

Facility Name & ID Number Lexington HCC Bloomingdale

0035188 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	166	Skilled (SNF)	166	60,590	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF			11,338	11,338	8
9	SNF/PED					9
10	ICF	33,199	6,851		40,050	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,199	6,851	11,338	51,388	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.81%

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 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

I. On what date did you start providing long term care at this location?

Date started 05/01/89

J. Was the facility purchased or leased after January 1, 1978?

YES Date New Construction NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 166 and days of care provided 9,836

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number

Lexington HCC Bloomingdale

0035188

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	365,494	39,841	4,459	409,794		409,794		409,794		1
2	Food Purchase		294,094		294,094		294,094	(14,959)	279,135		2
3	Housekeeping	287,707	34,338		322,045		322,045	293	322,338		3
4	Laundry	66,356	20,212		86,568		86,568		86,568		4
5	Heat and Other Utilities			190,391	190,391		190,391	5,938	196,329		5
6	Maintenance	41,285		208,974	250,259		250,259	63,725	313,984		6
7	Other (specify):* Mgmt. Co. Alloc. Ben							8,707	8,707		7
8	TOTAL General Services	760,842	388,485	403,824	1,553,151		1,553,151	63,704	1,616,855		8
	B. Health Care and Programs										
9	Medical Director			113,750	113,750		113,750		113,750		9
10	Nursing and Medical Records	3,654,825	282,452	126,217	4,063,494		4,063,494	35,007	4,098,501		10
10a	Therapy										10a
11	Activities	247,396	23,627	6,721	277,744		277,744		277,744		11
12	Social Services	97,300		4,999	102,299		102,299		102,299		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt. Co. Alloc. Ben							5,044	5,044		15
16	TOTAL Health Care and Programs	3,999,521	306,079	251,687	4,557,287		4,557,287	40,051	4,597,338		16
	C. General Administration										
17	Administrative	141,252		1,278,997	1,420,249		1,420,249	(1,230,066)	190,183		17
18	Directors Fees										18
19	Professional Services			211,136	211,136		211,136	(2,896)	208,240		19
20	Dues, Fees, Subscriptions & Promotions			27,243	27,243		27,243	11,030	38,273		20
21	Clerical & General Office Expenses	171,869	30,118	52,722	254,709		254,709	520,590	775,299		21
22	Employee Benefits & Payroll Taxes			861,093	861,093		861,093	13,996	875,089		22
23	Inservice Training & Education			11,674	11,674		11,674	753	12,427		23
24	Travel and Seminar			472	472		472	531	1,003		24
25	Other Admin. Staff Transportation			8,595	8,595		8,595	12,774	21,369		25
26	Insurance-Prop.Liab.Malpractice			377,866	377,866		377,866	4,988	382,854		26
27	Other (specify):* Mgmt. Co. Alloc. Ben							82,716	82,716		27
28	TOTAL General Administration	313,121	30,118	2,829,798	3,173,037		3,173,037	(585,584)	2,587,453		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,073,484	724,682	3,485,309	9,283,475		9,283,475	(481,829)	8,801,646		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 HCC Bloomingdale

#0035188

Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			211,299	211,299		211,299	318,106	529,405			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,393	25,393		25,393	196,087	221,480			32
33	Real Estate Taxes							176,336	176,336			33
34	Rent-Facility & Grounds			1,249,116	1,249,116		1,249,116	(1,245,725)	3,391			34
35	Rent-Equipment & Vehicles			58,305	58,305		58,305	3,564	61,869			35
36	Other (specify):*											36
37	TOTAL Ownership			1,544,113	1,544,113		1,544,113	(551,632)	992,481			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		327,959	1,427,408	1,755,367		1,755,367		1,755,367			39
40	Barber and Beauty Shops			17,010	17,010		17,010		17,010			40
41	Coffee and Gift Shops			2,238	2,238		2,238		2,238			41
42	Provider Participation Fee			343,045	343,045		343,045		343,045			42
43	Other (specify):* Non-Allowable Co	95,424		148,764	244,188		244,188	(244,188)				43
44	TOTAL Special Cost Centers	95,424	327,959	1,938,465	2,361,848		2,361,848	(244,188)	2,117,660			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,168,908	1,052,641	6,967,887	13,189,436		13,189,436	(1,277,649)	11,911,787			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(963)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,234)	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	(1,733)	30		9
10	Interest and Other Investment Income	(88,587)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9,087)	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	(16,408)	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	(52,754)	43		24
25	Fund Raising, Advertising and Promotional	(33,147)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,367)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	234,654	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 16,374		\$	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	2	
		Amount	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)	(1,294,023)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,294,023)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,277,649)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lexington HCC Bloomingdale

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Radiology	\$ (17,933)	43	1
2	Laboratory	(8,217)	43	2
3	Out of period legal	(2,236)	19	3
4	Trust Fees	(60)	43	4
5	Collection Fees	(16,352)	19	5
6	Nonallowable Marketing Salaries	(95,424)	43	6
7	Education and training marketing	(472)	24	7
8	Unrealized loss on FMV swap	380,508	43	8
9	Development expense	(11)	43	9
10	Disallow Marketing Software	(5,149)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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	234,654		49

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. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Fees	\$	Sambell of Bloomingdale Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation Expense		Sambell of Bloomingdale Limited Partnership	**	277,073	277,073	2
3	V	32 Amortization of Mortgage Cost		Sambell of Bloomingdale Limited Partnership	**	2,171	2,171	3
4	V	32 Interest	78,789	Sambell of Bloomingdale Limited Partnership	**	347,358	268,569	4
5	V	33 Property Tax		Sambell of Bloomingdale Limited Partnership	**	169,116	169,116	5
6	V	34 Rent	1,249,116	Sambell of Bloomingdale Limited Partnership	**		(1,249,116)	6
7	V	43 State Replacement Tax		Sambell of Bloomingdale Limited Partnership	**	4,394	4,394	7
8	V	43 Trust Fees		Sambell of Bloomingdale Limited Partnership	**	60	60	8
9	V	43 Unrealized loss on FMV of Swap	380,508	Sambell of Bloomingdale Limited Partnership	**		(380,508)	9
10	V							10
11	V			** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Sambell of Bloomingdale Limited Partnership				11
12	V							12
13	V							13
14	Total		\$ 1,708,413			\$ 800,372	\$ * (908,041)	14

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.	**	4,894		4,894	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	289		289	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	755		755	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	56,973		56,973	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	6,474		6,474	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	278		278	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	8,707		8,707	22	
23	V	10 Medical consultant		Royal Management Corp.	**	1,998		1,998	23	
24	V	10 Management allocation - salaries		Royal Management Corp.	**	33,009		33,009	24	
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	5,044		5,044	25	
26	V	17 Management allocation - salaries		Royal Management Corp.	**	48,931		48,931	26	
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	13,212		13,212	27	
28	V	19 Professional fees		Royal Management Corp.	**	7,429		7,429	28	
29	V	20 Dues & subscriptions		Royal Management Corp.	**	617		617	29	
30	V	20 Advertising - help wanted		Royal Management Corp.	**	10,413		10,413	30	
31	V	21 Management allocation - salaries		Royal Management Corp.	**	492,324		492,324	31	
32	V	21 Bank charges		Royal Management Corp.	**	3,360		3,360	32	
33	V	21 Office supplies & printing		Royal Management Corp.	**	11,150		11,150	33	
34	V	21 Postage		Royal Management Corp.	**	3,490		3,490	34	
35	V	21 Telephone		Royal Management Corp.	**	10,266		10,266	35	
36	V								36	
37	V	**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Sambell Bloomingdale Partnership								37
38	V								38	
39	Total		\$			\$ 719,906	\$ *	719,906	39	

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	23 <u>Inservice Training</u>	\$	<u>Royal Management Corp.</u>	**	\$ 753	\$	753	15
16	V	24 <u>Travel & seminar</u>		<u>Royal Management Corp.</u>	**	1,003		1,003	16
17	V	25 <u>Auto expense</u>		<u>Royal Management Corp.</u>	**	12,774		12,774	17
18	V	26 <u>Insurance general</u>		<u>Royal Management Corp.</u>	**	4,988		4,988	18
19	V	27 <u>Management allocation - employee benefits</u>		<u>Royal Management Corp.</u>	**	82,716		82,716	19
20	V	30 <u>Depreciation</u>		<u>Royal Management Corp.</u>	**	42,766		42,766	20
21	V	32 <u>Interest</u>		<u>Royal Management Corp.</u>	**	11,847		11,847	21
22	V	32 <u>Amortization of mortgage costs</u>		<u>Royal Management Corp.</u>	**	2,087		2,087	22
23	V	33 <u>Property taxes</u>		<u>Royal Management Corp.</u>	**	7,220		7,220	23
24	V	34 <u>Rent expense</u>		<u>Royal Management Corp.</u>	**	3,391		3,391	24
25	V	35 <u>Equipment rental</u>		<u>Royal Management Corp.</u>	**	1,563		1,563	25
26	V	17 <u>Management fees</u>	1,278,997	<u>Royal Management Corp.</u>	**	0		(1,278,997)	26
27	V	35 <u>Auto Lease</u>		<u>Royal Management Corp.</u>	**	2,001		2,001	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								38
39	Total		\$ 1,278,997			\$ 173,109	\$ *	(1,105,888)	39

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

Facility Name & ID Number

Lexington HCC Bloomingdale

0035188

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	22.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Vesta Mgmt	Lombard	Mgmt. Company	3
4	Jeffrey J. Bell Revocable Trust	8.25%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Group, LLC			4
5	Lawrence W. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Sambell of	Bloomingtondale	Real Estate	5
6	David S. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Bloomingtondale Ltd. Ptsp.		Property	6
7	David S. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Royal Management	Lombard	Mgmt. Company	7
8	Jeffrey J. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Corporation			8
9	Lawrence W. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Lexington Financial	Lombard	Finance Company	9
10					Services, LLC			10
11					Lexington Square	Lombard	Independent and	11
12					Life Care of		Assisted Living	12
13					Lombard, LLC		Facility	13
14					Lexington Square	Elmhurst	Independent	14
15					Life Care of		Living Facility	15
16					Elmhurst, LLC			16
17					Samvest of	Lombard	Lessor	17
18					Lombard II, LLC			18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington HCC Bloomingdale # 0035188 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,963	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,947	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,090	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,890	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	18,041	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 48,931		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

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01/01/13

Ending: 12/31/13

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 NO

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping supplies	Bed Days	723,430	10	\$ 3,503	0	60,590	\$ 293	1
2	5	Utilities - gas & electric	Bed Days	723,430	10	58,428	0	60,590	4,894	2
3	5	Utilities - water & sewer	Bed Days	723,430	10	3,454	0	60,590	289	3
4	5	Utilities - maintenance office	Bed Days	723,430	10	9,011	0	60,590	755	4
5	6	Management allocation - salaries	Bed Days	723,430	10	680,245	680,245	60,590	56,973	5
6	6	Repairs & maintenance	Bed Days	723,430	10	77,300	0	60,590	6,474	6
7	6	Scavenger & exterminating	Bed Days	723,430	10	3,323	0	60,590	278	7
8	7	Management allocation - employe	Bed Days	723,430	10	103,957	0	60,590	8,707	8
9	10	Medical consultant	Bed Days	723,430	10	23,850	0	60,590	1,998	9
10	10	Management allocation - salaries	Bed Days	723,430	10	394,114	394,114	60,590	33,009	10
11	15	Management allocation - employe	Bed Days	723,430	10	60,229	0	60,590	5,044	11
12	17	Management allocation - salaries	Bed Days	723,430	10	584,219	584,219	60,590	48,931	12
13	19	Computer consultant & supplies	Bed Days	723,430	10	157,743	0	60,590	13,212	13
14	19	Professional fees	Bed Days	723,430	10	88,700	0	60,590	7,429	14
15	20	Dues & subscriptions	Bed Days	723,430	10	7,368	0	60,590	617	15
16	20	Advertising - help wanted	Bed Days	723,430	10	124,332	0	60,590	10,413	16
17	21	Management allocation - salaries	Bed Days	723,430	10	5,878,235	5,878,235	60,590	492,324	17
18	21	Bank charges	Bed Days	723,430	10	40,121	0	60,590	3,360	18
19	21	Office supplies & printing	Bed Days	723,430	10	133,126	0	60,590	11,150	19
20	21	Postage	Bed Days	723,430	10	41,674	0	60,590	3,490	20
21	21	Telephone	Bed Days	723,430	10	122,578	0	60,590	10,266	21
22										22
23										23
24										24
25	TOTALS					\$ 8,595,510	\$ 7,536,813		\$ 719,906	25

Facility Name & ID Number Lexington HCC Bloomingdale

0035188

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 NO

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	23	Inservice Training	Bed Days	723,430	10	\$ 8,988	\$ 60,590	\$ 753	1
2	24	Travel and Seminar	Bed Days	723,430	10	11,975	60,590	1,003	2
3	25	Auto expense	Bed Days	723,430	10	152,523	60,590	12,774	3
4	26	Insurance general	Bed Days	723,430	10	59,556	60,590	4,988	4
5	27	Management allocation - employe	Bed Days	723,430	10	987,607	60,590	82,716	5
6	30	Depreciation	Bed Days	723,430	10	510,614	60,590	42,766	6
7	32	Interest	Bed Days	723,430	10	141,456	60,590	11,847	7
8	32	Amortization of mortgage costs	Bed Days	723,430	10	24,914	60,590	2,087	8
9	33	Property taxes	Bed Days	723,430	10	86,200	60,590	7,220	9
10	34	Rent expense	Bed Days	723,430	10	40,490	60,590	3,391	10
11	35	Equipment rental	Bed Days	723,430	10	18,660	60,590	1,563	11
12	35	Auto Lease	Bed Days	723,430	10	23,891	60,590	2,001	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					\$ 2,066,874	\$	\$ 173,109	25

Facility Name & ID Number

Lexington HCC Bloomingdale

0035188

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Lexington Financial						\$	\$			\$	1						
2	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,375,000	5,596,405	1/1/2033	Variable	341,042	2						
3												3						
4												4						
5							Interest on financing insurance premium				1,077	5						
Working Capital																		
6	Bank of America		X	Working Capital	Varies	9/30/13	13,700,000	610,000	9/30/14	Prime/Libor	24,316	6						
7	Shareholder	X		Capital Improvements	Varies	6/26/10	783,500		12/1/13	Prime +1%	6,316	7						
8												8						
9	TOTAL Facility Related						\$ 20,858,500	\$ 6,206,405			\$ 372,751	9						
B. Non-Facility Related*																		
10											(161,060)	10						
11											2,171	11						
12											(6,316)	12						
13											13,934	13						
14	TOTAL Non-Facility Related						\$	\$			(151,271)	14						
15	TOTALS (line 9+line14)						\$ 20,858,500	\$ 6,206,405			\$ 221,480	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.			\$	163,200	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.)	2012		\$	163,116	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(84)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	169,200	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 Mgmt. Co.		7,220	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	176,336	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	128,400	8	FOR BHF USE ONLY	
	2009	129,666	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$
	2010	133,694	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2011	157,453	11	15	LESS REFUND FROM LINE 6 \$
	2012	163,116	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
See attached real estate accrual sheet					

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington HCC Bloomingdale COUNTY Dupage
 FACILITY IDPH LICENSE NUMBER 0035188
 CONTACT PERSON REGARDING THIS REPORT Karen Gillis
 TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-15-401-003</u>	<u>Land & Building</u>	\$ <u>163,115.88</u>	\$ <u>163,115.88</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>262,977.74</u>	\$ <u>7,220.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>426,093.62</u></u>	\$ <u><u>170,335.88</u></u>

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	1
2	<u>Management Company Allocation</u>			<u>17,359</u>	2
3	TOTALS	43,000		\$ 419,907	3

Facility Name & ID Number Lexington HCC Bloomingdale

0035188

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82	1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 2,101,403	4
5	9	1992	1992	178,974		35	5,114	5,114	112,501	5
6	75	1994	1994	2,022,894		35	57,797	57,797	1,127,040	6
7										7
8										8
	Improvement Type**									
9	Capitalized repairs	1989		9,080		10			9,080	9
10	Building Improvements	1990		3,674		10			3,674	10
11	Building Improvements	1991		2,586		10			2,586	11
12	Building Improvements	1992		3,154		10			2,997	12
13	Building Improvements	1993		1,582		10			1,503	13
14	Building Improvements	1994		15,734		10			15,734	14
15	Land Improvements	1994		1,381		10			1,381	15
16	Land Improvements	1995		1,074		15			1,068	16
17	Building Improvements	1995		1,288		35	37	37	699	17
18	Building Improvements	1995		9,433	270	35	270		4,995	18
19	Building Improvements	1995		43,839	1,252	35	1,252		23,163	19
20	Concrete flooring, fire doors, tile, sprinkler heads, and basement renovation	1996		8,706		15			3,606	20
21	Land improvements	1996		7,858		15			7,858	21
22										22
23										23
24	Resident room heaters	1997		3,563	102	35	102		1,732	24
25	Automatic doors	1997		12,950	370	35	370		5,951	25
26	Basement renovation	1997		59,358		10			59,358	26
27	Land Improvement - outdoor flagpoles	1997		1,574		15			1,574	27
28	1st Floor Remodel (Nurses Station/Lounge)	1998		76,487		10			76,487	28
29	Wiring for MDS	1998		4,506		10			4,506	29
30	Flag Pole	1998		787		10			787	30
31	Resurface/Stripe Parking Lot	1998		9,777		10			9,777	31
32	Kitchen tile/paint	1999		718		10			718	32
33	1st Floor Remodel	1999		3,296		10			3,296	33
34	Roof repairs	2000		5,748	383	15	383		5,172	34
35	Sump pump	2000		2,534		10			2,534	35
36	Sump pump basin repair	2000		6,307		10			6,307	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington HCC Bloomingdale

0035188

Report Period Beginning:

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Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic door closers	2000	\$ 1,300	\$ 87	15	\$ 87	\$	\$ 1,172	37
38	Infrared curtains for elevator doors	2001	3,000		10			3,000	38
39	Ejector pump	2002	3,050		5			3,050	39
40	Lift station pump	2002	3,359		5			3,359	40
41	New asphalt parking lot	2003	16,450	1,371	10	1,371		16,450	41
42	Roof repairs	2003	2,900	266	10	266		2,900	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		2,085	43
44	Kitchen remodel	2003	7,188	359	20	359		3,742	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		32,734	45
46	Floor tile	2003	16,305	815	20	815		8,967	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		38,204	47
48	Rehab-floor tile	2003	8,117	406	20	406		4,093	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		21,528	49
50	Foundation repair	2003	4,800	240	20	240		2,500	50
51	Parking lot	2004	24,550	2,455	10	2,455		23,118	51
52	Kitchen walk-in cooler floor	2004	7,161	716	10	716		6,683	52
53	Old Towne rehab	2004	13,967	698	20	698		6,458	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		94,893	54
55	Create first floor therapy room	2004	185	9	20	9		63	55
56	Transitional unit	2005	213	11	20	11		76	56
57	Landscaping	2005	8,814	441	20	441		3,601	57
58	Roof repairs	2005	3,250	163	20	163		1,330	58
59	HVAC upgrade	2005	7,048	352	20	352		2,935	59
60	Kitchen repair	2005	1,631	82	20	82		695	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		7,960	61
62	Window treatments	2005	3,606		5			3,606	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		3,223	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		16,857	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		14,693	65
66	Basement renovation	2005	14,176	709	20	709		5,671	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,126,921	\$ 36,363		\$ 184,503	\$ 148,140	\$ 3,933,133	70

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

Facility Name & ID Number Lexington HCC Bloomingdale

0035188

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,126,921	\$ 36,363		\$ 184,503	\$ 148,140	\$ 3,933,133	1
2	Landscaping Enhancement	2006	7,084	472	15	472		3,462	2
3	Install Kitchen Sink	2006	2,915	146	20	146		1,131	3
4	Common area rehab	2006	2,382	119	20	119		913	4
5	Paint Building Exterior	2006	19,500		5			19,500	5
6	Patio	2006	53,305	3,554	15	3,554		25,173	6
7	Retaining Wall	2007	2,950	197	15	197		1,313	7
8	Roof Repair	2007	17,050	853	20	853		5,757	8
9	Air Conditioning units	2007	4,338	217	20	217		1,501	9
10	Paver walk and stairway	2007	10,500	525	20	525		3,500	10
11	Fire exit stairways	2007	9,379	469	20	469		2,892	11
12	Landscaping	2008	35,147	2,343	15	2,343		11,910	12
13	Parking Lot - Seal & Striping	2008	6,460	323	20	323		1,777	13
14	Roof	2008	15,300	765	20	765		4,335	14
15	HVAC - Spot Coolers	2008	5,589	140	40	140		700	15
16	Electrical - Storage Room	2008	4,768	238	20	238		1,289	16
17	Electrical - Fire Alarm Panel	2008	118,395	5,920	20	5,920		30,093	17
18	1st floor remodel-Carpentry,Flooring,Electrical,Parking fixtures	2008	557,202		27	20,262	20,262	114,818	18
19	Lawn Irrigation	2009	14,435	962	15	962		4,169	19
20	Landscaping	2009	12,950	863	15	863		3,596	20
21	Roof	2009	49,330	2,467	20	2,467		10,279	21
22	Front Entrance	2009	19,392	485	40	485		2,021	22
23	HVAC-Window unit	2009	41,315	4,131	10	4,131		19,623	23
24	HVAC Quick connectors	2009	7,058	706	10	706		3,353	24
25	Lift pump	2009	14,783	1,478	10	1,478		6,158	25
26	Fire alarm panel	2009	93,279	4,664	20	4,664		19,045	26
27	Pantry Cabinets	2009	3,523	352	10	352		1,467	27
28	Therapy Room counter tops-carpentry	2009	2,500	250	10	250		1,188	28
29	Patio Pergola	2009	7,930	397	20	397		1,720	29
30	Patio Stamped Concrete	2009	13,901	927	15	927		4,094	30
31	Lobby 1st floor remodel-Carpentry,doors frames,electrical painting,wallpaper	2009	52,018		27	1,892	1,892	7,568	31
32									32
33	OT Remodel-carpentry,electrical	2010	791,224		27	62,223	62,223	197,040	33
34	TOTAL (lines 1 thru 33)		\$ 8,122,823	\$ 70,326		\$ 302,843	\$ 232,517	\$ 4,444,518	34

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

Facility Name & ID Number Lexington HCC Bloomingdale

0035188

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,122,823	\$ 70,326		\$ 302,843	\$ 232,517	\$ 4,444,518	1
2									2
3	Lawn irrigation system	2010	5,503	367	15	367		1,284	3
4	Roof work	2010	15,268	557	27	557		1,949	4
5	HVAC Chiller	2010	84,004	3,064	27	3,064		9,703	5
6	Pantry-shelves	2010	23,805	868	27	868		2,966	6
7	Wanderguard	2010	3,747	137	27	137		445	7
8	Concrete work	2010	7,080	258	27	258		817	8
9	Automatic Doors	2010	4,903	490	10	490		1,715	9
10	Physician office carpentry and electrical update	2010	4,677	171	27	171		527	10
11	Library/Lounge-art, painting	2010	13,763	502	27	502		1,632	11
12	Pergola and patio wall	2010	21,186	3,982	27	3,982		14,264	12
13	Office carpentry and electrical changes	2010	5,744	209	27	209		662	13
14	Pavroll office-painting, carpentry	2011	18,505	673	27	673		1,458	14
15	Mulch stone and perennials	2011	4,364	291	15	291		630	15
16	Admissions office-painting, carpentry	2011	2,868	104	27	104		225	16
17	Parking lot lights	2011	6,070	221	27	221		479	17
18	Roof work	2011	93,530	3,401	27	3,401		7,085	18
19	Front entrance-awning, doors	2011	11,869	432	27	432		1,223	19
20	Duct extension	2011	3,476	126	27	126		368	20
21	HVAC unit	2011	23,400	851	27	851		1,844	21
22	Fluid pump	2011	8,400	305	27	305		865	22
23	Plumbing valves	2011	9,257	337	27	337		702	23
24	Laundry room-painting, electrical, tile	2011	8,386	305	27	305		686	24
25	Elevator-electrical work	2011	60,523	2,201	27	2,201		4,769	25
26	VCT Floor OT-painting, electrical, carpentry	2011	49,344	1,794	27	1,794		3,738	26
27									27
28	Front entrance door	2012	5,387	196	27	196		261	28
29	Sprinklers building	2012	6,500	236	27	236		275	29
30	Washing machine slab	2012	3,500	127	27	127		201	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,627,881	\$ 92,531		\$ 325,048	\$ 232,517	\$ 4,505,291	34

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

Facility Name & ID Number Lexington HCC Bloomingdale

0035188

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,627,881	\$ 92,531		\$ 325,048	\$ 232,517	\$ 4,505,291	1
2	Generator Exhaust Pipe - Rooftop	2013	9,715	177	27	177		177	2
3	EMR Wiring - Entire Facility	2013	14,022	42	27	42		42	3
4									4
5	Reconcile to book depreciation			1,735			(1,735)		5
6									6
7									7
8	Building - management company	2002	240,208		40	6,995	6,995	85,146	8
9	HVAC, electrical, security system - management company	2003	2,110		30	529	529	1,483	9
10	Key card system - management company	2004	332		20	16	16	156	10
11	VAV TX controls - management company	2005	101		20	5	5	45	11
12	Interior Signs - management company	2006	73		5	5	5	35	12
13	Building improvements - management company	2008	11,545		5	554	554	3,829	13
14	Building improvements - management company	2009	2,133		15	39	39	516	14
15	Building improvements - management company	2010	2,081		15	86	86	491	15
16	Building improvements - management company	2011	1,495		15	68	68	172	16
17	Building improvements - management company	2012	5,036		15	10	10	302	17
18	Building improvements - management company	2013	3,902		15	75	75	75	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,920,634	\$ 94,485		\$ 333,647	\$ 239,162	\$ 4,597,760	34

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

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	\$ 1,218,612	\$ 116,144	\$ 160,702	\$ 44,558	5	\$ 796,479	71
72	Current Year Purchases	12,399	670	670		5	670	72
73	Fully Depreciated Assets	143,890				5	143,890	73
74	Allocated from Mgmt. Co.	421,633		30,890	30,890	5-7	225,373	74
75	TOTALS	\$ 1,796,534	\$ 116,814	\$ 192,262	\$ 75,448		\$ 1,166,412	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.			41,855		3,496	3,496	5	35,539	79
80	TOTALS			\$ 41,855	\$	\$ 3,496	\$ 3,496		\$ 35,539	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)	\$ 11,178,930	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 211,299	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 529,405	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 318,106	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,799,711	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				3,391			6
7	TOTAL				\$ 3,391			7

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: _____ *

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: \$ 59,868 Description: Copier-\$9,665, Mail Sys-\$225,Printer-\$3,484, Med Eq.-\$20,261, Oxy Eq.-\$24,670, Mgmt. Co.-\$1,563

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Mgmt. Co.			2,001	20
21	TOTAL		\$	\$ 2,001	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 HCC Bloomingdale # 0035188 Report Period Beginning: 01/01/13 Ending: 12/31/13
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8			
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
			Units of Service			Units	Cost							
1	Licensed Occupational Therapist	39(3)	hrs	\$	10,861	\$	500,583	\$	10,861	\$	500,583	1		
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,719		162,742		2,719		162,742	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39(3)	hrs		11,111		764,083		11,111		764,083	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 prescripts					316,823			316,823	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Other (specify): <u>Oxygen</u>	39(2)						8,579			8,579	12		
13	Other (specify): <u>DME</u>	39(2)						2,557			2,557	13		
14	TOTAL			\$	24,691	\$	1,427,408	\$	327,959	\$	24,691	\$	1,755,367	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lexington HCC Bloomingdale# 0035188Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 446,064	\$ 491,902	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (149,958))	1,789,829	1,789,829	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,313,464	8
9	Other(specify): <u>PA Interest Income</u>	21,499	21,499	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,257,392	\$ 3,616,694	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,261	64,261	12
13	Land		419,907	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	2,039,552	3,737,903	15
16	Equipment, at Historical Cost	789,113	1,838,389	16
17	Accumulated Depreciation (book methods)	(1,327,236)	(5,799,711)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage Cost, net</u>		42,086	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,565,690	\$ 5,485,566	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,823,082	\$ 9,102,260	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 506,152	\$ 506,152	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	610,000	610,000	29
30	Accrued Salaries Payable	437,490	437,490	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,716	3,716	31
32	Accrued Real Estate Taxes(Sch.IX-B)		169,200	32
33	Accrued Interest Payable		24,637	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	543,211	1,171,933	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,100,569	\$ 2,923,128	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,596,405	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)	\$	\$ 5,596,405	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,100,569	\$ 8,519,533	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,722,513	\$ 582,727	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,823,082	\$ 9,102,260	48

*(See instructions.)

Lexington Health Care Center of Bloomington, Inc.
Provider # 0035188
1/1/13-12/31/13

Schedule 17A

XV. Balance Sheet
 C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to Merit Hospice	10,000	10,000
Due to/from Rehab Care Therapy	25,075	25,075
Due from LLC 1		1,451
Prepaid Insurance	29,741	29,741
Escrow-Insurance	(77,250)	(77,250)
Accrued Expenses	43,759	43,759
Accrued Resident Tax	57,270	57,270
Accrued Royl/Vesta Mgmt. Fees	(19,181)	(19,181)
Accrued Rent	230,533	
Accrued Insurance	77,870	77,870
Due to Patient Trust Fund	(47,328)	(47,328)
Advance Bi-weekly part A payments	(27,190)	(27,190)
Due to-Royal Operations	25,386	25,386
Due to Republic	5,458	5,458
Due to Lombard	836	836
Sambel Interest Rate Swap Liability	-	857,804
Professional Liabilities Claims	208,232	208,232
	<u>543,211</u>	<u>1,171,933</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,143,142	1
2	Restatements (describe):		2
3	Post closing adjustment	122,502	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,265,644	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(526,194)	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	(16,937)	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)	\$ (543,131)	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)	\$ 1,722,513	24 *

* This must agree with page 17, line 47.

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,041,899	1
2	Discounts and Allowances for all Levels	(7,437,741)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,604,158	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,273,045	6
7	Oxygen	5,622	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,278,667	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,427	12
13	Barber and Beauty Care	21,844	13
14	Non-Patient Meals	963	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	375,468	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	127,510	19
20	Radiology and X-Ray	25,192	20
21	Other Medical Services	144,742	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 698,146	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	82,271	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 82,271	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,663,242	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,553,151	31
32	Health Care	4,557,287	32
33	General Administration	3,173,037	33
B. Capital Expense			
34	Ownership	1,544,113	34
C. Ancillary Expense			
35	Special Cost Centers	2,018,803	35
36	Provider Participation Fee	343,045	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,189,436	40
41	Income before Income Taxes (line 30 minus line 40)**	(526,194)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (526,194)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,572,259	44
45	Private Pay - Net Inpatient Revenue	1,522,064	45
46	Medicare - Net Inpatient Revenue	1,476,755	46
47	Other-(specify) <u>Managed Care</u>	33,080	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,604,158	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 HCC Bloomingdale

0035188

Report Period Beginning:

01/01/13

Ending:

12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,901	2,270	\$ 124,745	\$ 54.95	1
2	Assistant Director of Nursing	22,359	27,153	741,269	27.30	2
3	Registered Nurses	21,880	26,844	870,827	32.44	3
4	Licensed Practical Nurses	18,221	21,747	573,506	26.37	4
5	CNAs & Orderlies	90,149	107,159	1,309,749	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,223	12,697	169,005	13.31	10
11	Social Service Workers	4,407	5,125	97,300	18.99	11
12	Dietician	1,723	1,983	33,142	16.71	12
13	Food Service Supervisor	1,730	2,021	42,062	20.81	13
14	Head Cook	1,828	2,174	34,048	15.66	14
15	Cook Helpers/Assistants	9,899	11,727	118,735	10.12	15
16	Dishwashers	12,967	15,091	137,507	9.11	16
17	Maintenance Workers	2,080	2,372	41,285	17.41	17
18	Housekeepers	25,382	30,276	287,707	9.50	18
19	Laundry	6,445	7,363	66,356	9.01	19
20	Administrator	1,587	2,126	141,252	66.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,282	11,164	171,869	15.39	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	1,772	2,185	34,729	15.89	31
32	Other Health C: <u>Memory Care</u>	3,667	4,261	78,391	18.40	32
33	Other(specify) <u>Marketing</u>	3,490	3,878	95,424	24.61	33
34	TOTAL (lines 1 - 33)	249,992	299,616	\$ 5,168,908 *	\$ 17.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 113,750	9(3)	36
37	Medical Records Consultant	Monthly 883	10(3)	37
38	Nurse Consultant	Monthly 63,574	10(3)	38
39	Pharmacist Consultant	Monthly 9,937	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	12 3,870	11(3)	44
45	Social Service Consultant	12 4,999	12(3)	45
46	Other(specify) <u>Pulmonary</u>	Monthly 13,111	10(3)	46
47	<u>Medical Consultant</u>	Monthly 1,998	10(7)	47
48				48
49	TOTAL (lines 35 - 48)	24 \$ 212,121		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	1,936 38,712	10(3)	52
53	TOTAL (lines 50 - 52)	1,936 \$ 38,712		53

Lexington Health Care Center of Bloomingdale, Inc.

Provider # 0035188

1/1/13 - 12/31/13

Schedule 21C

XIX. Support Schedules

C. Professional Services

Vendor/Payee

Amalgamated Bank of Chicago	Financial	474
Standard & Poor	Financial	533
Secretary of State	Filing Fees	238
Ability Network	Computer Services	1,112
Americorp Financial	Computer Services	65,849
Avalere Health	Computer Services	2,000
Avality	Computer Services	50
Bank of America (for EMR)	Computer Services	(1,900)
Compaq Commercial Repair	Computer Services	48
Corepoint	Computer Services	974
E-Fax Corp	Computer Services	480
E-Health Data Solutions	Computer Services	2,925
ESNF	Computer Services	700
Health Medx	Computer Services	12,426
Information Controls	Computer Services	1,105
Kronos	Computer Services	280
Lintech LLC	Computer Services	4,175
MNJ Technologies	Computer Services	215
MS Licensing	Computer Services	5,131
My Innerview	Computer Services	5,630
National Datacare	Computer Services	2,129
On Shift	Computer Services	8,317
Paragon Clinical	Computer Services	400
Real Med Corp	Computer Services	140
Relias	Computer Services	5,796
Rightpoint	Computer Services	140
Salesforce.com	Computer Services	5,149
SoftChoice Corporation	Computer Services	1,112
Telemedicine	Computer Services	5,400
Trisis	Computer Services	128
Tympani	Computer Services	1,935

133,091

Total, Agrees to Schedule V, Line 19, Column 3

211,136

Lexington Health Care Center of Bloomingdale, Inc.
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Allocated from Management Co.

Much Shelist	Legal	409
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	371
McGladrey LLP	Accounting	1,442
Illinois Secretary of State	Filing Fees	33
Gilson Labus & Silverman	KEP	36
Personnel Planners	U/C Consultant	36
LaSalle Network	Recruiting/Finance	1,880
Pension Administrators, Inc.	401K Administration	237
Katten, Muchin, Rosenman	KEP	238
Gene Whitehorn	Medicaid Reimb Specialist	542
Burlington Group	Recruitment	78
M Werner Consulting	Financial Consultant	1,898
Bussey Environment, Inc	Environmental Consulting	80
Computer Services	Computer Consulting	13,212
Allocated from Samvest of Lombard II	Accounting	135
	Filing Fees	13
Allocated from Sambell		
Secretary of State	Filing Fees	200
Nonallowable legal fees		(2,236)
Nonallowable collection fees		(16,352)
Disallow Marketing Software		(5,149)
Total, Agrees to Schedule V, Line 19, Column 8		<u><u>208,240</u></u>

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	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 HCC Bloomingdale# 0035188Report Period Beginning: 01/01/13Ending: 12/31/13**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. \$ 49,216 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. \$ 343,045
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,996 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 963
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.