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: 0041855

Facility Name: Lexington of Orland Park

Address: 14601 South John Humphrey Dr (Number) Orland Park (City) 60462 (Zip Code)

County: Cook

Telephone Number: (708) 349-8300 **Fax #** (708) 349-4093

HFS ID Number:

Date of Initial License for Current Owners: 7/8/96

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 Orland Park # 0041855 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	278	Skilled (SNF)	278	101,748	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	278	TOTALS	278	101,748	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			19,636	19,636	8
9	SNF/PED					9
10	ICF	53,788	10,804		64,592	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,788	10,804	19,636	84,228	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.78%

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 7/8/96

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 278 and days of care provided 17,710

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 Orland Park # 0041855 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 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	
	A. General Services											
1	Dietary	422,782	46,072	18,018	486,872		486,872		486,872			1
2	Food Purchase		476,300		476,300		476,300	(22,384)	453,916			2
3	Housekeeping	390,899	57,368		448,267		448,267	520	448,787			3
4	Laundry	58,210	25,917		84,127		84,127		84,127			4
5	Heat and Other Utilities			248,416	248,416		248,416	10,251	258,667			5
6	Maintenance	66,561		165,760	232,321		232,321	110,382	342,703			6
7	Other (specify):* Alloc. From Mgmt. C							15,558	15,558			7
8	**TOTAL General Services**	938,452	605,657	432,194	1,976,303		1,976,303	114,327	2,090,630			8
	B. Health Care and Programs											
9	Medical Director			104,610	104,610		104,610		104,610			9
10	Nursing and Medical Records	6,195,478	481,020	252,170	6,928,668		6,928,668	55,698	6,984,366			10
10a	Therapy											10a
11	Activities	286,744	36,494	7,978	331,216		331,216		331,216			11
12	Social Services	150,131		4,997	155,128		155,128		155,128			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt. C							7,983	7,983			15
16	**TOTAL Health Care and Programs**	6,632,353	517,514	369,755	7,519,622		7,519,622	63,681	7,583,303			16
	C. General Administration											
17	Administrative	169,803		1,994,420	2,164,223		2,164,223	(1,942,324)	221,899			17
18	Directors Fees											18
19	Professional Services			433,054	433,054		433,054	11,855	444,909			19
20	Dues, Fees, Subscriptions & Promotions			32,677	32,677		32,677	21,594	54,271			20
21	Clerical & General Office Expenses	248,364	44,901	78,496	371,761		371,761	855,962	1,227,723			21
22	Employee Benefits & Payroll Taxes			1,436,377	1,436,377		1,436,377	22,299	1,458,676			22
23	Inservice Training & Education			14,466	14,466		14,466	1,372	15,838			23
24	Travel and Seminar			325	325		325	3,751	4,076			24
25	Other Admin. Staff Transportation			1,733	1,733		1,733	25,964	27,697			25
26	Insurance-Prop.Liab.Malpractice			636,196	636,196		636,196	5,630	641,826			26
27	Other (specify):* Alloc. From Mgmt. C							137,659	137,659			27
28	**TOTAL General Administration**	418,167	44,901	4,627,744	5,090,812		5,090,812	(856,238)	4,234,574			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,988,972	1,168,072	5,429,693	14,586,737		14,586,737	(678,230)	13,908,507			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 Orland Park #0041855 **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			197,652	197,652		197,652	521,326	718,978			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,454	55,454		55,454	638,807	694,261			32
33	Real Estate Taxes							603,736	603,736			33
34	Rent-Facility & Grounds			2,397,557	2,397,557		2,397,557	(2,389,432)	8,125			34
35	Rent-Equipment & Vehicles			103,580	103,580		103,580	4,854	108,434			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,754,243	2,754,243		2,754,243	(620,709)	2,133,534			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		672,347	1,994,209	2,666,556		2,666,556		2,666,556			39
40	Barber and Beauty Shops			23,262	23,262		23,262		23,262			40
41	Coffee and Gift Shops			95	95		95		95			41
42	Provider Participation Fee			556,379	556,379		556,379		556,379			42
43	Other (specify):* **Non-Allowable Cos**	145,890		207,399	353,289		353,289	(353,289)				43
44	**TOTAL Special Cost Centers**	145,890	672,347	2,781,344	3,599,581		3,599,581	(353,289)	3,246,292			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,134,862	1,840,419	10,965,280	20,940,561		20,940,561	(1,652,228)	19,288,333			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 Orland Park # 0041855 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	(85)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,998)	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	(739)	30		9
10	Interest and Other Investment Income	(13,376)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14,644)	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	(352)	43		18
19	Entertainment				19
20	Contributions	(10,555)	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	(35,085)	43		24
25	Fund Raising, Advertising and Promotional	(68,944)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,158)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(195,332)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (349,268)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,302,960)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,302,960)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,652,228)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Lexington of Orland Park

ID# **0041855**

Report Period Beginning: **01/01/2012**

Ending: **12/31/2012**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (9,053)	43	1
2	X-Rays - Part A	(48,649)	43	2
3	Diagnostics Managed Care	(3,241)	43	3
4	Misc. Income	118	21	4
5	Marketing Salary	(145,890)	21	5
6	Collections	(2,913)	19	6
7	Out of period legal	(19,273)	19	7
8	Reclass LHI under 2500	1,027	6	8
9	Travel & Seminar Marketing	(325)	24	9
10	Dues & Subscriptions marketing	(617)	20	10
11	Unrealized loss on FMV swap	40,274	43	11
12	Trust Fees	(75)	43	12
13	Development expense	(6,715)	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**	(195,332)		49

Facility Name & ID Number Lexington of Orland Park # 0041855 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	30	Depreciation	$	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	$ 446,634	$ 446,634	1
2	V	32	Interest Expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	623,163	623,163	2
3	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	3,866	3,866	3
4	V	33	Property Taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	595,057	595,057	4
5	V	34	Rental Expense	2,395,057	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(2,395,057)	5
6	V	43	State Replacement Tax	5	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(5)	6
7	V	43	Unrealized loss on FMV swap	40,274	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(40,274)	7
8	V	43	Trust Fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	75	75	8
9	V	19	Professional Fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	405	405	9
10	V								10
11	V				** The owners of Lexington Health Care Center of Orland Park, Inc. own 100%				11
12	V				of Lexington Health Care Systems of Orland Park Ltd. Ptsp.				12
13	V								13
14	Total			$ 2,435,336			$ 1,669,200	$ * (766,136)	14

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

Facility Name & ID Number Lexington of Orland Park # 0041855 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.	**	$ 520	$ 520	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	8,688	8,688	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	384	384	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	1,182	1,182	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	97,913	97,913	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	10,931	10,931	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	511	511	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	15,558	15,558	22
23	V	10	Medical consultant		Royal Management Corp.	**	5,458	5,458	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	50,240	50,240	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	7,983	7,983	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	52,096	52,096	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	24,546	24,546	27
28	V	19	Professional fees		Royal Management Corp.	**	9,090	9,090	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,667	1,667	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	20,544	20,544	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	814,237	814,237	31
32	V	21	Bank charges		Royal Management Corp.	**	4,507	4,507	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	14,342	14,342	33
34	V	21	Postage		Royal Management Corp.	**	5,809	5,809	34
35	V	21	Telephone		Royal Management Corp.	**	16,946	16,946	35
36	V	23	Inservice Training		Royal Management Corp.	**	1,372	1,372	36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 1,164,524	$ * 1,164,524	39

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

Facility Name & ID Number Lexington of Orland Park # 0041855 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	24	Travel & seminar	$	Royal Management Corp.	**	$ 4,076	$ 4,076	15
16	V	25	Auto expense		Royal Management Corp.	**	25,964	25,964	16
17	V	26	Insurance general		Royal Management Corp.	**	5,630	5,630	17
18	V	27	Management allocation - employee benefits		Royal Management Corp.	**	137,659	137,659	18
19	V	30	Depreciation		Royal Management Corp.	**	75,431	75,431	19
20	V	32	Interest		Royal Management Corp.	**	23,008	23,008	20
21	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,146	2,146	21
22	V	33	Property taxes		Royal Management Corp.	**	8,679	8,679	22
23	V	34	Rent expense		Royal Management Corp.	**	5,625	5,625	23
24	V	35	Equipment rental		Royal Management Corp.	**	2,294	2,294	24
25	V	17	Management fees	1,994,420	Royal Management Corp.	**		(1,994,420)	25
26	V	35	Auto Lease		Royal Management Corp.	**	2,560	2,560	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 1,994,420			$ 293,072	$ * (1,701,348)	39

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

Facility Name & ID Number Lexington of Orland Park # 0041855 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	30%	Lexington HC Ctr. of Lombard, Inc.	Lombard	Eastgate Manor of	Algonquin	Supportive Living	1
2	John Samatas Discretionary Trust	30%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Algonquin, LLC		Facility	2
3	Cynthia Thiem Discretionary Trust	30%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Lexington Square	Lombard	Independent and	3
4	Dean Sweitzer	10%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Life Care of		Assisted Living	4
5			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Lombard, LLC		Facility	5
6			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Life Care of		Living Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Elmhurst, LLC			8
9			Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Vesta Mgmt	Lombard	Mgmt Co.	9
10					Group, LLC			10
11					Lexington Health	Orland Park	Real Estate	11
12					Care System of		Property	12
13					Orland Park			13
14					Ltd. Ptsp.			14
15					Royal Mgmt	Lombard	Mgmt Co.	15
16					Corporation			16
17					Lexington Financial	Lombard	Finance Co.	17
18					Services, LLC			18
19					Samvest of	Lombard	Lessor	19
20					Lombard II, LLC			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 Orland Park # 0041855 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	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 14,509	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	10,627	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	12,863	L17, C7	3
4	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,451	L17, C7	4
5	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,646	L17, C7	5
6											6
7	Dean Sweitzer	Owner*	Administrative	10.00	171,121	5	10.00	Salary	27,918	L21, C7	7
8											8
9											9
10		* Dean Sweitzer is an owner only in Lexington Health Care Center of Orland Park, Inc. He is an employee									10
11		of Royal Management Corp. and provides administrative services to Royal Management Corp. His compensation									11
12		has been allocated to all 10 Lexington facilities.									12
13								TOTAL	$ 80,014		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 Orland Park # 0041855 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	$	101,748	$ 520	1
2	5	Utilities - gas & electric	Bed Days	725,412	10	61,939		101,748	8,688	2
3	5	Utilities - water & sewer	Bed Days	725,412	10	2,741		101,748	384	3
4	5	Utilities - maintenance office	Bed Days	725,412	10	8,424		101,748	1,182	4
5	6	Management allocation - salaries	Bed Days	725,412	10	698,068	698,068	101,748	97,913	5
6	6	Repairs & maintenance	Bed Days	725,412	10	77,933		101,748	10,931	6
7	6	Scavenger & exterminating	Bed Days	725,412	10	3,642		101,748	511	7
8	7	Management allocation - employe	Bed Days	725,412	10	110,922		101,748	15,558	8
9	10	Medical consultant	Bed Days	725,412	10	38,914		101,748	5,458	9
10	10	Management allocation - salaries	Bed Days	725,412	10	358,188	358,188	101,748	50,240	10
11	15	Management allocation - employe	Bed Days	725,412	10	56,916		101,748	7,983	11
12	17	Management allocation - salaries	Bed Days	725,412	10	371,421	371,421	101,748	52,096	12
13	19	Computer consultant & supplies	Bed Days	725,412	10	174,999		101,748	24,546	13
14	19	Professional fees	Bed Days	725,412	10	64,806		101,748	9,090	14
15	20	Dues & subscriptions	Bed Days	725,412	10	11,884		101,748	1,667	15
16	20	Advertising - help wanted	Bed Days	725,412	10	146,469		101,748	20,544	16
17	21	Management allocation - salaries	Bed Days	725,412	10	5,805,098	5,805,098	101,748	814,237	17
18	21	Bank charges	Bed Days	725,412	10	32,134		101,748	4,507	18
19	21	Office supplies & printing	Bed Days	725,412	10	102,249		101,748	14,342	19
20	21	Postage	Bed Days	725,412	10	41,415		101,748	5,809	20
21	21	Telephone	Bed Days	725,412	10	120,819		101,748	16,946	21
22	23	Inservice Training	Bed Days	725,412	10	9,785		101,748	1,372	22
23	24	Travel and Seminar	Bed Days	725,412	10	29,058		101,748	4,076	23
24										24
25	TOTALS					$ 8,331,531	$ 7,232,775		$ 1,168,600	25

Facility Name & ID Number Lexington of Orland Park # 0041855 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	$	101,748	$ 25,964	1
2	26	Insurance general	Bed Days	725,412	10	40,142		101,748	5,630	2
3	27	Management allocation - employe	Bed Days	725,412	10	981,440		101,748	137,659	3
4	30	Depreciation	Bed Days	725,412	10	537,783		101,748	75,431	4
5	32	Interest	Bed Days	725,412	10	164,037		101,748	23,008	5
6	32	Amortization of mortgage costs	Bed Days	725,412	10	15,301		101,748	2,146	6
7	33	Property taxes	Bed Days	725,412	10	61,875		101,748	8,679	7
8	34	Rent expense	Bed Days	725,412	10	40,101		101,748	5,625	8
9	35	Equipment rental	Bed Days	725,412	10	16,356		101,748	2,294	9
10	35	Auto Lease	Bed Days	725,412	10	18,252		101,748	2,560	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	$		$ 288,996	25

Facility Name & ID Number Lexington of Orland Park # 0041855 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 Services						$	$			$	1
2	L.L.C.	X		Mortgage	Varies	5/22/08	11,354,000	10,249,532	1/1/2033	Variable	623,163	2
3												3
4												4
5							Interest on Financing Insurance Premium				1,952	5
	Working Capital											
6	Bank of America		X	Line of Credit	Varies	9/30/12	13,700,000	1,730,000	9/30/13	Prime/Libor	44,010	6
7	Shareholder loan	X		Working capital	Varies	5/3/12	400,000	449,000	Demand	Prime	9,492	7
8												8
9	TOTAL Facility Related						$ 25,454,000	$ 12,428,532			$ 678,617	9
	B. Non-Facility Related*											
10								Amortization of Mortgage Cost			3,866	10
11								Interest Income Offset			(3,884)	11
12								Shareholder Interest			(9,492)	12
13								Allocated from Management Co.			25,154	13
14	TOTAL Non-Facility Related						$	$			$ 15,644	14
15	TOTALS (line 9+line14)						$ 25,454,000	$ 12,428,532			$ 694,261	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 Orland Park # 0041855 **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.**	$ 576,000	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	$ 595,423	2
3. Under or (over) accrual (line 2 minus line 1).		$ 19,423	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 614,400	4
	Allocated from Mgmt. Co.	8,679	
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.)**		$ 12,700	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** $ (51,466) **For** 2009 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (51,466)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 603,736	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	489,435	8
	2008	492,801	9
	2009	549,706	10
	2010	559,216	11
	2011	595,423	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 Orland Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

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.	27-10-100-099-0000	Land & Building	$ 595,422.95	$ 595,422.95
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-021	Land & Building	$ 230,165.98	$ 8,679.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 825,588.93	$ 604,101.95

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 Orland Park # 0041855 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block & Steel Number of Stories 3

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

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

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

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

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

N/A

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

1. Total Amount Incurred:
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	152,460	1995	$ 776,408	1
2	Management Company Allocation			26,547	2
3	TOTALS	152,460		$ 802,955	3

Facility Name & ID Number Lexington of Orland Park # 0041855 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	250		1996	1996	$ 8,569,286	$	40	$ 214,232	$ 214,232	$ 3,532,256	4
5	10		1998	1998	63,790	1,595	40	1,595		22,327	5
6	18		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Electrical wiring			1996	2,304	58	40	58		933	9
10	Paving			1997	11,589		40	385	385	11,589	10
11	Wiring			1998	3,932		40			3,932	11
12	Additional building costs - 10 bed addition			1999	1,808	45	10	45		632	12
13	Seal/restrip parking lot			1999	3,450	230	40	230		3,105	13
14	Wiring			1999	1,798	45	15	45		607	14
15	Roof repairs			2000	23,201	1,547	40	1,547		19,336	15
16	Electrical wiring			2000	5,732	164	15	164		2,048	16
17	Ceiling mount curtain rod hardware			2000	6,952	199	35	199		2,485	17
18	Automatic door closer/sensors			2000	3,624	242	35	242		3,022	18
19	Seal and restripe parking lot			2001	2,277		15			2,277	19
20	HVAC control			2001	2,548		10			2,548	20
21	Infrared curtains for elevator doors			2001	4,500		10			4,500	21
22	Fire alarm panel			2002	5,120	256	10	256		5,120	22
23	Parking lot lights			2002	9,975	497	10	497		9,975	23
24	Chiller room compressor			2002	8,879		10			8,879	24
25	Carpeting			2002	7,038		5			7,038	25
26	Pave and seal parking lot			2005	4,180	209	5	209		1,533	26
27	HVAC			2005	6,143	307	20	307		2,175	27
28	Electrical wiring			2005	3,637	182	20	182		1,304	28
29	Kitchen rehab			2005	6,360	318	20	318		2,464	29
30	Elevator rehab			2005	8,948	447	20	447		3,428	30
31	Lounge, lobby, and reception area rehab			2005	27,662	1,383	20	1,383		9,912	31
32	Landscaping enhancements			2006	5,795	386	20	386		2,445	32
33	HVAC			2006	9,300	465	15	465		2,829	33
34	LHI-therapy room rehab LL TCU/main therapy			2006	33,184	1,659	20	1,659		10,507	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Orland Park # 0041855 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	Landscaping	2007	$ 17,383	$ 1,159	15	$ 1,159	$	$ 6,278	37
38	Parking lot	2007	1,120	56	20	56		299	38
39	Plumbing-Fine Dining	2007	2,068	103	20	103		610	39
40	Laundry Room Rehab	2007	37,283	1,864	20	1,864		10,718	40
41	Employee lunch room	2007	2,865	143	20	143		822	41
42	Basement Renovation	2007	1,148	57	20	57		309	42
43	Patio Improvements	2007	7,000	350	20	350		1,838	43
44	1st floor remodel-carpentry, flooring, plumbing, electrical-	2007	1,481,886		40	37,426	37,426	202,725	44
45	fixtures, painting	2007							45
46									46
47	Basement Renovation	2007	20,191	1,010	20	1,010		5,046	47
48	Therapy Room Renovation	2007	978	49	20	49		245	48
49	Landscaping	2008	4,300	287	15	287		1,172	49
50	Spot Coolers	2008	3,790	189	20	189		756	50
51	Emergency A/C	2008	32,295	807	40	807		3,564	51
52	Plumbing & Sprinkler-Showers	2008	5,047	126	40	126		504	52
53	Parking lot repairs	2008	5,285	264	20	264		1,210	53
54	Phone closet	2008	5,954	149	40	149		683	54
55	Landscaping	2009	4,190	279	15	279		860	55
56	1st floor admin room-heating, fire protection	2009	16,422	821	20	821		3,010	56
57	Quick connectors	2009	7,091	355	20	355		1,183	57
58	Electrical Room	2009	4,692	235	20	235		705	58
59	Glass and Mirrors Med Room	2009	4,954	142	35	142		497	59
60	Key pad common areas	2009	3,757	107	35	107		402	60
61	2nd Floor remodel-Doors and Locks	2009	32,130	803	40	803		3,011	61
62	Patio Pergola	2009	7,930	529	15	529		1,719	62
63	Patio Fence	2009	11,293	712	15	712		2,195	63
64	2nd floor remodel-carpentry,flooring,electrical,painting	2009	1,014,056		27	36,875	36,875	147,500	64
65	2nd floor remodel-carpentry	2009	17,258		27	628	628	2,459	65
66	Office carpentry,flooring,electrical,painting,plumbing	2010	70,270	3,806	27	3,806		7,612	66
67	Landscaping	2010	11,399	760	15	760		1,710	67
68	Physican office carpentry	2010	2,926	106	27	106		212	68
69	Repave/Seal Cracks in parking lot	2010	21,817	1,091	20	1,091		2,545	69
70	TOTAL (lines 4 thru 69)		$ 11,701,790	$ 26,593		$ 316,139	$ 289,546	$ 4,091,605	70

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

Facility Name & ID Number Lexington of Orland Park # 0041855 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		$ 11,701,790	$ 26,593		$ 316,139	$ 289,546	$ 4,091,605	1
2	Roof	2010	74,000	2,691	27	2,691		6,952	2
3	HVAC-Exhaust Modification	2010	4,202	153	27	153		331	3
4	Nurse pull cord station	2010	3,933	143	27	143		286	4
5	Paint lights over bed	2010	7,738	281	27	281		586	5
6	Trench/Awning	2010	11,666	424	27	424		938	6
7	Remodel Library/Lounge-art,flooring,carpentry	2010	4,120	150	27	150		300	7
8	3rd floor remodel-carpentry,electrical,plumbing	2010	868,783		27	67,183	67,183	162,359	8
9									9
10	Office-carpentry, flooring, electrical, painting, plumbing and signs	2011	6,710	244	27	244		366	10
11	Office Remodel- Doors and Locks	2011	31,324	1,139	27	1,139		1,993	11
12	Office Remodel- Doors and Locks	2011	5,282	192	27	192		352	12
13	Additional parking spaces	2011	196,376	7,141	27	7,141		8,926	13
14	Roof Repairs	2011	58,800	2,138	27	2,138		3,207	14
15	Fire Dampers	2011	5,586	203	27	203		220	15
16	Pantry Remodel - Millwork and Flooring	2011	3,730	136	27	136		159	16
17	Laundry Room Remodel - Flooring, Painting and Electrical	2011	9,172	334	27	334		417	17
18	2nd Floor Remodel - Doors	2011	12,612	459	27	459		612	18
19									19
20	Parking lot	2012	12,906	39	27	39		39	20
21	Chiller replacement kitchen	2012	108,732	1,647	27	1,647		1,647	21
22									22
23									23
24	Reconcile to book depreciation			742			(742)		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)		$ 13,127,462	$ 44,849		$ 400,836	$ 355,987	$ 4,281,295	34

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

Facility Name & ID Number Lexington of Orland Park # 0041855 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		$ 13,127,462	$ 44,849		$ 400,836	$ 355,987	$ 4,281,295	1
2	Building - management company	2002	367,348		40	11,472	11,472	119,285	2
3	HVAC, electrical, security system - management company	2003	3,225		30	845	845	2,105	3
4	Key card system - management company	2004	505		20	27	27	213	4
5	VAV TX controls - management company	2005	156		20	8	8	60	5
6	Interior Signs - Management Company	2006	114		20	8	8	47	6
7	Building improvements - management company	2008	17,798		20	980	980	4,818	7
8	Building improvements - management company	2009	3,322		15	65	65	624	8
9	Building improvements - management company	2010	3,238		15	141	141	546	9
10	Building improvements - management company	2011	2,287		15	112	112	156	10
11	Building improvements - management company	2012	7,900		15	2	2	181	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	TOTAL (lines 1 thru 33)		$ 13,533,355	$ 44,849		$ 414,496	$ 369,647	$ 4,409,330	34

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

Facility Name & ID Number Lexington of Orland Park # 0041855 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	$ 1,455,362	$ 128,091	$ 217,999	$ 89,908	5	$ 934,338	71
72	Current Year Purchases	169,696	24,712	24,712		5	24,712	72
73	Fully Depreciated Assets	95,888				5	95,888	73
74	Allocated from Mgmt. Co.	646,126		55,520	55,520	5	373,035	74
75	TOTALS	$ 2,367,072	$ 152,803	$ 298,231	$ 145,428		$ 1,427,973	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.			63,059		6,251	6,251	5	50,205	79
80	TOTALS			$ 63,059	$	$ 6,251	$ 6,251		$ 50,205	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)	$ 16,766,441	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 197,652	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 718,978	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 521,326	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,887,508	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Lexington of Orland Park # 0041855 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	Parking space lease				2,500			5
6	Allocated from Management Company				5,625			6
7	TOTAL				$ 8,125 **			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: $ 105,874 Description: Copier-$13,221;Printer-$1,295;Mailing-$186;Med Equip-$36,096;Oxygen-$52,782;Alloc. Mgmt Co.-$2,294
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20	Allocated from Management Company			2,560	20
21	TOTAL		$	$ 2,560	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 Orland Park # 0041855 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 Orland Park # 0041855 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	$	15,470	$ 772,345	$	15,470	$ 772,345	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		6,509	301,877		6,509	301,877	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		14,959	916,447		14,959	916,447	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				672,347		672,347	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Ambulance	39(3)				3,540			3,540	13
14	TOTAL			$	36,938	$ 1,994,209	$ 672,347	36,938	$ 2,666,556	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 of Orland Park # 0041855 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	$ 663,053	$ 760,148	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,116,174)	7,324,245	7,324,245	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)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,987,298	$ 8,084,393	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	114,386	114,386	12
13	Land		802,955	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	1,161,832	4,964,069	15
16	Equipment, at Historical Cost	988,894	2,430,131	16
17	Accumulated Depreciation (book methods)	(711,962)	(5,887,508)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Mortgage cost net		78,811	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,553,150	$ 11,072,130	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,540,448	$ 19,156,523	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 873,210	$ 873,210	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,179,000	2,179,000	29
30	Accrued Salaries Payable	360,822	360,822	30
31	Accrued Taxes Payable (excluding real estate taxes)	190,729	190,729	31
32	Accrued Real Estate Taxes(Sch.IX-B)		614,400	32
33	Accrued Interest Payable		43,697	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	8,049,628	7,610,205	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 11,653,389	$ 11,872,063	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,249,532	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)**	$	$ 10,249,532	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,653,389	$ 22,121,595	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,112,941)	$ (2,965,072)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,540,448	$ 19,156,523	48

***(See instructions.)**

Lexington Health Care Center of Orland Park
Provider # 0041855
1/1/12-12/31/12

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Medicare Payment Voucher Recon		
Due to Merit Hospice	40,000	40,000
Pa Audit Settlement	257,466	257,466
Professional Liabilities Claims	2,471,998	2,471,998
Due To / From Rehab Care Therapy	36,121	36,121
Due from LLC		2,643
Prepaid Insurance	52,298	52,298
Escrow-Insurance	351,852	351,852
401k Withholding	336	336
Accrued Expenses	124,742	124,742
Accrued Royl / Vesta Mgmt Fees	1,441,640	1,441,640
Accrued Rent	2,647,120	-
Accrued Insurance	172,916	172,916
Due To Patient Trust Fund	46,275	46,275
Advance - Biweekly Part A Paym	(48,688)	(48,688)
Uncollectible Part A Co Pvts	(73,284)	(73,284)
Deferred Income	450,531	450,531
Due To - Royal Operations	78,865	78,865
Due To Republic	(560)	(560)
Interest Rate Swap Liability		2,205,054
	8,049,628	7,610,205

Facility Name & ID Number Lexington of Orland Park # 0041855 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**	$ 240,724	1
2	Restatements (describe):		2
3	**Post closing adjustment**	(433,173)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (192,449)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,920,492)	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	( )	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)**	$ (1,920,492)	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)**	$ (2,112,941)	24 *

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

Facility Name & ID Number Lexington of Orland Park # 0041855 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	$ 24,452,145	1
2	Discounts and Allowances for all Levels	(12,224,350)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,227,795	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,590,536	6
7	Oxygen	11,560	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,602,096	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	818	12
13	Barber and Beauty Care	29,870	13
14	Non-Patient Meals	85	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	631,000	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	257,848	19
20	Radiology and X-Ray		20
21	Other Medical Services	266,790	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,186,411	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,884	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,884	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income/Recovery of bad debt write off	(117)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (117)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,020,069	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,976,303	31
32	Health Care	7,519,622	32
33	General Administration	5,090,812	33
	B. Capital Expense		
34	Ownership	2,754,243	34
	C. Ancillary Expense		
35	Special Cost Centers	3,043,202	35
36	Provider Participation Fee	556,379	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,940,561	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,920,492)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,920,492)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,188,244	44
45	Private Pay - Net Inpatient Revenue	1,512,079	45
46	Medicare - Net Inpatient Revenue	2,840,144	46
47	Other-(specify) Managed Care	687,328	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,227,795	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 Orland Park # 0041855 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	2,123	2,473	$ 152,007	$ 61.47	1
2	Assistant Director of Nursing	39,412	46,943	1,274,913	27.16	2
3	Registered Nurses	24,218	29,387	872,682	29.70	3
4	Licensed Practical Nurses	58,664	70,647	1,800,578	25.49	4
5	CNAs & Orderlies	151,473	163,874	2,056,615	12.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,937	17,859	198,777	11.13	10
11	Social Service Workers	6,865	7,959	150,131	18.86	11
12	Dietician	2,756	3,154	63,108	20.01	12
13	Food Service Supervisor	1,773	2,004	42,425	21.17	13
14	Head Cook	1,773	2,004	33,687	16.81	14
15	Cook Helpers/Assistants	9,394	10,933	110,784	10.13	15
16	Dishwashers	17,465	20,022	172,778	8.63	16
17	Maintenance Workers	3,408	4,256	66,561	15.64	17
18	Housekeepers	34,857	41,740	390,899	9.37	18
19	Laundry	5,188	6,397	58,210	9.10	19
20	Administrator	1,855	2,289	169,803	74.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,363	14,652	248,364	16.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,005	2,396	38,683	16.14	31
32	Other Health C: Memory Care	3,444	3,986	87,967	22.07	32
33	Other(specify) Marketing	4,182	4,646	145,890	31.40	33
34	TOTAL (lines 1 - 33)	397,155	457,621	$ 8,134,862 *	$ 17.78	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	152	$ 16,604	1(3)	35
36	Medical Director	Monthly	104,610	9(3)	36
37	Medical Records Consultant	21	1,128	10(3)	37
38	Nurse Consultant	Monthly	123,326	10(3)	38
39	Pharmacist Consultant	11	14,703	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	104	5,446	11(3)	44
45	Social Service Consultant	12	4,869	12(3)	45
46	Other(specify)				46
47	Pulmonary Consulting	Monthly	113,013	10(3)	47
48	Medical Consultant	Monthly	5,458	10(7)	48
49	TOTAL (lines 35 - 48)	300	$ 389,157		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Saggese	Administrator	0	$ 169,803
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,803

B. Administrative - Other

Description	Amount
MANAGEMENT FEES-ROYAL OPERATNS	$ 1,426,529
MANAGEMENT FEES- VESTA MGMT	567,891
Eliminated in col. 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,994,420
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center	Collections	$ 2,913
Cassiday Schade, LLP	Legal	191,340
Illinois Secretary of State	Accounting	423
McGladrey LLP	Accounting	42,653
Duane Morris	Legal	3,719
Much Shelist	Legal	6,754
Personnel Planners	U/C Consulting	5,915
Kamensky Rubins	Legal	12,688
Serpico, Novelle, Petrosino LTD	Legal	12,157
Pension Administrators	Pension Administration	745
McCracken & Frank	Legal	351
See Sch 21C		153,396
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 433,054

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 173,143
Unemployment Compensation Insurance	344,617
FICA Taxes	601,640
Employee Health Insurance	242,960
Employee Meals	22,299
Illinois Municipal Retirement Fund (IMRF)*	
401K	5,504
Other Employee Benefits	68,513
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,458,676

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	9,969
Health Care Worker Background Check	
(Indicate # of checks performed 284)	3,408
Patient Background Checks 899	10,792
Miscellaneous Licenses & Fees	4,833
Miscellaneous Dues & Subscriptions	1,685
Less: Marketing Dues and Subscriptions	(617)
Management Company Allocation	22,211
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,271

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Management Company Allocation	4,076
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,076

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Orland Park
Provider # 0041855
1/1/12-12/31/12

Section XIX.

Schedule 21C

C. Professional Fees

Vendor/Payee	Type	Amount
Standard and Poor	Financial	950
Ability Network Inc.	Computer Consulting	1,472
Americorp Financial	Computer Consulting	64,002
Curaspan	Computer Consulting	2,750
EFAX Corporate	Computer Consulting	1,162
E-Health Data Solutions	Computer Consulting	2,400
Eltron Designs	Computer Consulting	260
Facility Wizard	Computer Consulting	358
Health MedX	Computer Consulting	19,072
Information Control	Computer Consulting	1,537
Kronos	Computer Consulting	1,392
Lintech LLC	Computer Consulting	4,391
MicroSoft Licensing GP	Computer Consulting	8,728
MY Innerview	Computer Consulting	6,335
National Datacare	Computer Consulting	2,597
On Shift	Computer Consulting	8,017
Oracle	Computer Consulting	8,927
Paragon Clinical	Computer Consulting	1,200
Realmed	Computer Consulting	134
Relias Learning LLC	Computer Consulting	3,864
SilverChair Learning Systems	Computer Consulting	3,864
Softchoice	Computer Consulting	963
Telemedicine Solutions	Computer Consulting	7,200
Topnotch	Computer Consulting	109
Trisys Inc.	Computer Consulting	140
Tympani	Computer Consulting	1,444
Virtual Rabbit	Computer Consulting	10

XO Communications	Computer Consulting	118
		153,396
Total Schedule V, line 19, column 3		433,054
Less Collection fees		(2,913)
Out of period legal		(19,273)
Allocated from Sambell of Orland Park		
Secretary of State		406
Samvest of Lombard		
Accounting		360

Allocated from Mgmt Co.

Much Shelist	Legal	779
Duane Morris	Legal	51
Cassiday Schade	Legal	2
McGladrey LLP	Accounting	1,860
Illinois Secretary of State	Filing Fees	44
Gilson Labus & Silverman	KEP	521
Tam Kaiden	Investigative Services	66
Bank of America Leasing	UCC Search & Filing	27
Versight Inc.	Annual Report-Health Ins	154
Personnel Planners	U/C Consultant	27
LaSalle Network	Recruiting/Finance	1,969
Pension Administrators, Inc.	401K Administration	380
Gene Whitehorn	Medicaid Reimb Specialist	1,506
Christine Toolan	Social Service Consulting	24
M Werner Consulting	Financial Consultant	1,319
Computer Services	Computer Consulting	24,546
		33,275
Total Schedule V, line 19, column 8		444,909

Facility Name & ID Number Lexington of Orland Park # 0041855 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 Orland Park # 0041855 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. $ **102,739** 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. $ **556,379**
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. $ **22,299** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **85**

(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.