1st floor Admin-Tile,electical	2009	11,679	292	40	292		584	20
21	Kitchen Plumbing	2009	8,210	821	10	821		2,053	21
22	Fire Alarm Electrical	2009	31,710	793	40	793		1,850	22
23	Glass & Mirror Med Room	2009	2,836	284	10	284		781	23
24	2nd Floor Remodel -Carpentry	2009	14,592	730	20	730		2,078	24
25	Patio Pergola	2009	9,505	475	20	475		1,069	25
26	Patio Fence	2009	5,100	255	20	255		531	26
27	Landscaping	2009	17,332	1,155	15	1,155		2,888	27
28	3rd Floor Remodel-Carpentry,flooring,electrical,painting	2009	627,866		27	22,832	22,832	51,372	28
29	Landscaping Enhancement	2010	14,885	992	15	992		1,654	29
30	Physician Office carpentry	2010	4,849	177	27	177		192	30
31	Kitchen Pantries construction	2010	5,676	207	27	207		207	31
32	HVAC Admin Office	2010	7,357	268	27	268		302	32
33	Loading Ramp/Foundation Wall	2010	3,000	200	15	200		383	33
34	TOTAL (lines 1 thru 33)		$ 9,504,497	$ 65,620		$ 300,249	$ 234,629	$ 4,586,727	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 Schaumburg, Inc. # 0036095 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		$ 9,504,497	$ 65,620		$ 300,249	$ 234,629	$ 4,586,727	1
2	Hallway doors	2010	14,916	1,492	10	1,492		1,616	2
3	Library/Lounge carpentry,electrical,painting,signs	2010	5,009	183	27	183		183	3
4	Basement carpentry	2010	3,945	144	27	144		264	4
5	Patio/Pergola	2010	12,005	1,201	10	1,201		1,401	5
6	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	50,935	3,993	27	3,993		3,993	6
7									7
8	Fire Dampers	2011	65,681		27	199	199	199	8
9	Parking Lot Remodel	2011	169,749		27				9
10	Kitchen Hood/duct work	2011	22,604	205	27	205		205	10
11	Payroll Office Remodel	2011	2,696	57	27	57		57	11
12	Metal edging & drain tile	2011	5,442	30	27	30		30	12
13	Repair doors on 1st floor	2011	39,986		27				13
14	Office Remodel - carpentry,flooring,electrical,painting,signs	2011	22,584	68	27	68		68	14
15	Exhaust Study HVAC	2011	5,736	156	27	156		156	15
16	Pipe and fitting	2011	4,375	40	27	40		40	16
17	Laundry Room Remodel	2011	9,388	142	27	142		142	17
18	New Marker Boards	2011	9,887	330	27	330		330	18
19	Interior Doors	2011	6,183	56	27	56		56	19
20	2nd Floor Doors	2011	27,318	331	27	331		331	20
21									21
22									22
23	Building - management company	2002	304,917		40	8,847	8,847	89,944	23
24	HVAC, electrical, security system - management company	2003	2,678		30	507	507	1,559	24
25	Key card system - management company	2004	421		20	21	21	156	25
26	VAV TX controls - management company	2005	128		20	6	6	44	26
27	Interior Signs - management company	2006	93		5	6	6	32	27
28	Building improvements - management company	2008	14,775		5	756	756	3,054	28
29	Building improvements - management company	2009	2,758		15	50	50	366	29
30	Building improvements - management company	2010	2,688		15	108	108	278	30
31	Building improvements - management company	2011	1,898		15	41	41	42	31
32	Reconcile to book depreciation			471			(471)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,313,292	$ 74,519		$ 319,218	$ 244,699	$ 4,691,273	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 Schaumburg, Inc. # 0036095 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	$ 1,365,773	$ 138,144	$ 221,355	$ 83,211		$ 772,255	71
72	Current Year Purchases	151,264	10,539	10,539			10,543	72
73	Fully Depreciated Assets	58,162					58,162	73
74	Allocated from Mgmt Co.	355,211		34,707	34,707		276,938	74
75	TOTALS	$ 1,930,410	$ 148,683	$ 266,601	$ 117,918		$ 1,117,898	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.			49,970		4,974	4,974		38,716	79
80	TOTALS			$ 49,970	$	$ 4,974	$ 4,974		$ 38,716	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)	$ 12,527,239	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 223,202	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 590,793	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 367,591	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,847,887	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	NA	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	NA	$	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 Schaumburg, Inc. # 0036095 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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Company				4,338			6
7	TOTAL				$ 4,338 **			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: $ 106,560 Description: Copier-$12,255; Medical Equip $48,580; Oxygen-$44,473; Mgmt. Co.-$1252
(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			2,248	20
21	TOTAL		$	$ 2,248	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 Schaumburg, Inc. # 0036095 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 Schaumburg, Inc. # 0036095 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	$	11,839	$ 480,632	$	11,839	$ 480,632	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,746	193,652		4,746	193,652	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		13,240	710,609		13,240	710,609	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				700,264		700,264	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)					16,160		16,160	12
13	Other (specify):									13
14	TOTAL			$	29,825	$ 1,384,893	$ 716,424	29,825	$ 2,101,317	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 Schaumburg, Inc. # 0036095 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	$ 232,037	$ 241,009	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,002,719)	4,048,712	4,048,712	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	124,244	124,244	6
7	Other Prepaid Expenses	3,980	3,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Unpaid premiums	7,766	7,766	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,416,739	$ 4,425,711	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	80,308	80,308	12
13	Land		233,567	13
14	Buildings, at Historical Cost		6,091,126	14
15	Leasehold Improvements, at Historical Cost	1,787,225	4,222,166	15
16	Equipment, at Historical Cost	1,063,554	1,980,380	16
17	Accumulated Depreciation (book methods)	(1,164,407)	(5,847,887)	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		58,117	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,766,680	$ 6,817,777	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,183,419	$ 11,243,488	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 670,587	$ 670,587	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,370,000	1,370,000	29
30	Accrued Salaries Payable	536,103	536,103	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,921	9,921	31
32	Accrued Real Estate Taxes(Sch.IX-B)		394,800	32
33	Accrued Interest Payable		31,703	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,969,694	2,623,640	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,556,305	$ 5,636,754	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,392,507	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)**	$	$ 7,392,507	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,556,305	$ 13,029,261	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,627,114	$ (1,785,773)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,183,419	$ 11,243,488	48

*(See instructions.)

Lexington Health Care Center of Schaumburg, Inc.
Provider # 0036095
1/1/11-12/31/11

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other current liabilities

Description	Operating	After Consolidation
LHCC Current portion of Long Term Debt	-	14,785
LHCC PA AUDIT SETTLEMENT	274,695	274,695
LHCC Rent Receivable	-	(872,555)
LHCC DUE FRM IRS	(21,513)	(21,513)
LHCC DUE FROM REMODELING	68,678	68,678
LHCC DUE TO/FROM REPUBLIC CONS	25,583	25,583
LHCC Due from LLC	-	1,908
LHCC Due from/(to) LHCC Schaumburg	-	(68,678)
LHCC DUE FROM -/Lexington Fin Serv L	536	536
LHCC 401K WITHHOLDING	26	26
LHCC ACCRUED EXPENSES	53,638	53,638
LHCC ACCRUED RESIDENT TAX	162,980	162,980
LHCC ACCRUED ROYL / VESTA MGMT	41,529	41,529
LHCC ACCRUED RENT	872,555	872,555
LHCC Accrued Insurance	184,937	184,937
LHCC DUE TO PATIENT TRUST FUND	2,308	2,308
LHCC ADVANCE - BIWEEKLY PART A F	4,808	4,808
LHCC UNCOLLECTIBLE PART A CO PV	(49,961)	(49,961)
LHCC DEFERRED INCOME	306,575	306,575
LHCC DUE TO - ROYAL OPERATIONS	39,550	39,550
LHCC DUE TO REPUBLIC	1,627	1,627
LHCC Due to Orland Park	1,143	1,143
LHCC Interest Rate Swap Liability	-	1,578,486
	1,969,694	2,623,640
	-	-

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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**	$ 1,835,396	1
2	Restatements (describe):		2
3	**Post closing adjustment**	(157,014)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,678,382	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(53,033)	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	1,765	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)**	$ (51,268)	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)**	$ 1,627,114	24 *

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

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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	$ 19,501,396	1
2	Discounts and Allowances for all Levels	(7,784,430)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,716,966	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,608,047	6
7	Oxygen	9,684	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,617,731	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	5,176	12
13	Barber and Beauty Care	22,787	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	689,724	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	239,986	19
20	Radiology and X-Ray		20
21	Other Medical Services	358,964	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,316,637	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	706	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 706	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Recovery bad debt write off	754	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 754	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,652,794	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,890,821	31
32	Health Care	7,536,948	32
33	General Administration	3,814,757	33
	B. Capital Expense		
34	Ownership	2,171,123	34
	C. Ancillary Expense		
35	Special Cost Centers	1,012,033	35
36	Provider Participation Fee	280,145	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,705,827	40
41	**Income before Income Taxes (line 30 minus line 40)****	(53,033)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (53,033)	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 entity 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 Schaumburg, Inc. # 0036095 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	1,289	1,598	$ 108,334	$ 67.79	1
2	Assistant Director of Nursing	27,219	34,478	1,128,464	32.73	2
3	Registered Nurses	31,162	40,822	1,310,815	32.11	3
4	Licensed Practical Nurses	24,261	31,770	812,941	25.59	4
5	CNAs & Orderlies	109,691	135,481	1,545,629	11.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,161	10,306	151,583	14.71	8
9	Activity Director					9
10	Activity Assistants	17,934	20,368	257,581	12.65	10
11	Social Service Workers	7,529	9,030	152,447	16.88	11
12	Dietician					12
13	Food Service Supervisor	1,734	2,006	36,041	17.97	13
14	Head Cook	1,753	2,107	33,366	15.84	14
15	Cook Helpers/Assistants	15,347	18,204	181,024	9.94	15
16	Dishwashers	13,542	15,599	135,569	8.69	16
17	Maintenance Workers	1,799	2,183	39,412	18.05	17
18	Housekeepers	36,218	41,767	379,902	9.10	18
19	Laundry	6,683	8,234	77,188	9.37	19
20	Administrator	1,207	1,914	134,276	70.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,762	15,837	229,075	14.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,647	2,060	32,285	15.67	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	2,956	3,478	124,234	35.72	33
34	TOTAL (lines 1 - 33)	319,894	397,242	$ 6,870,166 *	$ 17.29	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	$ 28,028	1(3)	35
36	Medical Director	Monthly	71,938	9(3)	36
37	Medical Records Consultant	Monthly	1,437	10(3)	37
38	Nurse Consultant	Monthly	11,851	10(3)	38
39	Pharmacist Consultant	Monthly	12,957	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	14,057	11(3)	44
45	Social Service Consultant	Monthly	4,853	12(3)	45
46	Other(specify) Pulmonary Exhange	Monthly	47,253	10(3)	46
47	Psychosocial	Monthly	1,728	12(3)	47
48	Medical Consultant	Monthly	3,984	10(7)	48
49	TOTAL (lines 35 - 48)		$ 198,086		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa Bowen	Administrator		$ 134,276
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,276

B. Administrative - Other

Description	Amount
Management Fees-royal Operatns	$ 1,041,096
Royal Capital Mgmt Fees	64,956
Management Fees- Vesta Mgmt	499,075
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,605,127
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center	Collections	$ 4,395
Chicago Legal Clinic	Legal	2,398
Cassiday Schade, LLP	Legal	50,069
Lexington Financial Services, Llc	Financial	10,824
McGladrey & Pullen, LLP	Accounting	31,139
Personal Planners	U/C Consulting	1,630
Much Shelist	Legal	7,115
Secretary of State	Filing Fees	100
Serpico, Petrosino & Dipiero LTD	Legal	275
Pension Administration	Pension Administrators	899
RealMed	WC Consulting	150
See Sch 21C		148,408
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 257,402

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 229,185
Unemployment Compensation Insurance	66,347
FICA Taxes	20,761
Employee Health Insurance	6,604
Employee Meals	18,385
Illinois Municipal Retirement Fund (IMRF)*	0
401K Contributions	145,437
Other Employee Benefits	555,079
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,041,798

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	$
Advertising: Employee Recruitment	18,140
Health Care Worker Background Check	
(Indicate # of checks performed 144)	1,729
Patient Background Checks 766	9,191
Misc. Dues & Subscriptions	1,591
Misc. License & Fees	2,658
AANC	
Management Company Allocation	7,766
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,075

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Management Company Allocation	2,938
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,938

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Schaumburg
1/1/11-12/31/11
XIX. Support Schedules

Schedule 21C

C. Professional Fees

Vendor/Payee	Type	Amount
Duane Morris	Legal	5,923
CT Corporation	Legal	195
Ability Network	Computer Consulting	765
Action Computer Service	Computer Consulting	391
Adi	Computer Consulting	174
Americorp Financial LLC	Computer Consulting	49,083
Avtech	Computer Consulting	308
BSKLIVE INC (STAFFKNEX)	Computer Consulting	2,110
CDW Government	Computer Consulting	90
Efax Corporate	Computer Consulting	2,105
E-Health Data Solutions	Computer Consulting	2,400
Elton Designs INC	Computer Consulting	2,019
Facility Wizard Software	Computer Consulting	358
Information Controls	Computer Consulting	1,336
Kronos	Computer Consulting	1,400
Lintech L LC	Computer Consulting	5,289
Lodgenet Interactive Corporation	Computer Consulting	1,871
Microsoft Licensing	Computer Consulting	7,315
MJN Technologies	Computer Consulting	1,824
My Innerview	Computer Consulting	1,848
National Datacare	Computer Consulting	1,899
Paragon Clinical	Computer Consulting	1,100
Question Pro	Computer Consulting	67
On Shift	Computer Consulting	2,331
Right Now Technologies	Computer Consulting	8,927
Royal Mgmt Maint Labor	Computer Consulting	582
Silverchair Learning Systems (SLS)	Computer Consulting	8,007
Softchoice	Computer Consulting	1,735
Survey Analytics	Computer Consulting	300
Telemedicine Solutions LLC	Computer Consulting	7,200
Tympani	Computer Consulting	7,420
Vision Share	Computer Consulting	85
Vocollect	Computer Consulting	20,905
XO Communications	Computer Consulting	1,047
		148,408
Total Schedule V, line 19, column 3		257,402
Less Collection fees		(4,395)
Less out of period legal		(10,260)
Sambell of Schaumburg		
Secretary of State		200
Allocated from Management Co.		
Katten, Muchin, Rosenman	Legal	453
Much Shelist	Legal	409
Laner Muchin	Legal	17
Seyfarth Shaw LLP	Legal	310
McGladrey & Pullen LLP	Accounting	1,542
Illinois Secretary of State	Filing Fees	42
LaSalle Network	Recruiting/Finance	1,895
Gilson Labus & Silverman	KEP	210
Pension Administrators, Inc.	401K Administration	292
Susan Parker	Social Service Consulting	32
M Werner Consulting	Financial Consultant	4
Christine Toolan	Social Service Consulting	7
Gene Whitehorn	Medicaid Reimb Specialis	1,127
Computer Services	Computer Consulting	18,163
Allocated from Samvest of Lombard II		
Legal		243
Accounting		263
Total Schedule V, line 19, column 8		267,956

Facility Name & ID Number Lexington Health Care Center of Schaumburg, Inc. # 0036095 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 Schaumburg, Inc. # 0036095 **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. $ **72,349** 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. $ **280,145**
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. $ **18,385** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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 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.