FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

I. IDPH License ID Number: 0028860

Facility Name: Lexington Hlth Cr Ctr Lombrd

Address: 2100 S Finley Road (Number) Lombard (City) 60148 (Zip Code)

County: Dupage

Telephone Number: (630) 495-4000 **Fax #** (630) 495-2809

HFS ID Number:

Date of Initial License for Current Owners: 10/09/84

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 01/01/14 to 12/31/14 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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	224	Skilled (SNF)	224	81,760	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	224	TOTALS	224	81,760	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			15,445	15,445	8
9	SNF/PED					9
10	ICF	38,454	11,244		49,698	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,454	11,244	15,445	65,143	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.68%

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 10/9/84

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 215 and days of care provided 11,503

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	478,547	39,602	2,184	520,333		520,333		520,333			1
2	Food Purchase		411,704		411,704		411,704	(19,388)	392,316			2
3	Housekeeping	385,244	38,964		424,208		424,208	293	424,501			3
4	Laundry	66,116	25,028		91,144		91,144		91,144			4
5	Heat and Other Utilities			275,747	275,747		275,747	8,769	284,516			5
6	Maintenance	20,850		187,585	208,435		208,435	78,238	286,673			6
7	Other (specify):* Mgmt Co.-Allocated I							11,980	11,980			7
8	TOTAL General Services	950,757	515,298	465,516	1,931,571		1,931,571	79,892	2,011,463			8
	B. Health Care and Programs											
9	Medical Director			57,150	57,150		57,150		57,150			9
10	Nursing and Medical Records	4,972,196	416,366	134,065	5,522,627		5,522,627	52,539	5,575,166			10
10a	Therapy											10a
11	Activities	251,065	20,006	9,643	280,714		280,714		280,714			11
12	Social Services	117,331		3,817	121,148		121,148		121,148			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co.-Allocated I							7,178	7,178			15
16	TOTAL Health Care and Programs	5,340,592	436,372	204,675	5,981,639		5,981,639	59,717	6,041,356			16
	C. General Administration											
17	Administrative	118,785		1,672,465	1,791,250		1,791,250	(1,611,237)	180,013			17
18	Directors Fees											18
19	Professional Services			366,109	366,109		366,109	9,432	375,541			19
20	Dues, Fees, Subscriptions & Promotions			45,221	45,221		45,221	15,425	60,646			20
21	Clerical & General Office Expenses	209,393	23,174	52,500	285,067		285,067	696,735	981,802			21
22	Employee Benefits & Payroll Taxes			1,169,318	1,169,318		1,169,318	19,268	1,188,586			22
23	Inservice Training & Education			6,245	6,245		6,245	882	7,127			23
24	Travel and Seminar							1,812	1,812			24
25	Other Admin. Staff Transportation			5,147	5,147		5,147	16,235	21,382			25
26	Insurance-Prop.Liab.Malpractice			508,500	508,500		508,500	11,904	520,404			26
27	Other (specify):* Mgmt Co.-Allocated I							112,186	112,186			27
28	TOTAL General Administration	328,178	23,174	3,825,505	4,176,857		4,176,857	(727,358)	3,449,499			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,619,527	974,844	4,495,696	12,090,067		12,090,067	(587,749)	11,502,318			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 Hlth Cr Ctr Lombrd #0028860 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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			236,909	236,909		236,909	322,940	559,849			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,270	31,270		31,270	(4,098)	27,172			32
33	Real Estate Taxes							209,983	209,983			33
34	Rent-Facility & Grounds			1,653,854	1,653,854		1,653,854	(1,648,936)	4,918			34
35	Rent-Equipment & Vehicles			91,384	91,384		91,384	2,788	94,172			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,013,417	2,013,417		2,013,417	(1,117,323)	896,094			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		534,705	1,535,629	2,070,334		2,070,334		2,070,334			39
40	Barber and Beauty Shops	18,746		5,699	24,445		24,445		24,445			40
41	Coffee and Gift Shops			142	142		142		142			41
42	Provider Participation Fee			441,569	441,569		441,569		441,569			42
43	Other (specify):* **Non-Allowable Cos**	137,377		161,616	298,993		298,993	(298,993)				43
44	**TOTAL Special Cost Centers**	156,123	534,705	2,144,655	2,835,483		2,835,483	(298,993)	2,536,490			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,775,650	1,509,549	8,653,768	16,938,967		16,938,967	(2,004,065)	14,934,902			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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(120)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,562)	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	1,258	30		9
10	Interest and Other Investment Income	(95,085)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,487)	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	(22,008)	43		18
19	Entertainment				19
20	Contributions	(3,250)	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	(19,471)	43		24
25	Fund Raising, Advertising and Promotional	(29,033)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(20,724)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(236,866)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (445,348)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,558,717)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,558,717)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,004,065)		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 Hlth Cr Ctr Lombrd

ID# **0028860**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics managed care	$ (5,572)	43	1
2	Labs - Part A	(16,226)	43	2
3	X-Rays - Part A	(25,263)	43	3
4	Marketing Salary	(137,377)	43	4
5	Trust Fees	(505)	43	5
6	Collections	(455)	19	6
7	Out of period legal	(17,376)	19	7
8	Education & Seminar Marketing	(20)	43	8
9	Reclass LHI under 2,500 to R&M	(220)	30	9
10	Salesforce.com Martketing Offset	(5,004)	19	10
11	State Replacement Tax	(16,995)	43	11
12	Lombard Area Chamber of Commerce	(795)	20	12
13	Reclass Repairs & Maintenance to LHI	(7,521)	06	13
14	Misc Income	(3,538)	21	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**	(236,866)		49

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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-Supplemen		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	$ 200	$ 200	1
2	V	30	Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	243,926	243,926	2
3	V	32	Interest Expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	72,475	72,475	3
4	V	33	Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	201,854	201,854	4
5	V	34	Rental Expense	1,653,854	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**		(1,653,854)	5
6	V	43	State Replacement Tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	16,995	16,995	6
7	V	43	Trust Fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	505	505	7
8	V								8
9	V								9
10	V								10
11	V				** The owners of Lexington Health Care Center of Lombard, Inc. own				11
12	V				100% of Lexington Health Care Systems of Lombard Limted Partnership.				12
13	V								13
14	Total			$ 1,653,854			$ 535,955	$ * (1,117,899)	14

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.	**	$ 293	$ 293	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	7,646	7,646	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	342	342	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	781	781	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	78,815	78,815	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	6,908	6,908	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	36	36	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	11,980	11,980	22
23	V	10	Medical consultant		Royal Management Corp.	**	5,314	5,314	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	47,225	47,225	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	7,178	7,178	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	61,228	61,228	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	17,533	17,533	27
28	V	19	Professional fees		Royal Management Corp.	**	14,534	14,534	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	2,367	2,367	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	2,461	2,461	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	676,838	676,838	31
32	V	21	Bank charges		Royal Management Corp.	**	2,741	2,741	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	13,853	13,853	33
34	V	21	Postage		Royal Management Corp.	**	4,906	4,906	34
35	V	21	Telephone		Royal Management Corp.	**	13,327	13,327	35
36	V								36
37	V								37
38	V		** The owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 976,306	$ * 976,306	39

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	23	Inservice Training	$	Royal Management Corp.	**	$ 882	$ 882	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,812	1,812	16
17	V	25	Auto expense		Royal Management Corp.	**	16,235	16,235	17
18	V	26	Insurance general		Royal Management Corp.	**	11,904	11,904	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	112,186	112,186	19
20	V	30	Depreciation		Royal Management Corp.	**	77,975	77,975	20
21	V	32	Interest		Royal Management Corp.	**	15,799	15,799	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,713	2,713	22
23	V	33	Property taxes		Royal Management Corp.	**	8,129	8,129	23
24	V	34	Rent expense		Royal Management Corp.	**	4,918	4,918	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,585	1,585	25
26	V	17	Management fees	1,672,465	Royal Management Corp.	**		(1,672,465)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,203	1,203	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		** The owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 1,672,465			$ 255,341	$ * (1,417,124)	39

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	33.33%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas	33.33%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem	33.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Vesta Mgmt	Lombard	Mgmt. Company	3
4			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Group, LLC			4
5			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Lexington Square	Lombard	Independent and	5
6			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Life Care of		Assisted Living	6
7			Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Lombard, LLC		Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Lexington Square	Elmhurst	Independent	8
9			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Life Care of		Living Facility	9
10					Elmhurst, LLC			10
11					Lexington Health	Lombard	Real Estate	11
12					Care Systems of		Property	12
13					Lombard Ltd. Pts			13
14					Royal Management	Lombard	Mgmt Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance Company	16
17					Services, LLC			17
18					Heron Point	Lombard	Mgmt Company	18
19					Management Corp.			19
20					Samvest of	Lombard	Lessor	20
21					Lombard II, LLC			21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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					Sambell of	Bloomingdale	Real Estate	1
2					Bloomingdale Ltd. Ptsp.		Property	2
3								3
4					Sambell of Chicago	Chicago Ridge	Real Estate	4
5					Ridge Ltd. Ptsp.		Property	5
6								6
7					Sambell of	Elmhurst	Real Estate	7
8					Elmhurst II Ltd. Ptsp.		Property	8
9								9
10					Sambell of	LaGrange	Real Estate	10
11					LaGrange Ltd. Ptsp.		Property	11
12								12
13					Lexington Health	Lake Zurich	Real Estate	13
14					Care Systems of		Property	14
15					Lake Zurich Ltd. Ptsp.			15
16								16
17					Lexington Health	Orland Park	Real Estate	17
18					Care Systems of		Property	18
19					Orland Park Ltd. Ptsp.			19
20								20
21					Sambell of	Schaumburg	Real Estate	21
22					Schaumburg Ltd. Ptsp.		Property	22
23								23
24					Sambell of	Streamwood	Real Estate	24
25					Streamwood Ltd. Ptsp.		Property	25
26								26
27					Lexington Health	Wheeling	Real Estate	27
28					Care Systems of		Property	28
29					Wheeling Ltd. Ptsp.			29
30								30

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 10,753	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,836	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,817	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	12,759	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	20,063	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 61,228		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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	723,430	10	$ 2,591	$	81,760	$ 293	1
2	5	Utilities - gas & electric	Bed Days	723,430	10	67,650		81,760	7,646	2
3	5	Utilities - water & sewer	Bed Days	723,430	10	3,027		81,760	342	3
4	5	Utilities - maintenance office	Bed Days	723,430	10	6,910		81,760	781	4
5	6	Management allocation - salaries	Bed Days	723,430	10	697,374	697,374	81,760	78,815	5
6	6	Repairs & maintenance	Bed Days	723,430	10	61,125		81,760	6,908	6
7	6	Scavenger & exterminating	Bed Days	723,430	10	320		81,760	36	7
8	7	Management allocation - employe	Bed Days	723,430	10	106,001		81,760	11,980	8
9	10	Medical consultant	Bed Days	723,430	10	47,016		81,760	5,314	9
10	10	Management allocation - salaries	Bed Days	723,430	10	417,860	417,860	81,760	47,225	10
11	15	Management allocation - employe	Bed Days	723,430	10	63,515		81,760	7,178	11
12	17	Management allocation - salaries	Bed Days	723,430	10	541,757	541,757	81,760	61,228	12
13	19	Computer consultant & supplies	Bed Days	723,430	10	155,132		81,760	17,533	13
14	19	Professional fees	Bed Days	723,430	10	128,599		81,760	14,534	14
15	20	Dues & subscriptions	Bed Days	723,430	10	20,945		81,760	2,367	15
16	20	Advertising - help wanted	Bed Days	723,430	10	21,776		81,760	2,461	16
17	21	Management allocation - salaries	Bed Days	723,430	10	5,988,811	5,988,811	81,760	676,838	17
18	21	Bank charges	Bed Days	723,430	10	24,252		81,760	2,741	18
19	21	Office supplies & printing	Bed Days	723,430	10	122,570		81,760	13,853	19
20	21	Postage	Bed Days	723,430	10	43,413		81,760	4,906	20
21	21	Telephone	Bed Days	723,430	10	117,921		81,760	13,327	21
22										22
23										23
24										24
25	TOTALS					$ 8,638,565	$ 7,645,802		$ 976,306	25

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	23	Inservice Training	Bed Days	723,430	10	$ 7,807	$	81,760	$ 882	1
2	24	Travel and Seminar	Bed Days	723,430	10	16,032		81,760	1,812	2
3	25	Auto expense	Bed Days	723,430	10	143,653		81,760	16,235	3
4	26	Insurance general	Bed Days	723,430	10	105,333		81,760	11,904	4
5	27	Management allocation - employe	Bed Days	723,430	10	992,646		81,760	112,186	5
6	30	Depreciation	Bed Days	723,430	10	689,938		81,760	77,975	6
7	32	Interest	Bed Days	723,430	10	139,794		81,760	15,799	7
8	32	Amortization of mortgage costs	Bed Days	723,430	10	24,007		81,760	2,713	8
9	33	Property taxes	Bed Days	723,430	10	71,926		81,760	8,129	9
10	34	Rent expense	Bed Days	723,430	10	43,516		81,760	4,918	10
11	35	Equipment rental	Bed Days	723,430	10	14,023		81,760	1,585	11
12	35	Auto Lease	Bed Days	723,430	10	10,648		81,760	1,203	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					$ 2,259,323	$		$ 255,341	25

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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							$	$			$	1
2												2
3												3
4								Finance Charge - Insurance Policy			1,362	4
5												5
	Working Capital											
6	Bank of America		X	Line of Credit	Varies	4/30/12	2,500,000	250,000	9/30/15	Prime/Libor	14,380	6
7	Shareholder Loan	X		Capital Improvements	Varies	7/16/08	499,000	499,000	Demand	Prime	15,529	7
8	Shareholder Loan	X		Working Capital	Varies	4/30/08	2,230,000	2,230,000	Demand	Prime	72,475	8
9	TOTAL Facility Related						$ 5,229,000	$ 2,979,000			$ 103,745	9
	B. Non-Facility Related*											
10								Interest Income Offset			(7,081)	10
11								Offset of Shareholder Interest			(88,004)	11
12								Amortization of mortgage cost			2,713	12
13								Allocation of Management Costs			15,799	13
14	TOTAL Non-Facility Related						$	$			$ (76,573)	14
15	TOTALS (line 9+line14)						$ 5,229,000	$ 2,979,000			$ 27,172	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 Hlth Cr Ctr Lombrd # 0028860 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 178,800	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.)	2013	$ 187,527	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,727	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 193,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
	Allocated from Managment Co.	8,129	
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** $ 73 **For** 2013 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (73)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 209,983	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	146,768	8
	2010	140,430	9
	2011	178,187	10
	2012	188,895	11
	2013	187,527	12

See attached real estate accrual sheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Hlth Cr Ctr Lombrd COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0028860

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-19-307-002		$ 187,527.04	$ 187,527.04
2.	Royal Management Corp. (Samvest of Lombard II)		$ 282,411.00	$ 8,129.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 469,938.04	$ 195,656.04

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,770 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).

Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square fee

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	30,000	1984	$ 616,761	1
2	Management Company Allocation			22,398	2
3	TOTALS	30,000		$ 639,159	3

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	215		1984	1984	$ 3,661,472	$	35	$ 104,614	$ 104,614	$ 3,162,377	4
5	9		1995	1995	284,156	8,119	35	8,119		150,197	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1990	96,219		10			96,218	9
10	Leasehold Improvements Additions			1995	71,493		10			71,493	10
11	Building Improvements			1994	20,200		10			20,200	11
12	Building Improvements			1995	14,535	415	35	415		8,096	12
13	Building Improvements - dishwater hood			1996	2,748		10			2,748	13
14	Building Improvements - outside painting			1996	11,308		10			11,308	14
15	Building Improvements - dining room			1996	3,752		10			3,752	15
16	Leasehold Improvements			1992	16,299	466	35	466		10,481	16
17	Leasehold Improvements			1994	21,836		10			21,836	17
18	Leasehold Improvements - 2nd floor			1996	19,319		10			18,353	18
19	Leasehold Improvements - bathroom rehab			1996	9,216		10			8,909	19
20	Leasehold Improvements - fan coil repairs			1996	6,669	191	35	191		3,497	20
21	Land Improvements			1993	2,985		15			2,985	21
22	Land Improvements			1995	4,596		15			4,595	22
23	Capitalized Repairs			1986	1,730		10			1,730	23
24	Building Improvements - basement			1996	18,993		10			18,993	24
25	Leasehold Improvements - Corner Guards			1997	520		10			520	25
26	Leasehold Improvements - Corridor flooring			1997	10,380		10			10,380	26
27	BI: Kitchen Rehab			1998	2,494		10			2,494	27
28	Wiring for MDS project			1998	3,365		10			3,365	28
29	Install Fire Sprinklers in Mechanical Rms			1998	4,600	131	35	131		2,166	29
30	Tile for Lobby			1998	20,530		10			20,530	30
31	Walk in Freezers/Coolers			1998	3,183	91	35	91		1,501	31
32	Fire Wall Repairs			1998	12,411	355	35	355		5,854	32
33	Underground storage tank			1998	2,613		10			2,613	33
34	Repave parking lot			1999	7,625	508	15	508		7,369	34
35	Lounge Floor Tile			1999	2,963		10			2,963	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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Rewire Building	1999	$ 9,083	$ 260	35	$ 260	$	$ 4,026	37
38	Heat exchanger for water heater	1999	1,660		5			1,660	38
39	Compressor and tank for freezer	1999	2,924		5			2,924	39
40	Plumbing Improvements	2000	2,833		10			2,833	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		912	41
42	Water heater repairs	2000	3,831		5			3,831	42
43	Automatic door	2000	4,556	130	35	130		1,886	43
44	Install sprinklers	2001	6,082		10			6,082	44
45	Infrared curtains for elevator	2001	4,500		10			4,500	45
46	Elevator upgrade	2002	3,006		5			3,006	46
47	Condensor	2002	2,679		5			2,679	47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		17,522	48
49	Plumbing loop repairs	2003	6,125		10			6,125	49
50	Fire alarm panel/call system	2003	8,495	425	20	425		5,063	50
51	Facility Rehab - Painting	2003	6,872		10			6,872	51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		16,300	52
53	Nurse call system	2003	49,451	2,473	20	2,473		27,407	53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		3,344	54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		188,688	55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		165,794	56
57	Floor Tile	2003	58,720	2,936	20	2,936		35,232	57
58	Carpeting/cove base	2003	29,518		10			29,518	58
59	Water heater	2004	9,209	767	10	767		9,209	59
60	Kitchen sewer and dishroom	2004	31,233	1,562	20	1,562		15,749	60
61	Landscaping	2005	3,255	163	20	163		1,534	61
62	HVAC	2005	8,028	401	20	401		3,677	62
63	Kitchen sewer, dishroom and ceiling	2005	22,924	1,146	20	1,146		10,983	63
64	Lobby and reception redecorating - painting/wallpaper	2005	37,999	1,900	20	1,900		18,367	64
65	Rehab therapy room - electrical, carpet, tile	2005	66,393	3,320	20	3,320		32,092	65
66	Rehab 1st floor therapy room - electrical, carpet, tile	2005	39,341	1,967	20	1,967		19,014	66
67	Wallpaper, tile, electrical for transitional unit	2005	22,946	1,147	20	1,147		11,184	67
68	Window treatments	2005	8,053	403	20	403		3,861	68
69	Tile, flooring, and wallpaper	2005	57,699	2,885	20	2,885		27,648	69
70	TOTAL (lines 4 thru 69)		$ 5,504,063	$ 65,036		$ 169,650	$ 104,614	$ 4,367,045	70

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 5,504,063	$ 65,036		$ 169,650	$ 104,614	$ 4,367,045	1
2	Countertops	2005	845		5			845	2
3	Curtains and blinders	2005	4,672		5			4,672	3
4	Mini scroll	2005	527		5			527	4
5	Medical Records Storage/Office Room	2006	5,901	148	40	148		1,208	5
6	Office Remodel	2006	5,537	138	40	138		1,104	6
7	Piping	2006	4,511	301	15	301		2,508	7
8	HVAC	2006	7,985	200	40	200		1,600	8
9	Emergency A/C	2006	9,385	235	40	235		1,880	9
10	Adm Office-HVAC	2006	6,421	161	40	161		1,354	10
11	Sink installation	2006	2,561	64	40	64		560	11
12	Land Improvements Patio	2006	23,736	1,582	15	1,582		13,184	12
13	Brick Pavers	2007	8,500	567	15	567		4,347	13
14	Landscaping	2007	16,420	821	20	821		6,089	14
15	Parking Lot	2007	13,219	661	20	661		4,902	15
16	Roof	2007	9,800	490	20	490		3,798	16
17	HVAC	2007	8,197	410	20	410		3,075	17
18	LHI-Emergency A/C	2007	11,126	556	20	556		3,985	18
19	LHI-Plumbing & Sprinkler	2007	6,799	680	10	680		4,930	19
20	Automatic Doors is Common Areas	2007	20,874	1,044	20	1,044		7,743	20
21	Tike System & Foundation	2007	4,500	225	20	225		1,594	21
22	Exterior of Building Painting	2007	16,600	830	20	830		6,018	22
23	Landscaping	2008	21,600	1,440	15	1,440		9,720	23
24	Parking Lot	2008	9,625	481	20	481		3,167	24
25	Roof Repair	2008	11,001	550	20	550		3,483	25
26	HVAC	2008	20,164	1,102	20	1,102		7,157	26
27	Sink and Toliet	2008	4,000	400	10	400		2,667	27
28	Elevator Upgrades	2008	171,955	4,299	40	4,299		26,869	28
29	Metal Doors	2008	3,907	195	20	195		1,317	29
30	Basement Renovation	2008	25,195	1,260	20	1,260		8,400	30
31	Trash Compactor	2008	11,590	580	20	580		3,770	31
32	Painting Gazebo	2008	4,450	223	20	223		1,430	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,975,666	$ 84,679		$ 189,293	$ 104,614	$ 4,510,948	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 5,975,666	$ 84,679		$ 189,293	$ 104,614	$ 4,510,948	1
2	2nd floor remodel-Electric, flooring,painting	2008	561,165		27	20,406	20,406	124,137	2
3	Kitchen Upgrade-Carpentry, painting, plumbing	2008	18,364		27	668	668	4,064	3
4	1st floor remodel-painting, electrical, flooring,plumbing	2008	547,836		27	19,921	19,921	137,787	4
5	Irrigation System	2009	14,235	949	15	949		5,140	5
6	Landscaping Enhancements	2009	22,005	1,467	15	1,467		8,069	6
7	Roof	2009	139,578	6,979	20	6,979		37,803	7
8	Fan Coil	2009	5,607	280	20	280		1,611	8
9	Quick Connectors	2009	5,300	265	20	265		1,502	9
10	Room Convector	2009	4,962	248	20	248		1,302	10
11	Nurse Call System	2009	35,509	1,291	27	1,291		6,882	11
12	Electrical key pad	2009	5,995	218	27	218		1,181	12
13	PT Room Countertops	2009	4,050	147	27	147		748	13
14	2nd floor remodel-Electric, flooring,painting	2009	2,935	107	27	107		624	14
15	Patio Pergola	2009	10,849	542	20	542		2,801	15
16	Landscaping/Retaining wall	2010	4,741	316	15	316		1,422	16
17	Ejector Pump	2010	6,983	466	15	466		2,096	17
18	Parking lot repair/signs	2010	8,970	727	15	727		3,284	18
19	Repair Roof	2010	24,000	1,200	20	1,200		4,900	19
20	Key pad entrance	2010	3,085	308	10	308		1,464	20
21	Canopy	2010	2,567	257	10	257		1,177	21
22	Exhaust HVAC	2010	4,003	146	27	146		608	22
23	Drainline	2010	4,130	151	27	151		616	23
24	Pantry carpentry,electrical,plumbing	2010	7,566	276	27	276		1,219	24
25	Paint over bed lights	2010	6,319	231	27	231		1,077	25
26	Library/Lounge carpentry,painting,signs	2010	8,441	308	27	308		1,335	26
27	Second floor doors	2010	3,144	314	10	314		1,492	27
28	Med Room carpentry,plumbing	2010	7,678	280	27	280		1,237	28
29	Patio Pergola	2010	11,695	2,339	5	2,339		9,941	29
30	Stamped concrete	2010	15,862	1,057	15	1,057		4,933	30
31	Office carpentry,flooring,electrical,painting,plumbing,signs	2010	64,446	5,409	27	5,409		21,636	31
32	3rd floor remodel-carpentry,plumbing,electrical,painting	2010	753,399		27	60,085	60,085	275,389	32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,291,085	$ 110,957		$ 316,651	$ 205,694	$ 5,178,425	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,291,085	$ 110,957		$ 316,651	$ 205,694	$ 5,178,425	1
2									2
3	Office Remodel - carpentry,plumbing,electrical,painting	2011	11,187	407	27	407		1,492	3
4	Front Entrance remodel of kitchen doors	2011	3,584	130	27	130		390	4
5	Remodel Shower Room - Carpentry, Flooring, Electrical,	2011	53,886	1,959	27	1,959		6,367	5
6	-Plumbing, Showers, Millwork & Painting								6
7	Boiler Coll HVAC	2011	3,175	115	27	115		404	7
8	Roof Top Unit HVAC	2011	40,890	1,487	27	1,487		4,833	8
9	Fire Dampers HVAC	2011	67,012	2,437	27	2,437		7,514	9
10	Remodel Laundry Room - Electrical, Painting and Flooring	2011	9,814	357	27	357		1,220	10
11	Replace Doors on 1st Floor	2011	57,237	2,081	27	2,081		6,416	11
12	Replace doors on 2nd Floor	2011	39,952	1,453	27	1,453		4,843	12
13	Doctors office-keys, painting, flooring	2012	5,484	83	27	83		249	13
14	Generator Exhaust	2012	21,590	785	27	785		2,093	14
15	Sprinklers in building - Front Canopy & Lobby Area	2012	11,558	420	27	420		910	15
16	Replace sanitary pipe	2012	5,800	211	27	211		545	16
17	Replace lights, mirrors in 1st floor resident rooms	2012	10,962	399	27	399		997	17
18	Replacement faucets in 1st floor resident rooms	2012	6,410	233	27	233		563	18
19									19
20	Fence- Entire Facility	2013	5,840	389	15	389		454	20
21	Sprinkler Heads- Entire Facility	2013	25,361	922	27	922		1,537	21
22	EMR Wiring- Entire Facility	2013	18,690	680	27	680		1,473	22
23	Holding Tank- Kitchen	2013	25,724	935	27	935		935	23
24									24
25	R/M Reclass: Generator transfer switch in Mechanical Room	2014	4,681		12	195	195	195	25
26	R/M Reclass: Landscaping for flowers around main entrance	2014	2,840		15	96	96	96	26
27									27
28									28
29				253			(253)		29
30	Reconcile to book								30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,722,763	$ 126,693		$ 332,425	$ 205,732	$ 5,221,951	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12D, Carried Forward		$ 8,722,763	$ 126,693		$ 332,425	$ 205,732	$ 5,221,951	1
2									2
3	Building-management company	2002	309,939		40	9,346	9,346	119,083	3
4	HVAC, electrical, security system-management company	2003	2,722		30	676	676	1,996	4
5	Key card system-management company	2004	428		20	22	22	223	5
6	VAV TX controls-management compnay	2005	130		20	7	7	64	6
7	Building Improvements-management company	2006	95		20	6	6	52	7
8	Building Improvements-management company	2008	14,968		20	506	506	5,624	8
9	Building Improvements-management company	2009	2,781		20	53	53	825	9
10	Building Improvements-management company	2010	2,712		20	115	115	814	10
11	Building Improvements-management company	2011	1,929		20	91	91	313	11
12	Building Improvements-management company	2012	6,593		20	13	13	640	12
13	Building Improvements-management company	2013	5,035		20	372	372	464	13
14	Building Improvements-management company	2014	2,725		20	141	141	139	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)		$ 9,072,820	$ 126,693		$ 343,771	$ 217,078	$ 5,352,188	34

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,254,582	$ 107,315	$ 146,548	$ 39,233		$ 1,026,617	71
72	Current Year Purchases	34,755	2,901	2,901			2,901	72
73	Fully Depreciated Assets	18,400				5	18,400	73
74	Allocated from Mgmt. Co.	528,597		62,414	62,414	5-7	340,238	74
75	TOTALS	$ 1,836,334	$ 110,216	$ 211,863	$ 101,647		$ 1,388,156	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.			56,071		4,215	4,215	5	49,053	79
80	TOTALS			$ 56,071	$	$ 4,215	$ 4,215		$ 49,053	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,604,384	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 236,909	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 559,849	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 322,940	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,789,397	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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Company				4,918			6
7	TOTAL				$ 4,918 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 92,969 Description: Copier-$7,915;Mail Sys-$180;Printer-$8,107;Oxygen-$42,284;Med Equip-$32,898;Mgmt. Co.-$1,585
    (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			1,203	20
21	TOTAL		$	$ 1,203	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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

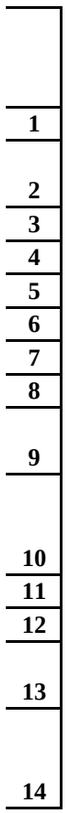
	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	11,466	$ 535,385	$	11,466	$ 535,385	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		6,948	167,153		6,948	167,153	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		13,769	839,592		13,769	839,592	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				522,589		522,589	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					10,508		10,508	12
13	Other (specify): See Sch 16A					(6,501)	1,608		(4,893)	13
14	TOTAL			$	32,183	$ 1,535,629	$ 534,705	32,183	$ 2,070,334	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.

Lexington Health Care Center of Lombard, Inc.
Provider # 0039768
12/31/2014 **Schedule 16A**

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

		1	2	3	4	5	6	7	8
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost			
1	Licensed Occupational Therapist		hrs	$		$	$		$
2	Licensed Speech and Language Development Therapist		hrs						
3	Licensed Recreational Therapist		hrs						
4	Licensed Physical Therapist		hrs						
5	Physician Care		visits						
6	Dental Care		visits						
7	Work Related Program		hrs						
8	Habilitation		hrs						
9	Pharmacy		# of prescrpts						
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						
11	Academic Education		hrs						
12	Other (specify): DME	39(2)					1,608		1,608
13	Other (specify): Ambulance	39(3)				(6,501)			(6,501)
14	TOTAL			$		$ (6,501)	$ 1,608		$ (4,893)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STATE OF ILLINOIS

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 393,771	$ 420,494	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 459,604)	3,486,929	3,486,929	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,338	70,338	6
7	Other Prepaid Expenses	4,990	4,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): PA Interest Receivable	11,703	11,703	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,967,731	$ 3,994,454	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		639,159	13
14	Buildings, at Historical Cost		3,945,628	14
15	Leasehold Improvements, at Historical Cost	2,936,278	5,127,192	15
16	Equipment, at Historical Cost	661,280	1,892,405	16
17	Accumulated Depreciation (book methods)	(1,751,021)	(6,789,397)	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 (spe			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,846,537	$ 4,814,987	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,814,268	$ 8,809,441	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 629,442	$ 629,442	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	250,000	250,000	29
30	Accrued Salaries Payable	461,703	461,703	30
31	Accrued Taxes Payable (excluding real estate taxes)	68,478	68,478	31
32	Accrued Real Estate Taxes(Sch.IX-B)		193,200	32
33	Accrued Interest Payable		6,155	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,671,243	776,660	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,080,866	$ 2,385,638	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	499,000	2,729,000	39
40	Mortgage Payable			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)**	$ 499,000	$ 2,729,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,579,866	$ 5,114,638	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,234,402	$ 3,694,803	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,814,268	$ 8,809,441	48

*(See instructions.)

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660
12/31/2014

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other current liabilities

Account	Description	Operating	After Consolidation
00-12020-00	PA AUDIT SETTLEMENT	246,264	246,264
00-21100-00	401K WITHHOLDING	(389)	(389)
00-22030-00	ACCRUED EXPENSES	120,749	120,749
00-22060-00	ACCRUED ROYL / VESTA MGMT FEES	752	752
00-22120-00	ACCRUED RENT	894,583	
00-22140-00	ACCRUED INSURANCE	37,994	37,994
00-22270-00	DUE TO PATIENT TRUST FUND	3,988	3,988
00-22330-00	ADVANCE - BIWEEKLY PART A PAYM	(8,906)	(8,906)
00-22360-00	UNCOLLECTIBLE PART A CO PVTS	(10,893)	(10,893)
00-23530-00	DUE TO - ROYAL OPERATIONS	23,954	23,954
00-23720-00	DUE TO/FROM REPUBLIC CONSTRUCTION	(3,269)	(3,269)
00-23730-00	Due to Bloomingdale	932	932
00-23830-00	DUE/TO FROM SQUARE LOMBARD	7,095	7,095
00-24400-00	PROFESSIONAL LIABILITIES CLAIMS	358,389	358,389
		1,671,243	**776,660**
		-	-

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,684,241	1
2	Restatements (describe):		2
3	**Post closing adjustment**	(136,773)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,547,468	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	226,934	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	(540,000)	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)**	$ (313,066)	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)**	$ 2,234,402	24 *

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

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 21,050,347	1
2	Discounts and Allowances for all Levels	(10,393,431)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,656,916	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,153,445	6
7	Oxygen	46,308	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,199,753	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	403	12
13	Barber and Beauty Care	25,989	13
14	Non-Patient Meals	120	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	732,507	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	191,267	19
20	Radiology and X-Ray	40,706	20
21	Other Medical Services	307,621	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,298,613	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,081	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,081	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income and Recovery of write off	3,538	28
28a	Bed Hold Early Discharge		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,538	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,165,901	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,931,571	31
32	Health Care	5,981,639	32
33	General Administration	4,176,857	33
	B. Capital Expense		
34	Ownership	2,013,417	34
	C. Ancillary Expense		
35	Special Cost Centers	2,393,914	35
36	Provider Participation Fee	441,569	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,938,967	40
41	**Income before Income Taxes (line 30 minus line 40)****	226,934	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 226,934	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,053,470	44
45	Private Pay - Net Inpatient Revenue	3,998,087	45
46	Medicare - Net Inpatient Revenue	1,251,117	46
47	Other-(specify) Managed Care	354,242	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,656,916	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 Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,984	2,307	$ 131,466	$ 56.99	1
2	Assistant Director of Nursing	30,685	36,480	1,016,397	27.86	2
3	Registered Nurses	37,138	45,373	1,438,630	31.71	3
4	Licensed Practical Nurses	24,712	30,405	788,898	25.95	4
5	CNAs & Orderlies	107,482	128,616	1,559,678	12.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,276	3,856	57,946	15.03	9
10	Activity Assistants	8,462	10,348	127,421	12.31	10
11	Social Service Workers	5,870	6,716	117,331	17.47	11
12	Dietician	2,981	3,359	66,960	19.93	12
13	Food Service Supervisor	1,788	2,070	43,134	20.84	13
14	Head Cook	1,752	2,070	52,240	25.24	14
15	Cook Helpers/Assistants	22,528	26,453	270,742	10.23	15
16	Dishwashers	4,009	4,885	45,471	9.31	16
17	Maintenance Workers	1,023	1,267	20,850	16.46	17
18	Housekeepers	31,465	37,663	385,244	10.23	18
19	Laundry	5,337	6,353	66,116	10.41	19
20	Administrator	1,699	2,196	118,785	54.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,478	11,198	209,393	18.70	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	1,894	2,288	37,127	16.23	31
32	Other Health C: Memory Care	3,052	3,782	65,698	17.37	32
33	Other(specify) See Sch 20A	4,953	5,597	156,123	27.89	33
34	TOTAL (lines 1 - 33)	310,568	373,282	$ 6,775,650 *	$ 18.15	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		$		35
36	Medical Director	Monthly	57,150	9(3)	36
37	Medical Records Consultant	Monthly	568	10(3)	37
38	Nurse Consultant	Monthly	57,665	10(3)	38
39	Pharmacist Consultant	Monthly	12,869	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	3,115	11(3)	44
45	Social Service Consultant	Monthly	3,817	12(3)	45
46	Other(specify)				46
47	Pulmonary	Monthly	62,963	10(3)	47
48	Medical Consultant	Monthly	5,314	10(7)	48
49	TOTAL (lines 35 - 48)		$ 203,461		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: **Lexington Hlth Cr Ctr Lombrd**
IDPH License ID Number: **0028860**
Fiscal Year End: **12/31/14**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Barber Beauty	1,449	1,704	18,746	$ 11.00
Marketing	3,504	3,893	137,377	$ 35.29
Total - Line 33 Other (specify):	**4,953**	**5,597**	**156,123**	**$ 27.89**

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Danielle Gilbert	Administrator	0	$ 118,785
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,785

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 1,183,680
Management Fees-Vesta Mgmt.	488,785
Eliminated in Column 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,672,465
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center, LLC	Collections	$ 455
Cassiday Schade, LLP	Legal	71,016
Duane Morris	Legal	528
Generation Law	Legal	3,497
Monahan Law Group	Legal	656
Pension Administrators, Inc.	Pension Administration	945
McGladrey LLP	Accounting	32,302
Much Shelist	Legal	15,961
Personnel Planners	U/C Consulting	2,988
Secretary of State	Banking	225
Walinski & Associates	Legal	2,500
See Schedule 21C		235,036
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 366,109

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 239,885
Unemployment Compensation Insurance	77,744
FICA Taxes	514,613
Employee Health Insurance	280,075
Employee Meals	19,268
Illinois Municipal Retirement Fund (IMRF)*	
401K	22,519
Other Employee Benefits	34,317
Uniform Allowance	165
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,188,586

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	$
Advertising: Employee Recruitment	23,491
Health Care Worker Background Check	
(Indicate # of checks performed 132)	1,583
Patient Background Checks 555	6,663
Miscellaneous Licenses & Fess	10,193
Miscellaneous Dues & Subscriptions	3,291
Chamber of Commerce	(795)
Management Company Allocation	16,220
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 60,646

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Management Company Allocation	1,812
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,812

**See instructions.

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660
12/31/2014
Section XIX.

Schedule 21C

C. Professional Fees

Vendor/Payee	Type	Amount
Ability Network	Computer Consulting	1,873
AccuNurse	Computer Consulting	64,523
Americorp Financial	Computer Consulting	79,863
Availity	Computer Consulting	139
Avalere Health	Computer Consulting	2,000
Centino	Computer Consulting	750
CITRIX	Computer Consulting	348
Corepoint	Computer Consulting	945
E-Health Data Solutions	Computer Consulting	3,450
HEALTH MEDX	Computer Consulting	15,531
Information Control	Computer Consulting	341
Information Controls	Computer Consulting	9,721
Lintech L LC	Computer Consulting	230
MS LICENSING	Computer Consulting	23,226
National Datacare	Computer Consulting	1,923
National Research	Computer Consulting	513
On Shift	Computer Consulting	7,912
Relias	Computer Consulting	8,041
Royal	Computer Consulting	21
Salesforce.com	Computer Consulting	5,004
Soft Choice	Computer Consulting	-
SOFT CHOICE CORP	Computer Consulting	2,105
Soft choice Corporation	Computer Consulting	308
SOFTCHOICE	Computer Consulting	908
SYMBRIA	Computer Consulting	1,200
Tableau	Computer Consulting	1,716
Telemedicine Solutions	Computer Consulting	1,800
Touchpoint /Satisfication survey	Computer Consulting	233
Tympani	Computer Consulting	412

		235,036
Total Schedule V, line 19, column 3		366,109
Less: Collections		(455)
Out of period/Non Allowable legal		(17,376)
Salesforce.com		(5,004)
Lexington Health Care Systems of Lombard Partnerships		200
Allocated from Management Co.		
Much Shelist	Legal	181
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	58
Duane Morris	Legal	312
McGladrey LLP	Accounting	1,632
Frost, Ruttenberg & Rothblatt, P.C	Accounting	113
Gilson Labus & Silverman	Accounting	1,202
Illinois Secretary of State	Filing Fees	44
LaSalle Network	Recruiting/Finance	6,016
Pension Administrators, Inc.	401K Administration	374
Gene Whitehorn	Medicaid Reimb Specialist	1,621
M. Werner Consulting	Financial Consultant	2,125
McNamara & Associates	SNF Consultants	311
Healthcents	Managed Care Consultants	412
Computer Services	Computer Consulting	17,533
		31,936
Allocated from Samvest of Lombard II	Accounting	114
	Filing Fees	17
Total Schedule V, line 19, column 8		375,541

Facility Name & ID Number Lexington Hlth Cr Ctr Lombrd # 0028860 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlth Cr Ctr Lombrd **#** 0028860 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **65,271** 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. $ **441,569**
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. $ **19,268** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **120**

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.