		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.

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

I. IDPH License ID Number: 0035188

Facility Name: Lexington Health Care Center-Bloomingdale

Address: 165 South Bloomingdale Road (Number) Bloomingdale (City) 60108 (Zip Code)

County: Dupage

Telephone Number: (630) 980-8700 **Fax #** (630) 980-6170

HFS ID Number:

Date of Initial License for Current Owners: 5/1/89

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: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

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

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed 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	166	Skilled (SNF)	166	60,756	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	166	TOTALS	166	60,756	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			12,833	12,833	8
9	SNF/PED					9
10	ICF	34,075	7,434		41,509	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,075	7,434	12,833	54,342	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.44%

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 05/01/89

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 166 and days of care provided 11,753

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	355,400	33,217	13,383	402,000		402,000		402,000			1
2	Food Purchase		299,817		299,817		299,817	(14,190)	285,627			2
3	Housekeeping	302,395	33,661		336,056		336,056	310	336,366			3
4	Laundry	67,702	18,896		86,598		86,598		86,598			4
5	Heat and Other Utilities			192,165	192,165		192,165	6,124	198,289			5
6	Maintenance	42,138		134,329	176,467		176,467	68,966	245,433			6
7	Other (specify):* Mgmt. Co. Alloc. Ben							9,290	9,290			7
8	TOTAL General Services	767,635	385,591	339,877	1,493,103		1,493,103	70,500	1,563,603			8
	B. Health Care and Programs											
9	Medical Director			94,500	94,500		94,500		94,500			9
10	Nursing and Medical Records	3,711,916	274,170	123,663	4,109,749		4,109,749	33,259	4,143,008			10
10a	Therapy											10a
11	Activities	229,443	25,005	15,881	270,329		270,329		270,329			11
12	Social Services	100,583		5,007	105,590		105,590		105,590			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt. Co. Alloc. Ben							4,767	4,767			15
16	TOTAL Health Care and Programs	4,041,942	299,175	239,051	4,580,168		4,580,168	38,026	4,618,194			16
	C. General Administration											
17	Administrative	141,301		1,291,795	1,433,096		1,433,096	(1,260,687)	172,409			17
18	Directors Fees											18
19	Professional Services			195,178	195,178		195,178	16,259	211,437			19
20	Dues, Fees, Subscriptions & Promotions			28,345	28,345		28,345	12,645	40,990			20
21	Clerical & General Office Expenses	184,925	32,517	51,989	269,431		269,431	511,087	780,518			21
22	Employee Benefits & Payroll Taxes			774,257	774,257		774,257	13,890	788,147			22
23	Inservice Training & Education			14,497	14,497		14,497	820	15,317			23
24	Travel and Seminar			325	325		325	2,109	2,434			24
25	Other Admin. Staff Transportation			26	26		26	15,504	15,530			25
26	Insurance-Prop.Liab.Malpractice			330,590	330,590		330,590	3,362	333,952			26
27	Other (specify):* Mgmt. Co. Alloc. Ben							82,199	82,199			27
28	TOTAL General Administration	326,226	32,517	2,687,002	3,045,745		3,045,745	(602,812)	2,442,933			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,135,803	717,283	3,265,930	9,119,016		9,119,016	(494,286)	8,624,730			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-Bloomingdale #0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			209,530	209,530		209,530	366,779	576,309			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,682	38,682		38,682	284,746	323,428			32
33	Real Estate Taxes							175,835	175,835			33
34	Rent-Facility & Grounds			1,250,653	1,250,653		1,250,653	(1,247,294)	3,359			34
35	Rent-Equipment & Vehicles			57,513	57,513		57,513	2,899	60,412			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,556,378	1,556,378		1,556,378	(417,035)	1,139,343			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		401,184	1,533,766	1,934,950		1,934,950		1,934,950			39
40	Barber and Beauty Shops			19,858	19,858		19,858		19,858			40
41	Coffee and Gift Shops			2,595	2,595		2,595		2,595			41
42	Provider Participation Fee			349,716	349,716		349,716		349,716			42
43	Other (specify):* **Non-Allowable Cos**	95,610		153,467	249,077		249,077	(249,077)				43
44	**TOTAL Special Cost Centers**	95,610	401,184	2,059,402	2,556,196		2,556,196	(249,077)	2,307,119			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,231,413	1,118,467	6,881,710	13,231,590		13,231,590	(1,160,398)	12,071,192			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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(300)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,966)	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	(1,432)	30		9
10	Interest and Other Investment Income	(18,402)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,770)	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	(9,404)	43		18
19	Entertainment				19
20	Contributions	(555)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,571)	43		24
25	Fund Raising, Advertising and Promotional	(55,582)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,848)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(109,697)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (250,527)		$	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)	(909,871)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (909,871)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,160,398)		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-Bloomingdale

ID# 0035188

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Radiology	$ (21,293)	43	1
2	Laboratory	(9,796)	43	2
3	Out of period legal	(3,109)	19	3
4	Trust Fees	(50)	43	4
5	Collection Fees	(917)	19	5
6	Nonallowable Marketing Salaries	(95,610)	43	6
7	Dues & Subscriptions marketing	(617)	20	7
8	Reclass LHI to Repairs and Maintenance	3,668	6	8
9	Education and training marketing	(325)	24	9
10	Unrealized loss on FMV swap	22,391	43	10
11	Development expense	(4,039)	43	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**	(109,697)		49

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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 Bloomingdale Limited Partnership	**	$ 200	$ 200	1
2	V	30	Depreciation Expense		Sambell of Bloomingdale Limited Partnership	**	323,170	323,170	2
3	V	32	Interest	81,606	Sambell of Bloomingdale Limited Partnership	**	367,562	285,956	3
4	V	32	Amortization of Mortgage Cost		Sambell of Bloomingdale Limited Partnership	**	2,171	2,171	4
5	V	33	Property Tax		Sambell of Bloomingdale Limited Partnership	**	170,653	170,653	5
6	V	34	Rent	1,250,653	Sambell of Bloomingdale Limited Partnership	**		(1,250,653)	6
7	V	43	Trust Fees		Sambell of Bloomingdale Limited Partnership	**	50	50	7
8	V	43	State Replacement Tax		Sambell of Bloomingdale Limited Partnership	**	2,357	2,357	8
9	V	43	Unrealized loss on FMV of Swap	22,391	Sambell of Bloomingdale Limited Partnership	**		(22,391)	9
10	V	21	Office Supplies		Sambell of Bloomingdale Limited Partnership	**	45	45	10
11	V				** Certain owners of Lexington Health Care Center of Bloomingdale, Inc.				11
12	V				own 100% of Sambell of Bloomingdale Limited Partnership				12
13	V								13
14	Total			$ 1,354,650			$ 866,208	$ * (488,442)	14

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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.	**	$ 310	$ 310	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	5,188	5,188	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	230	230	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	706	706	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	58,466	58,466	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	6,527	6,527	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	305	305	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	9,290	9,290	22
23	V	10	Medical consultant		Royal Management Corp.	**	3,259	3,259	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	30,000	30,000	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	4,767	4,767	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	31,108	31,108	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	14,657	14,657	27
28	V	19	Professional fees		Royal Management Corp.	**	5,428	5,428	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	995	995	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	12,267	12,267	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	486,199	486,199	31
32	V	21	Bank charges		Royal Management Corp.	**	2,691	2,691	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	8,564	8,564	33
34	V	21	Postage		Royal Management Corp.	**	3,469	3,469	34
35	V								35
36	V								36
37	V		**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Sambell Bloomingdale Partnership						37
38	V								38
39	Total			$			$ 684,426	$ * 684,426	39

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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.	**	$ 10,119	$ 10,119	15
16	V	24	Travel & seminar		Royal Management Corp.	**	2,434	2,434	16
17	V	25	Auto expense		Royal Management Corp.	**	15,504	15,504	17
18	V	26	Insurance general		Royal Management Corp.	**	3,362	3,362	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	82,199	82,199	19
20	V	30	Depreciation		Royal Management Corp.	**	45,041	45,041	20
21	V	32	Interest		Royal Management Corp.	**	13,739	13,739	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,282	1,282	22
23	V	33	Property taxes		Royal Management Corp.	**	5,182	5,182	23
24	V	34	Rent expense		Royal Management Corp.	**	3,359	3,359	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,370	1,370	25
26	V	17	Management fees	1,291,795	Royal Management Corp.	**		(1,291,795)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,529	1,529	27
28	V	23	Inservice Training		Royal Management Corp.	**	820	820	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V		**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Sambell Bloomingdale Partnership						36
37	V								37
38	V								38
39	Total			$ 1,291,795			$ 185,940	$ * (1,105,855)	39

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	22.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Vesta Mgmt	Lombard	Mgmt. Company	3
4	Jeffrey J. Bell Revocable Trust	8.25%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Group, LLC			4
5	Lawrence W. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Sambell of	Bloomingdale	Real Estate	5
6	David S. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Bloomingdale Ltd. Ptsp.		Property	6
7	David S. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Royal Management	Lombard	Mgmt. Company	7
8	Jeffrey J. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Corporation			8
9	Lawrence W. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Lexington Financial	Lombard	Finance Company	9
10					Services, LLC			10
11					Lexington Square	Lombard	Independent and	11
12					Life Care of		Assisted Living	12
13					Lombard, LLC		Facility	13
14					Lexington Square	Elmhurst	Independent	14
15					Life Care of		Living Facility	15
16					Elmhurst, LLC			16
17					Samvest of	Lombard	Lessor	17
18					Lombard 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-Bloomingdal # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 8,664	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,346	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,681	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,760	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,657	L17, C7	5
6		Member									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 31,108		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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	725,412	10	$ 3,707	$	60,756	$ 310	1
2	5	Utilities - gas & electric	Bed Days	725,412	10	61,939		60,756	5,188	2
3	5	Utilities - water & sewer	Bed Days	725,412	10	2,741		60,756	230	3
4	5	Utilities - maintenance office	Bed Days	725,412	10	8,424		60,756	706	4
5	6	Management allocation - salaries	Bed Days	725,412	10	698,068	698,068	60,756	58,466	5
6	6	Repairs & maintenance	Bed Days	725,412	10	77,933		60,756	6,527	6
7	6	Scavenger & exterminating	Bed Days	725,412	10	3,642		60,756	305	7
8	7	Management allocation - employe	Bed Days	725,412	10	110,922		60,756	9,290	8
9	10	Medical consultant	Bed Days	725,412	10	38,914		60,756	3,259	9
10	10	Management allocation - salaries	Bed Days	725,412	10	358,188	358,188	60,756	30,000	10
11	15	Management allocation - employe	Bed Days	725,412	10	56,916		60,756	4,767	11
12	17	Management allocation - salaries	Bed Days	725,412	10	371,421	371,421	60,756	31,108	12
13	19	Computer consultant & supplies	Bed Days	725,412	10	174,999		60,756	14,657	13
14	19	Professional fees	Bed Days	725,412	10	64,806		60,756	5,428	14
15	20	Dues & subscriptions	Bed Days	725,412	10	11,884		60,756	995	15
16	20	Advertising - help wanted	Bed Days	725,412	10	146,469		60,756	12,267	16
17	21	Management allocation - salaries	Bed Days	725,412	10	5,805,098	5,805,098	60,756	486,199	17
18	21	Bank charges	Bed Days	725,412	10	32,134		60,756	2,691	18
19	21	Office supplies & printing	Bed Days	725,412	10	102,249		60,756	8,564	19
20	21	Postage	Bed Days	725,412	10	41,415		60,756	3,469	20
21	21	Telephone	Bed Days	725,412	10	120,819		60,756	10,119	21
22	24	Travel and Seminar	Bed Days	725,412	10	29,058		60,756	2,434	22
23										23
24										24
25	TOTALS					$ 8,321,746	$ 7,232,775		$ 696,979	25

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	725,412	10	$ 185,111	$	60,756	$ 15,504	1
2	26	Insurance general	Bed Days	725,412	10	40,142		60,756	3,362	2
3	27	Management allocation - employe	Bed Days	725,412	10	981,440		60,756	82,199	3
4	30	Depreciation	Bed Days	725,412	10	537,783		60,756	45,041	4
5	32	Interest	Bed Days	725,412	10	164,037		60,756	13,739	5
6	32	Amortization of mortgage costs	Bed Days	725,412	10	15,301		60,756	1,282	6
7	33	Property taxes	Bed Days	725,412	10	61,875		60,756	5,182	7
8	34	Rent expense	Bed Days	725,412	10	40,101		60,756	3,359	8
9	35	Equipment rental	Bed Days	725,412	10	16,356		60,756	1,370	9
10	35	Auto Lease	Bed Days	725,412	10	18,252		60,756	1,529	10
11	23	Inservice Training	Bed Days	725,412	10	9,785		60,756	820	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,070,183	$		$ 173,387	25

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,375,000	5,754,866	1/1/2033	Variable	349,941	2
3												3
4												4
5							Interest on financing insurance premium				1,175	5
	Working Capital											
6	Bank of America		X	Working Capital	Varies	9/30/12	13,700,000	1,730,000	9/30/13	Prime/Libor	37,507	6
7	Shareholder	X		Capital Improvements	Varies	6/26/10	783,500	272,322	12/1/13	Prime +1%	17,621	7
8												8
9	TOTAL Facility Related						$ 20,858,500	$ 7,757,188			$ 406,244	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			2,171	10
11								Interest Income offset			(82,387)	11
12								Management company allocation			15,021	12
13								Non-allowable shareholder interest			(17,621)	13
14	TOTAL Non-Facility Related						$	$			$ (82,816)	14
15	TOTALS (line 9+line14)						$ 20,858,500	$ 7,757,188			$ 323,428	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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 150,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011	$ 157,453	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,453	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 163,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	**Allocated Mgmt. Co.**	$ 5,182	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.		$ 175,835	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	126,167	8
	2008	128,400	9
	2009	129,666	10
	2010	133,694	11
	2011	157,453	12

See attached real estate accrual sheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Bloomingdale COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-401-003	Land & Building	$ 157,452.86	$ 157,452.86
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-021	Land & Building	$ 230,165.98	$ 5,182.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 387,618.84	$ 162,634.86

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

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: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	43,000	1987	$ 402,548	1
2	Management Company Allocation			16,911	2
3	TOTALS	43,000		$ 419,459	3

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	82		1989	1989	$ 2,980,863	$	35	$ 85,192	$ 85,192	$ 2,016,211	4
5	9		1992	1992	178,974		35	5,114	5,114	107,387	5
6	75		1994	1994	2,022,894		35	57,797	57,797	1,069,243	6
7											7
8											8
	Improvement Type**										
9	Capitalized repairs			1989	9,080		10			9,080	9
10	Building Improvements			1990	3,674		10			3,674	10
11	Building Improvements			1991	2,586		10			2,586	11
12	Building Improvements			1992	3,154		10			2,997	12
13	Building Improvements			1993	1,582		10			1,503	13
14	Building Improvements			1994	15,734		10			15,734	14
15	Land Improvements			1994	1,381		10			1,381	15
16	Land Improvements			1995	1,074		15			1,068	16
17	Building Improvements			1995	1,288		35	37	37	662	17
18	Building Improvements			1995	9,433	270	35	270		4,725	18
19	Building Improvements			1995	43,839	1,252	35	1,252		21,911	19
20	Concrete flooring, fire doors, tile, sprinkler heads,										20
21	and basement renovation			1996	8,706		15			3,606	21
22	Land improvements			1996	7,858		15			7,858	22
23											23
24	Resident room heaters			1997	3,563	102	35	102		1,630	24
25	Automatic doors			1997	12,950	370	35	370		5,581	25
26	Basement renovation			1997	59,358		10			59,358	26
27	Land Improvement - outdoor flagpoles			1997	1,574	53	15	53		1,574	27
28	1st Floor Remodel (Nurses Station/Lounge)			1998	76,487		10			76,487	28
29	Wiring for MDS			1998	4,506		10			4,506	29
30	Flag Pole			1998	787		10			787	30
31	Resurface/Stripe Parking Lot			1998	9,777		10			9,777	31
32	Kitchen tile/paint			1999	718		10			718	32
33	1st Floor Remodel			1999	3,296		10			3,296	33
34	Roof repairs			2000	5,748	383	15	383		4,789	34
35	Sump pump			2000	2,534		10			2,534	35
36	Sump pump basin repair			2000	6,307		10			6,307	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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic door closers	2000	$ 1,300	$ 87	15	$ 87	$	$ 1,085	37
38	Infrared curtains for elevator doors	2001	3,000		10			3,000	38
39	Ejector pump	2002	3,050		5			3,050	39
40	Lift station pump	2002	3,359		5			3,359	40
41	New asphalt parking lot	2003	16,450	1,645	10	1,645		15,079	41
42	Roof repairs	2003	2,900	290	10	290		2,634	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		1,885	43
44	Kitchen remodel	2003	7,188	359	20	359		3,383	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		29,758	45
46	Floor tile	2003	16,305	815	20	815		8,152	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		34,415	47
48	Rehab-floor tile	2003	8,117	406	20	406		3,687	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		19,393	49
50	Foundation repair	2003	4,800	240	20	240		2,260	50
51	Parking lot	2004	24,550	2,455	10	2,455		20,663	51
52	Kitchen walk-in cooler floor	2004	7,161	716	10	716		5,967	52
53	Old Towne rehab	2004	13,967	698	20	698		5,760	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		84,446	54
55	Create first floor therapy room	2004	185	9	20	9		54	55
56	Transitional unit	2005	213	11	20	11		65	56
57	Landscaping	2005	8,814	441	20	441		3,160	57
58	Roof repairs	2005	3,250	163	20	163		1,167	58
59	HVAC upgrade	2005	7,048	352	20	352		2,583	59
60	Kitchen repair	2005	1,631	82	20	82		613	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		6,965	61
62	Window treatments	2005	3,606		5			3,606	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		2,865	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		14,750	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		12,894	65
66	Basement renovation	2005	14,176	709	20	709		4,962	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,126,921	$ 36,714		$ 184,854	$ 148,140	$ 3,748,630	70

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,126,921	$ 36,714		$ 184,854	$ 148,140	$ 3,748,630	1
2	Landscaping Enhancement	2006	7,084	472	15	472		2,990	2
3	Install Kitchen Sink	2006	2,915	146	20	146		985	3
4	Common area rehab	2006	2,382	119	20	119		794	4
5	Paint Building Exterior	2006	19,500		5			19,500	5
6	Patio	2006	53,305	3,554	15	3,554		21,619	6
7	Retaining Wall	2007	2,950	197	15	197		1,116	7
8	Roof Repair	2007	17,050	853	20	853		4,904	8
9	Air Conditioning units	2007	4,338	217	20	217		1,284	9
10	Paver walk and stairway	2007	10,500	525	20	525		2,975	10
11	Fire exit stairways	2007	9,379	469	20	469		2,423	11
12	Landscaping	2008	35,147	2,343	15	2,343		9,567	12
13	Parking Lot - Seal & Striping	2008	6,460	323	20	323		1,454	13
14	Roof	2008	15,300	765	20	765		3,570	14
15	HVAC - Spot Coolers	2008	5,589	140	40	140		560	15
16	Electrical - Storage Room	2008	4,768	238	20	238		1,051	16
17	Electrical - Fire Alarm Panel	2008	118,395	5,920	20	5,920		24,173	17
18	1st floor remodel-Carpentry,Flooring,Electrical,Parking fixtures	2008	557,202		27	20,262	20,262	94,556	18
19	Lawn Irrigation	2009	14,435	962	15	962		3,207	19
20	Landscaping	2009	12,950	863	15	863		2,733	20
21	Roof	2009	49,330	2,467	20	2,467		7,812	21
22	Front Entrance	2009	19,392	485	40	485		1,536	22
23	HVAC-Window unit	2009	41,315	4,131	10	4,131		15,492	23
24	HVAC Quick connectors	2009	7,058	706	10	706		2,647	24
25	Lift pump	2009	14,783	1,478	10	1,478		4,680	25
26	Fire alarm panel	2009	93,279	4,664	20	4,664		14,381	26
27	Pantry Cabinets	2009	3,523	352	10	352		1,115	27
28	Therapy Room counter tops-carpentry	2009	2,500	250	10	250		938	28
29	Patio Pergola	2009	7,930	397	20	397		1,323	29
30	Patio Stamped Concrete	2009	13,901	927	15	927		3,167	30
31	Lobby 1st floor remodel-Carpentry,doors frames,electrical	2009	52,018		27	1,892	1,892	5,676	31
32	painting,wallpaper								32
33	OT Remodel-carpentry,electrical	2010	791,224		27	62,223	62,223	134,817	33
34	TOTAL (lines 1 thru 33)		$ 8,122,823	$ 70,677		$ 303,194	$ 232,517	$ 4,141,675	34

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,122,823	$ 70,677		$ 303,194	$ 232,517	$ 4,141,675	1
2									2
3	Lawn irrigation system	2010	5,503	367	15	367		917	3
4	Roof work	2010	15,268	557	27	557		1,392	4
5	HVAC Chiller	2010	84,004	3,064	27	3,064		6,639	5
6	Pantry-shelves	2010	23,805	868	27	868		2,098	6
7	Wanderguard	2010	3,747	137	27	137		308	7
8	Concrete work	2010	7,080	258	27	258		559	8
9	Automatic Doors	2010	4,903	490	10	490		1,225	9
10	Physician office carpentry and electrical update	2010	4,677	171	27	171		356	10
11	Library/Lounge-art, painting	2010	13,763	502	27	502		1,130	11
12	Pergola and patio wall	2010	21,186	3,982	27	3,982		10,282	12
13	Office carpentry and electrical changes	2010	5,744	209	27	209		453	13
14	Payroll office-painting, carpentry	2011	18,505	673	27	673		785	14
15	Mulch stone and perennials	2011	4,364	291	15	291		339	15
16	Addmissions office-painting, carpentry	2011	2,868	104	27	104		121	16
17	Parking lot lights	2011	6,070	221	27	221		258	17
18	Roof work	2011	93,530	3,401	27	3,401		3,684	18
19	Front entrance-awning, doors	2011	11,869	432	27	432		791	19
20	Duct extension	2011	3,476	126	27	126		242	20
21	HVAC unit	2011	23,400	851	27	851		993	21
22	Fluid pump	2011	8,400	305	27	305		560	22
23	Plumbing valves	2011	9,257	337	27	337		365	23
24	Laundry room-painting, electrical, tile	2011	8,386	305	27	305		381	24
25	Elevator-electrical work	2011	60,523	2,201	27	2,201		2,568	25
26	VCT Floor OT-painting, electrical, carpentry	2011	49,344	1,794	27	1,794		1,944	26
27									27
28	Front entrance door	2012	5,387	65	27	65		65	28
29	Sprinklers building	2012	6,500	39	27	39		39	29
30	Washing machine slab	2012	3,500	74	27	74		74	30
31									31
32	Reconcile to book depreciation			1,434			(1,434)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,627,881	$ 93,935		$ 325,018	$ 231,083	$ 4,180,243	34

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,627,881	$ 93,935		$ 325,018	$ 231,083	$ 4,180,243	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Building - management company	2002	234,013		40	6,850	6,850	75,990	8
9	HVAC, electrical, security system - management company	2003	2,055		30	504	504	1,339	9
10	Key card system - management company	2004	323		20	16	16	136	10
11	VAV TX controls - management company	2005	98		20	5	5	39	11
12	Interior Signs - management company	2006	72		5	5	5	29	12
13	Building improvements - management company	2008	11,340		5	585	585	3,068	13
14	Building improvements - management company	2009	2,117		15	39	39	396	14
15	Building improvements - management company	2010	2,063		15	84	84	348	15
16	Building improvements - management company	2011	1,456		15	67	67	100	16
17	Building improvements - management company	2012	5,031		15	2	2	116	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)		$ 8,886,449	$ 93,935		$ 333,175	$ 239,240	$ 4,261,804	34

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 1,169,202	$ 102,148	$ 192,803	$ 90,655	5	$ 756,831	71
72	Current Year Purchases	111,146	13,447	13,447		5	13,447	72
73	Fully Depreciated Assets	112,657				5	112,657	73
74	Allocated from Mgmt. Co.	411,605		33,152	33,152		237,633	74
75	TOTALS	$ 1,804,610	$ 115,595	$ 239,402	$ 123,807		$ 1,120,568	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.			40,172		3,732	3,732		31,981	79
80	TOTALS			$ 40,172	$	$ 3,732	$ 3,732		$ 31,981	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,150,690	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 209,530	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 576,309	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 366,779	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,414,353	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		$	$	$	86
87		N/S			87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93		N/A	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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Mgmt. Co.				3,359			6
7	TOTAL				$ 3,359 **			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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 58,883 Description: Copier-$10,161, Mail Sys-$186,Printer-$1,277, Med Eq.-$19,127, Oxy Eq.-$26,762, Mgmt. Co.-$1370
    (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 Mgmt. Co.			1,529	20
21	TOTAL		$	$ 1,529	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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	11,361	$ 722,980	$	11,361	$ 722,980	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,495	135,788		3,495	135,788	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		12,150	674,998		12,150	674,998	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				401,184		401,184	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	27,006	$ 1,533,766	$ 401,184	27,006	$ 1,934,950	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.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 819,768	$ 824,125	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (224,189))	3,089,398	3,089,398	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,351,495	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,909,166	$ 5,265,018	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,261	64,261	12
13	Land		419,459	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	2,017,389	3,703,718	15
16	Equipment, at Historical Cost	866,212	1,844,782	16
17	Accumulated Depreciation (book methods)	(1,207,007)	(5,414,353)	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): Mort Cost/Accum Amort Mort C		44,257	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,740,855	$ 5,844,855	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,650,021	$ 11,109,873	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 563,099	$ 563,099	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		272,322	29
30	Accrued Salaries Payable	407,698	407,698	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,987	3,987	31
32	Accrued Real Estate Taxes(Sch.IX-B)		163,200	32
33	Accrued Interest Payable		24,540	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	802,095	1,811,974	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,776,879	$ 3,246,820	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,730,000	1,730,000	39
40	Mortgage Payable		5,754,866	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)**	$ 1,730,000	$ 7,484,866	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,506,879	$ 10,731,686	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,143,142	$ 378,187	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,650,021	$ 11,109,873	48

***(See instructions.)**

Lexington Health Care Center of Bloominingdale, Inc.
Provider # 0035188
1/1/12-12/31/12

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Due to Merit Hospice	10,000	10,000
Due to/from Rehab Care Therapy	25,075	25,075
Due from Republic Construction		
Due from LLC 1		1,484
Accrued Expenses	106,143	106,143
Accrued Resident Tax	89,400	89,400
Accrued Royl/Vesta Mgmt. Fees	(105)	(105)
Accrued Sales Tax		
Accrued Rent	229,917	
Due to Patient Trust Fund	(26,005)	(26,005)
Advance Bi-weekly part A payments	(23,042)	(23,042)
Uncollectible Part A Co PVTS	(18,368)	(18,368)
Deferred Income	172,079	172,079
Due to-Royal Operations	34,870	34,870
Professional Liabilities Claims	168,396	168,396
Sambel Interest Rate Swap Liability		1,238,312
Accrued Insurance	104,429	104,429
Prepaid Insurance	32,357	32,357
Escrow-Insurance	(103,051)	(103,051)
	802,095	1,811,974

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,933,391	1	
2	Restatements (describe):		2	
3	**Post closing adjustment**	97,888	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,031,279	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	606,863	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	(495,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 111,863	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)**	$ 2,143,142	24	*

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

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,725,210	1
2	Discounts and Allowances for all Levels	(6,657,739)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,067,471	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,068,752	6
7	Oxygen	7,105	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,075,857	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	2,657	12
13	Barber and Beauty Care	24,371	13
14	Non-Patient Meals	300	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	400,655	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	146,821	19
20	Radiology and X-Ray		20
21	Other Medical Services	119,557	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 694,361	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	781	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 781	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Recovery of write off	(17)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (17)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,838,453	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,493,103	31
32	Health Care	4,580,168	32
33	General Administration	3,045,745	33
	B. Capital Expense		
34	Ownership	1,556,378	34
	C. Ancillary Expense		
35	Special Cost Centers	2,206,480	35
36	Provider Participation Fee	349,716	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,231,590	40
41	**Income before Income Taxes (line 30 minus line 40)****	606,863	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 606,863	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,832,226	44
45	Private Pay - Net Inpatient Revenue	1,677,184	45
46	Medicare - Net Inpatient Revenue	2,163,783	46
47	Other-(specify) Managed Care	394,278	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,067,471	49

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

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

*** **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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,651	2,176	$ 111,813	$ 51.38	1
2	Assistant Director of Nursing	20,710	26,303	704,558	26.79	2
3	Registered Nurses	21,927	26,859	856,162	31.88	3
4	Licensed Practical Nurses	19,749	23,392	602,796	25.77	4
5	CNAs & Orderlies	96,422	115,153	1,400,024	12.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,624	11,873	154,637	13.02	10
11	Social Service Workers	4,638	5,465	100,583	18.40	11
12	Dietician	1,626	1,915	31,078	16.23	12
13	Food Service Supervisor	1,599	1,959	39,614	20.22	13
14	Head Cook	1,641	2,222	33,575	15.11	14
15	Cook Helpers/Assistants	10,144	12,387	123,013	9.93	15
16	Dishwashers	12,215	14,458	128,120	8.86	16
17	Maintenance Workers	2,259	2,471	42,138	17.05	17
18	Housekeepers	26,548	32,189	302,395	9.39	18
19	Laundry	6,441	7,697	67,702	8.80	19
20	Administrator	1,618	2,289	141,301	61.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,093	12,647	184,925	14.62	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	1,885	2,348	36,563	15.57	31
32	Other Health C: Memory Care	3,639	4,179	74,806	17.90	32
33	Other(specify) Marketing	3,478	3,865	95,610	24.74	33
34	TOTAL (lines 1 - 33)	256,907	311,847	$ 5,231,413 *	$ 16.78	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	10	$ 11,380	1(3)	35
36	Medical Director	Monthly	94,500	9(3)	36
37	Medical Records Consultant	Monthly	1,073	10(3)	37
38	Nurse Consultant	Monthly	89,910	10(3)	38
39	Pharmacist Consultant	Monthly	10,627	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	12	5,846	11(3)	44
45	Social Service Consultant	12	5,007	12(3)	45
46	Other(specify) Pulmonary	Monthly	22,053	10(3)	46
47					47
48	Medical Consultant	Monthly	3,259	10(7)	48
49	TOTAL (lines 35 - 48)	34	$ 243,655		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-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rupal Mistry	Administrator	0	$ 141,301
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 141,301

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 877,694
Management Fees-Vesta Mgmt.	414,101
Management Fees (Eliminated in Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,291,795
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PARAGON	Computer Services	$ 1,100
ABILITY NETWORK INC	Computer Services	1,745
AMERICORP FINANCIAL	Computer Services	58,412
EFAX CORPORATE	Computer Services	1,122
EHEALTH DATA SOLUTIONS	Computer Services	2,400
ELTON DESIGNS	Computer Services	260
FACILITY WIZARD	Computer Services	358
INFORMATION CONTROLS	Computer Services	1,508
KRONOS	Computer Services	1,392
LINTECH	Computer Services	4,391
MICROSOFT LEASE	Computer Services	5,321
See Schedule 21C		117,169
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 195,178

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,832
Unemployment Compensation Insurance	52,561
FICA Taxes	381,698
Employee Health Insurance	175,902
Employee Meals	13,890
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contributions	21,095
Other Employee Benefits	32,998
Uniform Allowance	796
Tuition	3,375
TOTAL (agree to Schedule V, line 22, col.8)	$ 788,147

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	10,319
Health Care Worker Background Check	
(Indicate # of checks performed 172)	2,065
Patient Background Checks 586	7,026
Miscellaneous Licenses & Fees	1,574
Miscellaneous Dues & Subscriptions	5,371
Less Dues Marketing	(617)
Management Company Allocation	13,262
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,990

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Management Company Allocation	2,434
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,434

**See instructions.

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/12 - 12/31/12

Schedule 21C

XIX. Support Schedules
C. Professional Services

Vendor/Payee		
MY INNERVIEW	Computer Services	6,332
NATIONAL DATACARE	Computer Services	1,881
ON SHIFT	Computer Services	8,016
ORACLE AMERICA	Computer Services	8,927
REAL MED CORP	Computer Services	71
RELIAS	Computer Services	3,864
RYL B/O - HEALTHMEDX LL	Computer Services	11,742
SILVERCHAIR LEARNING S	Computer Services	3,864
SOFTCHOICE	Computer Services	198
TELEMEDICINE SOLUTION	Computer Services	7,200
TOP NOTCH	Computer Services	109
TRISYS	Computer Services	150
TYMPANI INC	Computer Services	1,113
VIRTUAL RABBIT	Computer Services	10
VOCOLLECT HEALTHCARE	Computer Services	5,882
XO COMMUNICATION	Computer Services	118
Cassiday Schade	Legal	167
Amalgamated Bank of Chica	Financial	457
Duane Morris LLP	Legal	6,584
McGladrey LLP	Accounting	36,464
Grabowski Law Center, LLC	Collections	917
Pension Administrators	401 (K) Administration	855
Personnel Planners	U/C Consulting	1,490
Polsinelli Shughart	Legal	384
Standard and Poor	Financial	533
Much Shelist	Legal	6,370
Reda Ciprian Magnone, LLC	Legal	955
McCracken & Frank	Legal	351
Real Med	WS Consulting	12
Serpico, Petroski	Legal	1,915
Secretary of State	Filing Fees	238

	117,169
Total, Agrees to Schedule V, Line 19, Column 3	195,178

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/12 - 12/31/12

Allocated from Management Co.

Much Shelist	Legal	465
Duane Morris	Legal	31
Cassiday Schade	Legal	1
McGladrey LLP	Accounting	1,112
Illinois Secretary of State	Filing Fees	26
Gilson Labus & Silverman	KEP	311
Tam Kaiden	Investigative Services	39
Bank of America Leasing	UCC Search & Filing	16
Versight Inc.	Annual Report-Health Ins	92
Personnel Planners	U/C Consultant	16
LaSalle Network	Recruiting/Finance	1,176
Pension Administrators, Inc.	401K Administration	227
Gene Whitehorn	Medicaid Reimb Specialist	899
Christine Toolan	Social Service Consulting	14
M Werner Consulting	Financial Consultant	788
Computer Services	Computer Consulting	14,657
Allocated from Samvest of Lombard II	Accounting Legal	215
Allocated from Sambell		
Secretary of State	Filing Fees	200
Nonallowable legal fees		(3,109)
Nonallowable collection fees		(917)
Total, Agrees to Schedule V, Line 19, Column 8		211,437

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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-Bloomingdale # 0035188 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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. $ **48,412** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **349,716**
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. $ **13,890** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **300**

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

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

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