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: 0037317

Facility Name: Lexington of Elmhurst

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

County: DuPage

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	145	Skilled (SNF)	145	53,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	53,070	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			17,528	17,528	8
9	SNF/PED					9
10	ICF	14,822	11,693		26,515	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,822	11,693	17,528	44,043	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.99%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 15,453

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

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	340,428	28,553	11,530	380,511		380,511		380,511			1
2	Food Purchase		256,546		256,546		256,546	(17,039)	239,507			2
3	Housekeeping	252,653	28,953		281,606		281,606	271	281,877			3
4	Laundry	72,647	15,982		88,629		88,629		88,629			4
5	Heat and Other Utilities			187,687	187,687		187,687	5,348	193,035			5
6	Maintenance	44,045		123,169	167,214		167,214	60,699	227,913			6
7	Other (specify):* Mgmt Co. Alloc. Bene							8,115	8,115			7
8	TOTAL General Services	709,773	330,034	322,386	1,362,193		1,362,193	57,394	1,419,587			8
	B. Health Care and Programs											
9	Medical Director			63,363	63,363		63,363		63,363			9
10	Nursing and Medical Records	3,516,841	265,550	224,609	4,007,000		4,007,000	29,051	4,036,051			10
10a	Therapy											10a
11	Activities	130,050	15,338	7,404	152,792		152,792		152,792			11
12	Social Services	120,703		5,332	126,035		126,035		126,035			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co. Alloc. Bene							4,164	4,164			15
16	TOTAL Health Care and Programs	3,767,594	280,888	300,708	4,349,190		4,349,190	33,215	4,382,405			16
	C. General Administration											
17	Administrative	144,363		1,164,799	1,309,162		1,309,162	(1,137,626)	171,536			17
18	Directors Fees											18
19	Professional Services			188,546	188,546		188,546	(4,835)	183,711			19
20	Dues, Fees, Subscriptions & Promotions			48,047	48,047		48,047	10,467	58,514			20
21	Clerical & General Office Expenses	170,188	27,769	35,534	233,491		233,491	446,392	679,883			21
22	Employee Benefits & Payroll Taxes			851,567	851,567		851,567	13,560	865,127			22
23	Inservice Training & Education			9,833	9,833		9,833	716	10,549			23
24	Travel and Seminar			862	862		862	1,264	2,126			24
25	Other Admin. Staff Transportation			1,210	1,210		1,210	13,542	14,752			25
26	Insurance-Prop.Liab.Malpractice			210,867	210,867		210,867	2,937	213,804			26
27	Other (specify):* Mgmt Co. Alloc. Bene							71,801	71,801			27
28	TOTAL General Administration	314,551	27,769	2,511,265	2,853,585		2,853,585	(581,782)	2,271,803			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,791,918	638,691	3,134,359	8,564,968		8,564,968	(491,173)	8,073,795			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 of Elmhurst #0037317 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			159,107	159,107		159,107	320,201	479,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,691	15,691		15,691	325,300	340,991			32
33	Real Estate Taxes							80,358	80,358			33
34	Rent-Facility & Grounds			1,011,832	1,011,832		1,011,832	(1,008,898)	2,934			34
35	Rent-Equipment & Vehicles			76,755	76,755		76,755	2,532	79,287			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,263,385	1,263,385		1,263,385	(280,507)	982,878			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		593,421	1,754,419	2,347,840		2,347,840		2,347,840			39
40	Barber and Beauty Shops			22,320	22,320		22,320		22,320			40
41	Coffee and Gift Shops			1,850	1,850		1,850		1,850			41
42	Provider Participation Fee			253,150	253,150		253,150		253,150			42
43	Other (specify):* **Non-Allowable Cos**	121,623		148,643	270,266		270,266	(270,266)				43
44	**TOTAL Special Cost Centers**	121,623	593,421	2,180,382	2,895,426		2,895,426	(270,266)	2,625,160			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,913,541	1,232,112	6,578,126	12,723,779		12,723,779	(1,041,946)	11,681,833			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 of Elmhurst # 0037317 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	(3,479)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,149)	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	1,188	30		9
10	Interest and Other Investment Income	(556)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,046)	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	(7,636)	43		18
19	Entertainment				19
20	Contributions	(2,075)	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	(10,211)	43		24
25	Fund Raising, Advertising and Promotional	(57,155)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,763)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(114,736)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (217,618)		$	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)	(824,328)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (824,328)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,041,946)		37

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

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

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

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (4,558)	43	1
2	Labs-Part A	(8,812)	43	2
3	X-Rays-Part A	(31,730)	43	3
4	Trust Fees	(50)	43	4
5	Dues & Subscriptions Marketing	(617)	20	5
6	Collection fees	(10,275)	19	6
7	Reclass assets to Repairs & Maintenance	3,662	6	7
8	Education & Seminar Marketing	(862)	24	8
9	Loss on FMV swap	76,441	43	9
10	Marketing Salary	(121,623)	43	10
11	Chamber of Commerce dues	(500)	20	11
12	Out of period legal	(12,304)	19	12
13	Development expenses	(3,508)	43	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**	(114,736)		49

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	34	Rental expense	$ 1,011,832	Sambell of Elmhurst II Limited Partnership	**	$	$ (1,011,832)	1
2	V	19	Professional Fees		Sambell of Elmhurst II Limited Partnership	**	200	200	2
3	V								3
4	V	30	Depreciation		Sambell of Elmhurst II Limited Partnership	**	279,670	279,670	4
5	V	32	Interest expense		Sambell of Elmhurst II Limited Partnership	**	309,331	309,331	5
6	V	32	Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	3,405	3,405	6
7	V	33	Property taxes		Sambell of Elmhurst II Limited Partnership	**	75,831	75,831	7
8	V	43	Unrealized loss on FMV swap	76,441	Sambell of Elmhurst II Limited Partnership	**		(76,441)	8
9	V	43	Trust fees		Sambell of Elmhurst II Limited Partnership	**	50	50	9
10	V								10
11	V								11
12	V				** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				12
13	V				of Sambell of Elmhust II Limited Partnership				13
14	Total			$ 1,088,273			$ 668,487	$ * (419,786)	14

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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.	**	$ 271	$ 271	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	4,531	4,531	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	201	201	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	616	616	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	51,070	51,070	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	5,701	5,701	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	266	266	21
22	V	6	Security service		Royal Management Corp.	**			22
23	V	7	Management allocation - employee benefits		Royal Management Corp.	**	8,115	8,115	23
24	V	10	Medical consultant		Royal Management Corp.	**	2,847	2,847	24
25	V	10	Management allocation - salaries		Royal Management Corp.	**	26,204	26,204	25
26	V	15	Management allocation - employee benefits		Royal Management Corp.	**	4,164	4,164	26
27	V	17	Management allocation - salaries		Royal Management Corp.	**	27,173	27,173	27
28	V	19	Computer consultant & supplies		Royal Management Corp.	**	12,803	12,803	28
29	V	19	Professional fees		Royal Management Corp.	**	4,741	4,741	29
30	V	20	Dues & subscriptions		Royal Management Corp.	**	869	869	30
31	V	23	Inservice Training		Royal Management Corp.	**	716	716	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	10,715	10,715	32
33	V	21	Management allocation - salaries		Royal Management Corp.	**	424,692	424,692	33
34	V	21	Bank charges		Royal Management Corp.	**	2,351	2,351	34
35	V	21	Office supplies & printing		Royal Management Corp.	**	7,480	7,480	35
36	V	21	Postage		Royal Management Corp.	**	3,030	3,030	36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.						38
39	Total			$			$ 598,556	$ * 598,556	39

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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.	**	$ 8,839	$ 8,839	15
16	V	24	Travel & seminar		Royal Management Corp.	**	2,126	2,126	16
17	V	25	Auto expense		Royal Management Corp.	**	13,542	13,542	17
18	V	26	Insurance general		Royal Management Corp.	**	2,937	2,937	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	71,801	71,801	19
20	V	30	Depreciation		Royal Management Corp.	**	39,343	39,343	20
21	V	32	Interest		Royal Management Corp.	**	12,001	12,001	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,119	1,119	22
23	V	33	Property taxes		Royal Management Corp.	**	4,527	4,527	23
24	V	34	Rent expense		Royal Management Corp.	**	2,934	2,934	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,197	1,197	25
26	V	17	Management fees	1,164,799	Royal Management Corp.	**		(1,164,799)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,335	1,335	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V		** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.						36
37	V								37
38	V								38
39	Total			$ 1,164,799			$ 161,701	$ * (1,003,098)	39

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	16.66%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	16.67%	Lexington HC Ctr. of Lombard, Inc.	Lombard	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	16.67%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Vesta Management	Lombard	Mgmt. Co.	3
4	David S. Bell Revocable Trust	12.50%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Group LLC			4
5	Jeffrey J. Bell Revocable Trust	12.50%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Sambell of	Elmhurst	Real Estate	5
6	Lawrence W. Bell Revocable Trust	12.50%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Elmhurst Ltd. Ptsp.		Property	6
7	David S. Bell 2001 Trust	4.16%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Royal Management	Lombard	Management	7
8	Jeffrey J. Bell 2001 Trust	4.17%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Corporation		Company	8
9	Lawrence W. Bell 2001 Trust	4.17%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Lexington Financial	Lombard	Finance Company	9
10			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Services II, LLC			10
11					Lexington Square	Lombard	Independent	11
12					Life Care of		and Assisted	12
13					Lombard, LLC		Living	13
14					Lexington Square	Elmhurst	Independent	14
15					Life Care of		Living Facility	15
16					Elmhurst, LLC			16
17					Samvest of Lombard	Lombard	Lessor	17
18					II, LLC			18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/Officer	Administrative	16.66	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 7,569	L 17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	16.67	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,543	L 17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	16.67	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,709	L 17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,031	L 17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,321	L 17, C7	5
6		Member		Certain Individuals work in excess of 40 hours per week.							6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,173		13

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

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	$	53,070	$ 271	1
2	5	Utilities - gas & electric	Bed Days	725,412	10	61,939		53,070	4,531	2
3	5	Utilities - water & sewer	Bed Days	725,412	10	2,741		53,070	201	3
4	5	Utilities - maintenance office	Bed Days	725,412	10	8,424		53,070	616	4
5	6	Management allocation - salaries	Bed Days	725,412	10	698,068	698,068	53,070	51,070	5
6	6	Repairs & maintenance	Bed Days	725,412	10	77,933		53,070	5,701	6
7	6	Scavenger & exterminating	Bed Days	725,412	10	3,642		53,070	266	7
8	6	Security service	Bed Days	725,412	10			53,070	0	8
9	7	Management allocation - employe	Bed Days	725,412	10	110,922		53,070	8,115	9
10	10	Medical consultant	Bed Days	725,412	10	38,914		53,070	2,847	10
11	10	Management allocation - salaries	Bed Days	725,412	10	358,188	358,188	53,070	26,204	11
12	15	Management allocation - employe	Bed Days	725,412	10	56,916		53,070	4,164	12
13	17	Management allocation - salaries	Bed Days	725,412	10	371,421	371,421	53,070	27,173	13
14	19	Computer consultant & supplies	Bed Days	725,412	10	174,999		53,070	12,803	14
15	19	Professional fees	Bed Days	725,412	10	64,806		53,070	4,741	15
16	20	Dues & subscriptions	Bed Days	725,412	10	11,884		53,070	869	16
17	23	Inservice Training	Bed Days	725,412	10	9,785		53,070	716	17
18	20	Advertising - help wanted	Bed Days	725,412	10	146,469		53,070	10,715	18
19	21	Management allocation - salaries	Bed Days	725,412	10	5,805,098	5,805,098	53,070	424,692	19
20	21	Bank charges	Bed Days	725,412	10	32,134		53,070	2,351	20
21	21	Office supplies & printing	Bed Days	725,412	10	102,249		53,070	7,480	21
22	21	Postage	Bed Days	725,412	10	41,415		53,070	3,030	22
23	21	Telephone	Bed Days	725,412	10	120,819		53,070	8,839	23
24	24	Travel and Seminar	Bed Days	725,412	10	29,058		53,070	2,126	24
25	TOTALS					$ 8,331,531	$ 7,232,775		$ 609,521	25

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	$	53,070	$ 13,542	1
2	26	Insurance general	Bed Days	725,412	10	40,142		53,070	2,937	2
3	27	Management allocation - employe	Bed Days	725,412	10	981,440		53,070	71,801	3
4	30	Depreciation	Bed Days	725,412	10	537,783		53,070	39,343	4
5	32	Interest	Bed Days	725,412	10	164,037		53,070	12,001	5
6	32	Amortization of mortgage costs	Bed Days	725,412	10	15,301		53,070	1,119	6
7	33	Property taxes	Bed Days	725,412	10	61,875		53,070	4,527	7
8	34	Rent expense	Bed Days	725,412	10	40,101		53,070	2,934	8
9	35	Equipment rental	Bed Days	725,412	10	16,356		53,070	1,197	9
10	35	Auto Lease	Bed Days	725,412	10	18,252		53,070	1,335	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,060,398	$		$ 150,736	25

Facility Name & ID Number Lexington of Elmhurst # 0037317 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** 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 II, L.L.C.	X		Mortgage	Varies	4/30/07	5,391,000	4,122,110	5/1/17	0.0625	309,331	2
3												3
4												4
5							Interest on financing insurance premium				1,102	5
	Working Capital											
6	JP Morgan Chase		X	Line of Credit	Various	4/30/07	800,000	490,000	6/29/13	Libor + 2.25%	14,589	6
7												7
8												8
9	TOTAL Facility Related						$ 6,191,000	$ 4,612,110			$ 325,022	9
	B. Non-Facility Related*											
10								Interest Income Offset			(556)	10
11								Amortization of Loan Cost			3,405	11
12								Allocated from Home Office			13,120	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 15,969	14
15	TOTALS (line 9+line14)						$ 6,191,000	$ 4,612,110			$ 340,991	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 of Elmhurst # 0037317 **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.**	$ 66,000	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**	$ 69,831	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,831	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 72,000	4
	Allocated from Mgmt. Co.	4,527	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 80,358	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	64,015	8
	2008	62,753	9
	2009	68,355	10
	2010	68,387	11
	2011	69,831	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 of Elmhurst COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0037317

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 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.	06-14-317-008	Land & Building	$ 69,831.84	$ 68,831.84
2.	Royal Management Corp. (Samvest of Lombard II)		$ 230,165.98	$ 4,527.00
3.	05-01-202-019	Land & Building	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 299,997.82	$ 73,358.84

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 of Elmhurst # 0037317 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	55,000	1991	$ 1,277,670	1
2	Management Company Allocation			14,748	2
3	TOTALS	55,000		$ 1,292,418	3

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	133		1991	1991	$ 4,110,586	$	35	$ 117,445	$ 117,445	$ 2,479,120	4
5	12		1995	1995	73,302	2,095	35	2,095		36,982	5
6			2001	2001							6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1992	693	20	35	20		402	9
10	Land Improvement			1995	7,500		15			7,500	10
11	Fan Coil Units			1996	4,904	140	35	140		2,311	11
12	Patio			1996	2,322	77	15	77		2,322	12
13	Basement rehab			1997	17,151		10			17,151	13
14	Baseboards			1997	3,129		10			3,129	14
15	Wiring			1998	3,090		10			3,090	15
16	Lobby Tile			1999	19,354		10			19,354	16
17	Patio			1999	4,196	280	15	280		3,638	17
18	Automatic Door			2000	1,300		10			1,300	18
19	Wallpaper			2000	6,853		10			6,853	19
20	Patio			2000	1,242	83	15	83		1,036	20
21	Storage closet for HVAC			2000	3,745	250	15	250		3,122	21
22	Fire pump system			2001	4,140		10			4,140	22
23	Door releases			2001	4,420		10			4,420	23
24	Infrared curtains for elevators			2001	3,000		10			3,000	24
25	Parking lot			2002	2,532		10			2,532	25
26	Kitchen tile and plumbing			2002	9,661	322	10	322		9,661	26
27	Elevator upgrade			2002	2,596		5			2,596	27
28	Facility Rehab-Painting/wallpaper/carpeting			2003	175,251	17,525	10	17,525		173,790	28
29	Facility Rehab-Floor tile/room upgrade			2003	38,140	1,907	20	1,907		18,911	29
30	Facility Rehab-Carpeting			2003	7,861	786	10	786		7,729	30
31	Parking lot			2004	2,000		5			2,000	31
32	Roof			2004	15,000	750	20	750		6,313	32
33	Landscaping			2005	5,396	270	20	270		2,024	33
34	Paint for building			2005	9,000	900	10	900		6,525	34
35	Roof			2005	14,300	715	20	715		5,124	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 of Elmhurst # 0037317 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	HVAC upgrade	2005	$ 3,230	$ 162	20	$ 162	$	$ 1,241	37
38	Sprinkler system	2005	1,060	53	20	53		384	38
39	Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		10,925	39
40	Window treatment	2005	1,932	193	10	193		1,480	40
41	Cubicle curtains	2005	820		5			820	41
42	Countertop	2005	845		5			845	42
43	HVAC	2006	3,793	190	20	190		1,155	43
44	Automatic Door Lock	2006	2,784	139	20	139		834	44
45	Storeroom Door Lock	2006	1,904	95	20	95		586	45
46	Service Door	2006	2,545	127	20	127		762	46
47	Landscaping Enhancement-Patio	2006	2,340	156	15	156		1,001	47
48	PT Therapy Room	2006	570	14	40	14		84	48
49									49
50									50
51									51
52	Transitional Unit	2007	1,864	93	20	93		535	52
53	Employee Lunch Room	2007	2,827	141	20	141		776	53
54	PT Room Rehab	2007	58,628	2,941	20	2,941		15,490	54
55	Landscaping-brick pavers	2008	43,813	2,921	15	2,921		12,414	55
56	Parking Lot	2008	31,700	1,585	20	1,585		7,265	56
57	Roof Repairs	2008	4,200	280	15	280		1,307	57
58	HVAC-New Chillers	2008	118,557	5,928	20	5,928		25,688	58
59	Emergency A/C	2008	5,706	285	20	285		1,235	59
60	Building Addition	2008			27				60
61	Kitchen Upgrade	2008	7,214		27	262	262	1,092	61
62	2nd Floor Remodel-painting,flooring, electrical	2008	561,274		27	20,410	20,410	85,042	62
63	Foundation Stabilization	2008	66,195		27	2,407	2,407	10,029	63
64	Irrigation System	2009	15,485	1,032	15	1,032		3,440	64
65	Landscaping Enhancements	2009	26,798	1,787	15	1,787		6,105	65
66	Patio Fence	2009	9,319	466	20	466		1,670	66
67	Chiller	2009	82,310	4,115	20	4,115		15,432	67
68	Plumbing	2009	4,280	214	20	214		642	68
69	2nd floor remodel-MDS office,HR office,Nursing call system	2009	6,853	250	27	250		760	69
70	TOTAL (lines 4 thru 69)		$ 5,649,111	$ 50,667		$ 191,191	$ 140,524	$ 3,045,114	70

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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		$ 5,649,111	$ 50,667		$ 191,191	$ 140,524	$ 3,045,114	1
2	Patio Pergola	2009	12,814	641	20	641		2,137	2
3	Tub Room carpentry,flooring,electrical	2009	5,828	212	27	212		636	3
4	2nd Floor remodel-Carpentry,doors,flooring,electrical	2009	455,801		7	16,575	16,575	62,156	4
5	painting,sprikler system								5
6	Landscaping	2010	3,314	221	15	221		497	6
7	Physician office remodel-carpentry,tiling	2010	6,450	235	27	235		490	7
8	Front Entrance-door and drain tile	2010	4,418	216	27	216		479	8
9	Nurse pull cord station	2010	3,256	118	27	118		236	9
10	Remodel Pantry-shelves	2010	7,146	260	27	260		520	10
11	Director of Nursing office painting	2010	5,539	201	27	201		402	11
12	Cooridor remodel-flag poll,tiling	2010	13,777	550	27	550		1,164	12
13	Library/Lounge remodel-art,carpentry,electrical	2010	11,870	432	27	432		864	13
14	Steel frame remodel	2010	6,740	245	27	245		613	14
15	2nd Floor remodel-Carpentry,doors,flooring,electrical	2010	17,168	624	27	624		1,872	15
16	Tub Room carpentry,plumbing	2010	11,731	427	27	427		1,210	16
17	Pergola	2010	8,180	1,636	5	1,636		3,817	17
18	Stamped concrete	2010	17,260	628	27	628		1,465	18
19	Landscaping	2011	4,443	296	15	296		395	19
20	Offices-doors, locks, keys	2011	66,131	2,405	27	2,405		3,808	20
21	Seal and stripe parking lot	2011	3,500	127	27	127		159	21
22	Laundry room-electrical, painting	2011	6,412	233	27	233		350	22
23	Floor install	2011	10,158	369	27	369		677	23
24	2nd floor doors	2011	9,654	351	27	351		673	24
25									25
26	Front entrance door	2012	3,733	34	27	34		34	26
27	Shower-Electrical	2012	4,982	30	27	30		30	27
28	Fire Dampers	2012	7,392	22	27	22		22	28
29	Low voltage wiring	2012	5,186	126	27	126		126	29
30	EMR Wiring	2012	14,543	44	27	44		44	30
31	1st floor doors	2012	8,476	128	27	128		128	31
32	Back patio fence	2012	3,536	107	27	107		107	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,388,549	$ 61,585		$ 218,684	$ 157,099	$ 3,130,225	34

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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		$ 6,388,549	$ 61,585		$ 218,684	$ 157,099	$ 3,130,225	1
2	Land improvements - management company	2002	204,081		15	5,984	5,984	66,270	2
3	Building - management company	2002	1,793		40	441	441	1,168	3
4	HVAC, electrical, security system - management company	2003	282		30	14	14	119	4
5	Key card system - management company	2004	86		20	4	4	34	5
6	VAV TX controls - management company	2005	62		20	4	4	26	6
7	Interior Signs- management company	2006	9,890		5	511	511	2,676	7
8	Building - management company	2008	1,847		5	34	34	345	8
9	Building - management company	2009	1,799		15	73	73	303	9
10	Building - management company	2010	1,270		15	58	58	88	10
11	Building - management company	2011	4,387		15	2	2	101	11
12									12
13									13
14									14
15									15
16									16
17									17
18	Reconcile to book depreciation			504			(504)		18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,614,046	$ 62,089		$ 225,809	$ 163,720	$ 3,201,355	34

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	$ 1,238,365	$ 81,881	$ 206,144	$ 124,263	5	$ 828,686	71
72	Current Year Purchases	130,013	15,137	15,137		5	15,137	72
73	Fully Depreciated Assets	79,643				5	79,643	73
74	Allocated from Mgmt. Co.	358,958		28,958	28,958	5	207,238	74
75	TOTALS	$ 1,806,979	$ 97,018	$ 250,239	$ 153,221		$ 1,130,704	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.			35,034		3,260	3,260		27,891	79
80	TOTALS			$ 35,034	$	$ 3,260	$ 3,260		$ 27,891	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,748,477	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 159,107	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 479,308	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 320,201	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,359,950	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP Room reconfigurement	$ 39,386	92
93			93
94			94
95		$ 39,386	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 of Elmhurst # 0037317 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:
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				2,934			6
7	TOTAL				$ 2,934 **			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: $ 77,952 Description: Copier-$8,986, Mail Sys-$154,Printer-$1,121, Med Equip.-$28,701, Oxy Equip.-$37,793, Mgmt. Co.-$1,197
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20	Allocated from Management Company			1,335	20
21	TOTAL		$	$ 1,335	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 of Elmhurst # 0037317 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 of Elmhurst # 0037317 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	$	9,584	$ 696,872	$	9,584	$ 696,872	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,477	205,634		4,477	205,634	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		16,135	850,796		16,135	850,796	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				593,421		593,421	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Dentist	39(3)				1,688			1,688	12
13	Other (specify): Ambulance	39(3)				(571)			(571)	13
14	TOTAL			$	30,196	$ 1,754,419	$ 593,421	30,196	$ 2,347,840	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 of Elmhurst # 0037317 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	$ 1,955,205	$ 2,284,067	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 449,840)	2,346,267	2,346,267	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,034	80,034	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,381,506	$ 4,710,368	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,319	6,319	12
13	Land		1,292,418	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	1,182,375	2,503,460	15
16	Equipment, at Historical Cost	755,851	1,842,013	16
17	Accumulated Depreciation (book methods)	(891,277)	(4,359,950)	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):	39,386	39,386	22
23	Other(specify): Mortgage Net Cost		66,672	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,092,654	$ 5,500,904	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,474,160	$ 10,211,272	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 741,945	$ 741,945	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	490,000	490,000	29
30	Accrued Salaries Payable	365,712	365,712	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,244	11,244	31
32	Accrued Real Estate Taxes(Sch.IX-B)		72,000	32
33	Accrued Interest Payable		25,273	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	696,436	1,621,278	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,305,337	$ 3,327,452	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,122,110	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,122,110	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,305,337	$ 7,449,562	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,168,823	$ 2,761,710	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,474,160	$ 10,211,272	48

***(See instructions.)**

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

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Interest Rate Swap Liability		916,318
Due to Merit Hospice	15,000	15,000
PA Audit settlement	172,095	172,095
Due to Republic Construction of Illinois, Inc.	(633)	(633)
Due to/from Lexington Financial Services LLC	19	19
Prepaid Insurance	24,901	24,901
Accrued Expenses	77,012	77,012
Accrued Royl Mgmt Fees/Vesta Fees	6,568	6,568
Accrued Rent	(8,524)	
Accrued Resident Tax	45,461	45,461
Accrued Insurance	93,330	93,330
Due to Patient Trust Fund	(7,268)	(7,268)
Deferered Income	129,931	129,931
Due to Royal Operations	48,931	48,931
Advance-Bi-weekly Part A Payments	(473)	(473)
Uncollectible Part A Co. Pvts.	(19,046)	(19,046)
Professional Liabilities Claims	119,132	119,132
	696,436	1,621,278

Facility Name & ID Number Lexington of Elmhurst **#** 0037317 **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**	$ 2,396,227	1	
2	Restatements (describe):		2	
3	**Post closing adjustment**	(112,004)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,284,223	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,280,600	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	(396,000)	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)**	$ 884,600	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)**	$ 3,168,823	24	*

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

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	$ 14,276,364	1
2	Discounts and Allowances for all Levels	(6,293,433)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,982,931	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,961,279	6
7	Oxygen	53,615	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,014,894	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		12
13	Barber and Beauty Care	28,230	13
14	Non-Patient Meals	3,479	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	577,844	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	183,413	19
20	Radiology and X-Ray		20
21	Other Medical Services	213,032	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,005,998	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	556	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 556	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,004,379	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,362,193	31
32	Health Care	4,349,190	32
33	General Administration	2,853,585	33
	B. Capital Expense		
34	Ownership	1,263,385	34
	C. Ancillary Expense		
35	Special Cost Centers	2,642,276	35
36	Provider Participation Fee	253,150	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,723,779	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,280,600	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,280,600	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,983,275	44
45	Private Pay - Net Inpatient Revenue	2,788,984	45
46	Medicare - Net Inpatient Revenue	2,417,070	46
47	Other-(specify) Managed Care	793,602	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,982,931	49

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

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

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

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

^ - Entity is a cash basis tax payer.

Facility Name & ID Number Lexington of Elmhurst # 0037317 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	1,881	2,323	$ 129,351	$ 55.68	1
2	Assistant Director of Nursing	24,869	30,449	872,180	28.64	2
3	Registered Nurses	15,725	19,378	587,007	30.29	3
4	Licensed Practical Nurses	25,141	30,162	770,785	25.55	4
5	CNAs & Orderlies	80,851	95,219	1,121,005	11.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,201	9,922	120,381	12.13	10
11	Social Service Workers	6,053	6,855	120,703	17.61	11
12	Dietician	1,660	1,961	31,891	16.26	12
13	Food Service Supervisor	1,640	1,961	40,294	20.55	13
14	Head Cook	1,660	1,961	30,004	15.30	14
15	Cook Helpers/Assistants	10,184	12,158	123,761	10.18	15
16	Dishwashers	10,765	12,576	114,478	9.10	16
17	Maintenance Workers	1,846	2,270	44,045	19.40	17
18	Housekeepers	22,520	26,413	252,653	9.57	18
19	Laundry	6,951	8,161	72,647	8.90	19
20	Administrator	1,656	2,430	144,363	59.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,253	11,271	170,187	15.10	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	1,753	2,240	36,513	16.30	31
32	Other Health C: Memory Care	424	406	9,670	23.82	32
33	Other(specify) Marketing	3,918	4,353	121,623	27.94	33
34	TOTAL (lines 1 - 33)	235,951	282,469	$ 4,913,541 *	$ 17.39	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	$ 9,483	1(3)	35
36	Medical Director	Number	63,363	9(3)	36
37	Medical Records Consultant	27	1,375	10(3)	37
38	Nurse Consultant	Monthly	122,611	10(3)	38
39	Pharmacist Consultant	Monthly	9,270	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,210	11(3)	44
45	Social Service Consultant	Monthly	5,194	12(3)	45
46	Other(specify) Joint Commission	Monthly	16,023	10(3)	46
47	Pulmonary	Monthly	75,330	10(3)	47
48	Medical Consultant	Monthly	2,847	10(7)	48
49	TOTAL (lines 35 - 48)	27	$ 310,706		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 of Elmhurst # 0037317 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Cubas	Administrator	0	$ 135,686
William Pfeiffer III	Administrator	0	8,677
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 144,363

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 745,024
Management Fees-Vesta Mgmt.	419,775
Removed in column 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,164,799
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center, LLC	Collections	$ 10,275
Cassidy Schade, LLP	Legal	42,535
McGladrey & Pullen, LLP	Accounting	32,582
Much Shelist	Legal	6,916
Personnel Planners	U/C Consulting	1,905
Polsinelli Shughart	Legal	2,774
Scott and Krause	Legal	6,495
Secretary of State	Filing Fees	100
Pension Administrators	Pension Administration	813
Duane Morris	Legal	5,823
Law Offices of Serpico	Legal	7,398
See Schedule 21C		70,930
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 188,546

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,796
Unemployment Compensation Insurance	148,534
FICA Taxes	365,158
Employee Health Insurance	184,704
Employee Meals	13,560
Illinois Municipal Retirement Fund (IMRF)*	
401K	15,994
Other Employee Benefits	37,381
Tuition Reimbursement	2,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 865,127

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	31,969
Health Care Worker Background Check	
(Indicate # of checks performed 473)	5,679
Patient Background Checks 175	2,101
Miscellaneous Licenses & Fees	5,191
Miscellaneous Subscriptions & Dues	1,117
Less: Dues & Subscriptions Marketing	(617)
Allocated from Mgmt Co.	11,584
Less: Chamber of commerce dues	(500)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 58,514

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Management Company Allocation	2,126
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,126

**See instructions.

Schedule 21C

C. Professional Services

Vendor/Payee	Type	Amount
McCracken & Frank LLC	Legal	286
Ability Network	Computer Consulting	1,519
EFAX Corporate	Computer Consulting	1,091
Ehealth Data Solutions	Computer Consulting	2,400
Elton Designs	Computer Consulting	260
FACILITY WIZARD	Computer Consulting	358
Health MedX	Computer Consulting	10,360
Information Controls	Computer Consulting	1,176
KRONOS	Computer Consulting	1,392
Lintech	Computer Consulting	4,418
Microsoft Licensing	Computer Consulting	5,382
MY Innerview	Computer Consulting	6,335
NATIONAL DATACARE	Computer Consulting	1,319
ON SHIFT	Computer Consulting	8,016
Oracle	Computer Consulting	8,927
Paragon Clinical	Computer Consulting	1,200
REAL MED CORP	Computer Consulting	134
Relias Learning	Computer Consulting	3,864
Silver Chair Learning Systems	Computer Consulting	3,864
Soft choice Corporation	Workers Compensation	186
TELEMEDICINE SOLUTIONS	Computer Consulting	7,200
Top Notch	Computer Consulting	109
Trisys	Computer Consulting	140
TYMPANI	Computer Consulting	865
Virtual Rabbit	Computer Consulting	10
XO COMMUNICATIONS	Computer Consulting	118
Tympani	Computer Consulting	
Vision Share, Inc.	Computer Consulting	
XO Communications	Computer Consulting	

	70,930
Schedule V, line 19, column 3	188,546
Collection Fees	(10,275)
Out of period legal	(12,304)
Allocated from Sambell of Elmhurst	
Secretary of State	200
Allocated from Samvest of Lombard II	
Accounting	188
	188

Allocated from Mgmt Co.

Much Shelist	Legal	406
Duane Morris	Legal	27
Cassiday Schade	Legal	1
McGladrey LLP	Accounting	971
Illinois Secretary of State	Filing Fees	23
Gilson Labus & Silverman	KEP	272
Tam Kaiden	Investigative Services	34
Bank of America Leasing	UCC Search & Filing	14
Versight Inc.	Annual Report-Health Ins	80
Personnel Planners	U/C Consultant	14
LaSalle Network	Recruiting/Finance	1,027
Pension Administrators, Inc.	401K Administration	198
Gene Whitehorn	Medicaid Reimb Specialis	786
Christine Toolan	Social Service Consulting	13
M Werner Consulting	Financial Consultant	687
Computer Services	Computer Consulting	12,803
		17,356

Schedule V, line 19, column 8 183,711

Facility Name & ID Number Lexington of Elmhurst # 0037317 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 of Elmhurst **#** 0037317 **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. $ **39,206** 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. $ **253,150**
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. $ **13,560** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,479**

(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.