FOR BHF USE

LL1

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: 0038083

Facility Name: Lexington of LaGrange

Address: 4735 Willow Sprgs Rd (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 352-6900 **Fax #** (708) 482-0239

HFS ID Number:

Date of Initial License for Current Owners: 7/31/92

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 01/01/2014 to 12/31/2014 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 LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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			28,717	28,717	8
9	SNF/PED					9
10	ICF	5,753	2,754		8,507	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,753	2,754	28,717	37,224	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.99%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/31/92

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 120 and days of care provided 22,479

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 of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	393,803	20,718	3,873	418,394		418,394		418,394			1
2	Food Purchase		233,712		233,712		233,712	(21,905)	211,807			2
3	Housekeeping	300,026	30,451		330,477		330,477	157	330,634			3
4	Laundry	40,652	11,326		51,978		51,978		51,978			4
5	Heat and Other Utilities			197,009	197,009		197,009	4,697	201,706			5
6	Maintenance	44,274		160,737	205,011		205,011	42,442	247,453			6
7	Other (specify):* Alloc. Mgmt Co. Bene							6,418	6,418			7
8	TOTAL General Services	778,755	296,207	361,619	1,436,581		1,436,581	31,809	1,468,390			8
	B. Health Care and Programs											
9	Medical Director			60,359	60,359		60,359		60,359			9
10	Nursing and Medical Records	3,946,932	409,531	190,829	4,547,292		4,547,292	28,146	4,575,438			10
10a	Therapy											10a
11	Activities	105,745	14,592	11,518	131,855		131,855		131,855			11
12	Social Services	160,966		3,817	164,783		164,783		164,783			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Mgmt Co. Bene							3,846	3,846			15
16	TOTAL Health Care and Programs	4,213,643	424,123	266,523	4,904,289		4,904,289	31,992	4,936,281			16
	C. General Administration											
17	Administrative	139,323		1,212,286	1,351,609		1,351,609	(1,179,485)	172,124			17
18	Directors Fees											18
19	Professional Services			324,243	324,243		324,243	6,058	330,301			19
20	Dues, Fees, Subscriptions & Promotions			38,207	38,207		38,207	2,298	40,505			20
21	Clerical & General Office Expenses	188,102	20,030	73,976	282,108		282,108	380,886	662,994			21
22	Employee Benefits & Payroll Taxes			1,010,693	1,010,693		1,010,693	14,352	1,025,045			22
23	Inservice Training & Education			7,956	7,956		7,956	473	8,429			23
24	Travel and Seminar			20	20		20	951	971			24
25	Other Admin. Staff Transportation			9,624	9,624		9,624	8,697	18,321			25
26	Insurance-Prop.Liab.Malpractice			149,260	149,260		149,260	6,377	155,637			26
27	Other (specify):* Alloc. Mgmt Co. Bene							60,100	60,100			27
28	TOTAL General Administration	327,425	20,030	2,826,265	3,173,720		3,173,720	(699,293)	2,474,427			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,319,823	740,360	3,454,407	9,514,590		9,514,590	(635,492)	8,879,098			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 LaGrange #0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			123,464	123,464		123,464	273,817	397,281			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,165	3,165		3,165	344,223	347,388			32
33	Real Estate Taxes							329,161	329,161			33
34	Rent-Facility & Grounds			1,107,118	1,107,118		1,107,118	(1,102,171)	4,947			34
35	Rent-Equipment & Vehicles			91,770	91,770		91,770	1,494	93,264			35
36	Other (specify):*											36
37	TOTAL Ownership			1,325,517	1,325,517		1,325,517	(153,476)	1,172,041			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		795,542	2,908,794	3,704,336		3,704,336		3,704,336			39
40	Barber and Beauty Shops	9,972		8,856	18,828		18,828		18,828			40
41	Coffee and Gift Shops			317	317		317		317			41
42	Provider Participation Fee			154,965	154,965		154,965		154,965			42
43	Other (specify):* Non-Allowable Cos	145,077		166,585	311,662		311,662	(311,662)				43
44	TOTAL Special Cost Centers	155,049	795,542	3,239,517	4,190,108		4,190,108	(311,662)	3,878,446			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,474,872	1,535,902	8,019,441	15,030,215		15,030,215	(1,100,630)	13,929,585			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 LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(7,553)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,291)	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	25	30		9
10	Interest and Other Investment Income	(3,511)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,966)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,527)	43		24
25	Fund Raising, Advertising and Promotional	(40,657)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,548)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(51,872)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (139,330)		$	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)	(961,300)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (961,300)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,100,630)		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 LaGrange

ID# **0038083**

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Reclass Repairs & Maintenance	$ (3,500)	6	1
2	Labs-Part A	(46,035)	43	2
3	X-Rays-Part A	(31,998)	43	3
4	Diagnostics Managed Care	(12,143)	43	4
5	Trust Fees	(145)	43	5
6	Collections	(5,584)	19	6
7	Out of Period legal	(1,586)	19	7
8	Marketing Salary	(145,077)	43	8
9	Education & Seminar marketing	(20)	24	9
10	Unrealized loss on FMV swap	199,017	43	10
11	Disallow Marketing Software	(4,150)	19	11
12	Misc Income	(363)	21	12
13	Disallowed Lobbying	(288)	20	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**	(51,872)		49

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Sambell of LaGrange Limited Partnership	**	$ 200	$ 200	1
2	V	30	Depreciation		Sambell of LaGrange Limited Partnership	**	232,020	232,020	2
3	V	32	Interest Expense		Sambell of LaGrange Limited Partnership	**	336,477	336,477	3
4	V	32	Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	1,339	1,339	4
5	V	33	Property Taxes		Sambell of LaGrange Limited Partnership	**	324,806	324,806	5
6	V	34	Rental Expense	1,104,806	Sambell of LaGrange Limited Partnership	**		(1,104,806)	6
7	V	43	Trust Fees		Sambell of LaGrange Limited Partnership	**	145	145	7
8	V	43	Unrealized loss on FMV swap	199,017	Sambell of LaGrange Limited Partnership	**		(199,017)	8
9	V	43	State Replacement Tax		Sambell of LaGrange Limited Partnership	**	10	10	9
10	V								10
11	V								11
12	V				** The owners of Lexington Health Care Center of LaGrange, Inc. own 100%				12
13	V				of Sambell of LaGrange Limited Partnership.				13
14	Total			$ 1,303,823			$ 894,997	$ * (408,826)	14

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.	**	$ 157	$ 157	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	4,096	4,096	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	183	183	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	418	418	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	42,222	42,222	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	3,701	3,701	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	19	19	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	6,418	6,418	22
23	V	10	Medical consultant		Royal Management Corp.	**	2,847	2,847	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	25,299	25,299	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	3,846	3,846	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	32,801	32,801	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	9,392	9,392	27
28	V	19	Professional fees		Royal Management Corp.	**	7,786	7,786	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,268	1,268	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	1,318	1,318	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	362,592	362,592	31
32	V	21	Bank charges		Royal Management Corp.	**	1,468	1,468	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	7,421	7,421	33
34	V	21	Postage		Royal Management Corp.	**	2,628	2,628	34
35	V	21	Telephone		Royal Management Corp.	**	7,140	7,140	35
36	V				Royal Management Corp.	**			36
37	V								37
38	V		**The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 523,020	$ * 523,020	39

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.	**	$ 473	$ 473	15
16	V	24	Travel & seminar		Royal Management Corp.	**	971	971	16
17	V	25	Auto expense		Royal Management Corp.	**	8,697	8,697	17
18	V	26	Insurance general		Royal Management Corp.	**	6,377	6,377	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	60,100	60,100	19
20	V	30	Depreciation		Royal Management Corp.	**	41,772	41,772	20
21	V	32	Interest		Royal Management Corp.	**	8,464	8,464	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,454	1,454	22
23	V	33	Property taxes		Royal Management Corp.	**	4,355	4,355	23
24	V	34	Rent expense		Royal Management Corp.	**	2,635	2,635	24
25	V	35	Equipment rental		Royal Management Corp.	**	849	849	25
26	V	17	Management fees	1,212,286	Royal Management Corp.	**		(1,212,286)	26
27	V	35	Auto Lease		Royal Management Corp.	**	645	645	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		**The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						36
37	V								37
38	V								38
39	Total			$ 1,212,286			$ 136,792	$ * (1,075,494)	39

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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					Lexington Health	Lake Zurich	Real Estate	10
11					Care Systems of		Property	11
12					Lake Zurich Ltd. Ptsp			12
13								13
14					Lexington Health	Lombard	Real Estate	14
15					Care Systems of		Property	15
16					Lombard Ltd. Ptsp.			16
17								17
18					Lexington Health	Orland Park	Real Estate	18
19					Care Systems of		Property	19
20					Orland Park Ltd. Ptsp			20
21								21
22					Sambell of	Schaumburg	Real Estate	22
23					Schaumburg Ltd. Ptsp		Property	23
24								24
25					Sambell of	Streamwood	Real Estate	25
26					Streamwood Ltd. Ptsp		Property	26
27								27
28					Lexington Health	Wheeling	Real Estate	28
29					Care Systems of		Property	29
30					Wheeling Ltd. Ptsp.			30

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 5,760	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,198	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,259	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,835	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	10,748	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 32,801		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 LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 Available	723,430	10	$ 2,591	$	43,800	$ 157	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,650		43,800	4,096	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	3,027		43,800	183	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	6,910		43,800	418	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	697,374	697,374	43,800	42,222	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	61,125		43,800	3,701	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	320		43,800	19	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	106,001		43,800	6,418	8
9	10	Medical consultant	Bed Days Available	723,430	10	47,016		43,800	2,847	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	417,860	417,860	43,800	25,299	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	63,515		43,800	3,846	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	541,757	541,757	43,800	32,801	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	155,132		43,800	9,392	13
14	19	Professional fees	Bed Days Available	723,430	10	128,599		43,800	7,786	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	20,945		43,800	1,268	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	21,776		43,800	1,318	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	5,988,811	5,988,811	43,800	362,592	17
18	21	Bank charges	Bed Days Available	723,430	10	24,252		43,800	1,468	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	122,570		43,800	7,421	19
20	21	Postage	Bed Days Available	723,430	10	43,413		43,800	2,628	20
21	21	Telephone	Bed Days Available	723,430	10	117,921		43,800	7,140	21
22										22
23										23
24										24
25	TOTALS					$ 8,638,565	$ 7,645,802		$ 523,020	25

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 Available	723,430	10	$ 7,807	$	43,800	$ 473	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	16,032		43,800	971	2
3	25	Auto expense	Bed Days Available	723,430	10	143,653		43,800	8,697	3
4	26	Insurance general	Bed Days Available	723,430	10	105,333		43,800	6,377	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	992,646		43,800	60,100	5
6	30	Depreciation	Bed Days Available	723,430	10	689,938		43,800	41,772	6
7	32	Interest	Bed Days Available	723,430	10	139,794		43,800	8,464	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	24,007		43,800	1,454	8
9	33	Property taxes	Bed Days Available	723,430	10	71,926		43,800	4,355	9
10	34	Rent expense	Bed Days Available	723,430	10	43,516		43,800	2,635	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,023		43,800	849	11
12	35	Auto Lease	Bed Days Available	723,430	10	10,648		43,800	645	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	$		$ 136,792	25

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Sevices II, LLC	X		Mortgage	Varies	4/30/07	5,991,000	5,092,486	5/1/17	0.0650	336,477	2
3												3
4								Finance Charge - Insurance Policy			828	4
5												5
	Working Capital											
6	JP Morgan Chase		X	Line of Credit	Various	6/29/13	5,600,000		6/29/15	Libor +2.25%	2,337	6
7												7
8												8
9	TOTAL Facility Related						$ 11,591,000	$ 5,092,486			$ 339,642	9
	B. Non-Facility Related*											
10								Amortization of Loan Cost			1,339	10
11								Interest Income offset			(3,511)	11
12												12
13								Allocated from Mgmt. Co.			9,918	13
14	TOTAL Non-Facility Related						$	$			$ 7,746	14
15	TOTALS (line 9+line14)						$ 11,591,000	$ 5,092,486			$ 347,388	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 LaGrange # 0038083 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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.**	$ 356,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013	$ 355,813	2
3. Under or (over) accrual (line 2 minus line 1).		$ (587)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 367,200	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.)**		$ 18,753	5
	Allocated from Managment Co.	4,355	
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** $ 60,559 **For** 03/11 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (60,559)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 329,161	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	241,653	8
	2010	244,173	9
	2011	331,522	10
	2012	345,195	11
	2013	355,813	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 of LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

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.	18-08-207-017-0000	Land & Building	$ 198,923.11	$ 198,923.11
2.	18-08-207-018-0000	Land & Building	$ 156,889.60	$ 156,889.60
3.	Royal Management Corp. (Samvest of Lombard II)		$	$
4.	05-01-202-021	Land & Building	$ 282,411.22	$ 4,355.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 638,223.93	$ 360,167.71

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 of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,072 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

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

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

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

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

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

N/A

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: 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	40,000	1991	$ 500,000	1
2	Management Company Allocation			10,899	2
3	TOTALS	40,000		$ 510,899	3

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	120		1992	1992	$ 2,661,448	$	35	$ 76,041	$ 76,041	$ 1,710,928	4
5			1995	1995	79,363		10			79,363	5
6			2005	2005	2,321,014		21	110,524	110,524	1,049,980	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1992	1,152		20			1,152	9
10	Building Improvements			1992	2,714		31			2,714	10
11	Building Improvements			1993	2,901		35	83	83	1,824	11
12	Leasehold Improvements			1994	6,402		10			6,402	12
13	Leasehold Improvements - Corner Guards			1996	2,195		10			2,122	13
14	Wiring			1998	3,378		10			3,378	14
15	Resurface & Restripe Parking Lot			1998	3,753		10			3,753	15
16	Lobby Tile			1998	19,488		10			19,488	16
17	Resurface & Restripe Parking Lot			2000	1,997		10			1,997	17
18	Automatic Door			2000	1,300		10			1,300	18
19	Kitchen Rehab			2001	1,441		10			1,441	19
20	Infrared curtains for elevator			2001	3,000		10			3,000	20
21	Dining room, resident rooms, and corridors renovations			2002	150,083	7,505	20	7,505		90,681	21
22	Elevator upgrade			2002	5,398		10			5,398	22
23	Air conditioner compressor			2003	9,218		10			9,218	23
24	Sidewalk and fencing			2005	46,701	2,335	20	2,335		21,404	24
25	HVAC			2005	8,141	407	20	407		3,697	25
26	Wiring			2005	4,506	225	20	225		2,082	26
27	Lobby, lounge and reception renovations			2005	24,362	1,218	20	1,218		11,368	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors			2005	326,862		20	16,343	16,343	147,087	28
29	Wallcoverings			2005	10,822		5			10,822	29
30	Medical records room rehab			2006	19,739	987	20	987		7,896	30
31	Activity/PT Room Rehab			2006	1,158	58	20	58		464	31
32	Land scape enhancement			2006	8,726	582	15	582		4,850	32
33	Roof			2006	29,700	1,980	15	1,980		16,500	33
34	HVAC			2006	3,254	163	20	163		1,358	34
35	Plumbing and sprinkler system			2006	20,725	1,036	20	1,036		9,325	35
36	Laundry Combustion Air			2006	16,814	841	20	841		7,358	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 LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Lobby/Lounge/Reception rehab	2006	$ 14,033	$ 1,403	10	$ 1,403	$	$ 11,926	37
38	Cubicle curtains/drapery	2006	6,955		5			6,955	38
39	Cabinets/counters for 2nd FI library	2006	2,665	267	10	267		2,202	39
40	TCU rehab	2006	2,402	120	20	120		970	40
41	First floor remodel	2006	212,084		20	10,604	10,604	84,832	41
42	Kitchen rehab	2006	8,165	408	20	408		3,469	42
43	Bath fixtures-2nd foor	2006	2,076	208	10	208		1,837	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		1,409	44
45	Landscaping	2007	3,862	257	15	257		1,949	45
46	HVAC	2007	58,326	2,916	20	2,916		21,627	46
47	Common Areas Remodel	2007	2,059	206	10	206		1,562	47
48	First Floor Remodel	2007	6,517		20	326	326	2,525	48
49	Garage	2007	16,487	824	20	824		5,837	49
50	Land Improvements	2008	3,745	250	15	250		1,521	50
51	Parking lot-paving	2008	8,720	436	20	436		2,798	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		840	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	16,260	16,260	111,110	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		19,459	55
56	Irrigation System	2009	16,740	1,116	15	1,116		5,859	56
57	Landscaping	2009	10,321	688	15	688		3,612	57
58	Parking lot repairs	2009	3,500	175	20	175		977	58
59	HVAC Chiller	2009	2,594	130	20	130		704	59
60	Patio Pergola	2009	6,760	338	20	338		1,972	60
61	Stamped Concrete	2009	16,658	833	20	833		4,443	61
62	Fence	2009	4,084	204	20	204		1,037	62
63	Patio Wall	2009	8,212	411	20	411		2,158	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		1,502	64
65									65
66	Brick Panel Replacement	2010	16,578	603	27	603		2,814	66
67	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	17,565	641	27	641		2,564	67
68	Landscaping Enhancements	2010	15,258	1,017	15	1,017		4,577	68
69	Drain tile,sewer concrete	2010	3,221	214	15	214		902	69
70	TOTAL (lines 4 thru 69)		$ 6,882,020	$ 35,411		$ 265,592	$ 230,181	$ 3,554,300	70

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,882,020	$ 35,411		$ 265,592	$ 230,181	$ 3,554,300	1
2	Retaining wall	2010	15,736	1,049	15	1,049		4,196	2
3	Canopy Installation	2010	4,466	163	27	163		679	3
4	Dining Room HVAC	2010	4,169	152	27	152		684	4
5	Pantry carpentry,flooring,plumbing	2010	2,911	106	27	106		459	5
6	Director of Nursing office painting	2010	4,245	155	27	155		620	6
7	Remodel Library/Lounge-art,painting,flooring	2010	6,477	236	27	236		944	7
8	2nd floor doors	2010	3,046	111	27	111		527	8
9	Office changes-carpentry, painting, flooring	2011	2,487	90	27	90		323	9
10	Fence	2011	2,750	183	15	183		580	10
11	Mulch and stone	2011	2,662	177	15	177		561	11
12	Laundry Room-Tile, Painting	2011	7,311	266	27	266		887	12
13	Locker Room - Installation of 6 tier box lockers	2011	2,573	94	27	94		337	13
14	Place beds back into service - Carpentry, Flooring, Electrical,	2011	117,350	4,267	27	4,267		15,290	14
15	-Painting and Plumbing								15
16									16
17									17
18	Electrical wiring for EMR	2012	13,699	498	27	498		1,038	18
19									19
20	Landscaping (Planting roses and day lilies Main Entrance)	2014	10,648	177	15	177		177	20
21	Install Automatic Doors (Front Entrance)	2014	6,859	83	15	83		83	21
22	Install LED Lights throughout facility	2014	22,200	67	27	67		67	22
23	R/M Reclass: Elevator door restrictor (Front Entrance)	2014	3,500		10	175	175	175	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	Reconcile book depreciation			149			(149)		33
34	TOTAL (lines 1 thru 33)		$ 7,115,109	$ 43,434		$ 273,641	$ 230,207	$ 3,581,924	34

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 7,115,109	$ 43,434		$ 273,641	$ 230,207	$ 3,581,924	1
2	Building - management company	2002	150,819		40	5,007	5,007	57,947	2
3	HVAC, electrical, security system - management company	2003	1,325		30	362	362	971	3
4	Key card system - management company	2004	208		20	12	12	108	4
5	VAV TX controls - management company	2005	63		20	4	4	31	5
6	Interior Signs-management company	2006	46		5	3	3	25	6
7	Building - management company	2008	7,283		5	271	271	2,737	7
8	Building - management company	2009	1,354		15	28	28	402	8
9	Building - management company	2010	1,320		15	61	61	396	9
10	Building - management company	2011	938		15	49	49	152	10
11	Building - management company	2012	3,209		15	7	7	311	11
12	Building - management company	2013	2,450		15	199	199	226	12
13	Building - management company	2014	1,326		15	75	75	68	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)		$ 7,285,450	$ 43,434		$ 279,719	$ 236,285	$ 3,645,298	34

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 598,275	$ 78,582	$ 80,420	$ 1,838	5	$ 340,832	71
72	Current Year Purchases	62,384	1,448	1,448		5	1,448	72
73	Fully Depreciated Assets	412,642				5	412,642	73
74	Allocated from Mgmt. Co.	257,220		33,436	33,436	5-7	165,563	74
75	TOTALS	$ 1,330,521	$ 80,030	$ 115,304	$ 35,274		$ 920,485	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.			27,285		2,258	2,258	5	23,870	79
80	TOTALS			$ 27,285	$	$ 2,258	$ 2,258		$ 23,870	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,154,155	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,464	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 397,281	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 273,817	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,589,653	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 LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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				2,312			5
6	Allocated from Management Company				2,635			6
7	TOTAL				$ 4,947 **			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: $ 92,619 Description: See Schedule 14A
    (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			645	20
21	TOTAL		$	$ 645	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: **Lexington of LaGrange**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2014**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	8,001
Mailing System	179
Printer	4,589
Medical Equipment	29,809
Oxygen Equipment	49,192
Management Company	849
Total - Line 16	**92,619**

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	24,474	$ 1,088,686	$	24,474	$ 1,088,686	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,164	184,939		4,164	184,939	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		27,371	1,633,285		27,371	1,633,285	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				781,045		781,045	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				1,884			1,884	12
13	Other (specify): See Sch. 16A						14,497		14,497	13
14	TOTAL			$	56,009	$ 2,908,794	$ 795,542	56,009	$ 3,704,336	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: Lexington of LaGrange
IDPH License ID Number: 0038083
Fiscal Year End: 12/31/2014

Schedule 16A

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

		1	2	3	4	5	6	7	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	To (Col.
			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): Oxygen	39(2)					13,957		
13	Other (specify): DME	39(2)					540		
14	TOTAL			$		$	$ 14,497		$

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.

8	
tal Cost 3 + 5 + 6)	
	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
13,957	12
540	13
14,497	14

STATE OF ILLINOIS

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 2,127,006	$ 2,164,101	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 280,171)	3,011,386	3,011,386	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,595	103,595	6
7	Other Prepaid Expenses	5,005	5,005	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): PA Interest Income	2,529	2,529	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,249,521	$ 5,286,616	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		510,899	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	1,103,390	4,624,002	15
16	Equipment, at Historical Cost	532,308	1,357,806	16
17	Accumulated Depreciation (book methods)	(767,266)	(4,589,653)	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): Mortgage cost net		23,536	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 875,484	$ 4,595,090	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,125,005	$ 9,881,706	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,033,121	$ 1,033,121	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	474,753	474,753	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,796	30,796	31
32	Accrued Real Estate Taxes(Sch.IX-B)		367,200	32
33	Accrued Interest Payable		29,233	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	864,588	1,097,410	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,403,258	$ 3,032,513	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,092,486	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)**	$	$ 5,092,486	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,403,258	$ 8,124,999	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,721,747	$ 1,756,707	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,125,005	$ 9,881,706	48

***(See instructions.)**

Facility Name: **Lexington of LaGrange**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2014**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
00-14530-00	Prepaid Insurance	**4,281**	**4,281**
00-22030-00	Accrued Expenses	**54,324**	**54,324**
00-22040-00	Accrued Resident Tax	**13,645**	**13,645**
00-22060-00	Accrued Royl / Vesta Mgmt Fees	**18,282**	**18,282**
00-22120-00	Accrued Rent	**289,711**	**-**
00-22140-00	Accrued Insurance	**18,207**	**18,207**
00-22270-00	Due To Patient Trust Fund	**(4,602)**	**(4,602)**
00-22330-00	Advance - Biweekly Part A Paym	**(51,083)**	**(51,083)**
00-22360-00	Uncollectible Part A Co Pvts	**(32,789)**	**(32,789)**
00-23530-00	Due To - Royal Operations	**26,021**	**26,021**
00-23720-00	Due To Republic	**(2,804)**	**(2,804)**
00-23820-00	Due To Wheeling	**580**	**580**
00-24345-00	Sambel Interest Rate Swap Liability	**-**	**522,533**
00-24400-00	Professional Liabilities Claims	**530,815**	**530,815**
		864,588	**1,097,410**
		-	**-**

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,232,621	1	
2	Restatements (describe):		2	
3	**Post closing adjustment**	(141,955)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,090,666	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,781,081	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	(150,000)	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)**	$ 1,631,081	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,721,747	24	*

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,271,495	1
2	Discounts and Allowances for all Levels	(10,905,680)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,365,815	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,180,558	6
7	Oxygen	73,304	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,253,862	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	1,037	12
13	Barber and Beauty Care	18,441	13
14	Non-Patient Meals	7,553	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,205,562	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	359,031	19
20	Radiology and X-Ray	67,669	20
21	Other Medical Services	528,452	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,187,745	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,511	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,511	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	363	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 363	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,811,296	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,436,581	31
32	Health Care	4,904,289	32
33	General Administration	3,173,720	33
	B. Capital Expense		
34	Ownership	1,325,517	34
	C. Ancillary Expense		
35	Special Cost Centers	4,035,143	35
36	Provider Participation Fee	154,965	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,030,215	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,781,081	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,781,081	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,002,532	44
45	Private Pay - Net Inpatient Revenue	695,475	45
46	Medicare - Net Inpatient Revenue	2,712,184	46
47	Other-(specify) Managed Care	(44,376)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,365,815	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 LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1,690	2,013	$ 119,913	$ 59.57	1
2	Assistant Director of Nursing	30,369	36,159	1,019,570	28.20	2
3	Registered Nurses	28,069	36,013	1,054,181	29.27	3
4	Licensed Practical Nurses	22,920	28,028	731,159	26.09	4
5	CNAs & Orderlies	69,606	84,556	989,108	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,278	7,566	98,021	12.96	10
11	Social Service Workers	6,920	7,782	160,966	20.68	11
12	Dietician	3,227	3,715	78,219	21.05	12
13	Food Service Supervisor	1,745	1,997	41,630	20.85	13
14	Head Cook	1,661	2,035	31,306	15.38	14
15	Cook Helpers/Assistants	17,273	20,650	207,251	10.04	15
16	Dishwashers	3,508	4,140	35,397	8.55	16
17	Maintenance Workers	1,896	2,301	44,274	19.24	17
18	Housekeepers	22,220	27,735	300,026	10.82	18
19	Laundry	3,730	4,325	40,652	9.40	19
20	Administrator	1,458	2,125	139,323	65.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,263	11,660	188,102	16.13	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	1,721	2,039	33,001	16.18	31
32	Other Health C: Memory Care	435	483	7,725	15.99	32
33	Other(specify) See Sch 20A	4,512	5,014	155,048	30.92	33
34	TOTAL (lines 1 - 33)	237,501	290,336	$ 5,474,872 *	$ 18.86	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	60,359	9(3)	36
37	Medical Records Consultant	25	940	10(3)	37
38	Nurse Consultant	Monthly	81,792	10(3)	38
39	Pharmacist Consultant	Monthly	7,975	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	4,651	11(3)	44
45	Social Service Consultant	25	3,817	12(3)	45
46	Other(specify)				46
47	Pulmonary	Monthly	100,122	10(3)	47
48	Medical Consultant	Monthly	2,847	10(7)	48
49	TOTAL (lines 35 - 48)	50	$ 262,503		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 of LaGrange**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2014**

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
Marketing	3,696	4,107	145,077	35.32
Beauty	816	907	9,972	10.99
Total - Line 33 Other (specify):	**4,512**	**5,014**	**155,048**	**$ 30.92**

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Renee Mills	Administrator	0	$ 139,323
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 139,323

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 708,975
Management Fees-Vesta Mgmt.	503,311
Management Fees (Eliminated in Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,212,286
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cassiday Schade	Legal	$ 110,189
Duane Morris	Legal	757
Grabowski Law Center, LLC	Collections	5,584
Appraisal Research Counselors	Appraisers	4,000
McGladrey LLP	Accounting	34,900
Personnel Planners	U/C Consulting	1,778
Much Shelist	Legal	100,874
Pension Administrators	401(k) Administration	540
Scott & Kraus	Legal	1,161
Secretary of State	Filing Fees	36
See Schedule 21C		64,425
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 324,243

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 164,379
Unemployment Compensation Insurance	138,403
FICA Taxes	425,922
Employee Health Insurance	230,965
Employee Meals	14,352
Illinois Municipal Retirement Fund (IMRF)*	
401K	14,410
Other Employee Benefits	19,518
Uniform Expense	275
Tuition	16,821
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,025,045

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	$ 1,945
Advertising: Employee Recruitment	17,842
Health Care Worker Background Check	
(Indicate # of checks performed 226)	2,715
Patient Background Checks 755	9,057
Miscellaneous Licenses & Fees	2,960
Miscellaneous Dues & Subscriptions	2,938
IHCA	750
Less non-allowable dues	(288)
Management Company Allocation	2,586
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,505

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Management Company Allocation	971
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 971

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Lexington of LaGrange**
IDPH License ID Number: **0038083**
Fiscal Year End: **12/31/2014**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Information Control	Computer Services	4,533
Ability Network	Computer Services	1,513
Avalere Health	Computer Services	2,000
Citrix	Computer Services	348
Corepoint	Computer Services	945
E-Health Data Solutions	Computer Services	3,450
Information Controls	Computer Services	2,829
National Research	Computer Services	513
On Shift	Computer Services	7,912
Relias	Computer Services	8,041
Salesforce.Com	Computer Services	4,150
Softchoice	Computer Services	1,608
Symbria	Computer Services	1,200
Tableau	Computer Services	1,716
Availity	Computer Services	139
Centino	Computer Services	750
Lintec	Computer Services	73
Natl Datacare	Computer Services	1,285
Tympani	Computer Services	228
Soft Choice Corporation	Computer Services	1,247
Genesis	Computer Services	75
Info Controls	Computer Services	253
Telemedicine	Computer Services	1,800
Ms Licensing	Computer Services	8,565
Health Medx	Computer Services	9,253

		64,425
Total Schedule V, line 19, column 3		**324,243**
Less: Non-Allowable Legal Fees		(7,170)
Less: Marketing Software		(4,150)
Allocated from Sambell		
Secretary of State	Filing Fees	200
Allocated from Management Company		
Much Shelist	Legal	97
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	31
Duane Morris	Legal	167
McGladrey LLP	Accounting	874
Frost, Ruttenberg & Rothblatt, P.C	Accounting	60
Gilson Labus & Silverman	Accounting	644
Illinois Secretary of State	Filing Fees	24
LaSalle Network	Recruiting/Finance	3,223
Pension Administrators, Inc.	401K Administration	200
Gene Whitehorn	Medicaid Reimb Specialist	868
M. Werner Consulting	Financial Consultant	1,139
McNamara & Associates	SNF Consultants	167
Healthcents	Managed Care Consultants	221
Computer Services	Computer Consulting	9,392
Allocated from SV of Lombard II		
Gilson Labus & Silverman	Accounting	61
Illinois Secretary of State	Filing Fees	9
	Total (agree to Schedule V, line 19, column 8)	330,301

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 LaGrange # 0038083 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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? **Yes**
If YES, give association name and amount. **IHCA - $462**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **25,129** 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. $ **154,965**
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. $ **14,352** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,553**

(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.