

Facility Name & ID Number Lexington of LaGrange

0038083 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			25,140	25,140	8
9	SNF/PED					9
10	ICF	6,765	3,146		9,911	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,765	3,146	25,140	35,051	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.03%

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 7/31/92

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 120 and days of care provided 21,141

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 of LaGrange

0038083

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	344,749	20,795	3,591	369,135		369,135		369,135		1
2	Food Purchase		216,229		216,229		216,229	(19,409)	196,820		2
3	Housekeeping	251,468	29,343		280,811		280,811	212	281,023		3
4	Laundry	50,888	11,306		62,194		62,194		62,194		4
5	Heat and Other Utilities			175,815	175,815		175,815	4,293	180,108		5
6	Maintenance	35,135		132,820	167,955		167,955	49,787	217,742		6
7	Other (specify):* Alloc. Mgmt Co. Bene							6,294	6,294		7
8	TOTAL General Services	682,240	277,673	312,226	1,272,139		1,272,139	41,177	1,313,316		8
	B. Health Care and Programs										
9	Medical Director			79,375	79,375		79,375		79,375		9
10	Nursing and Medical Records	3,905,869	397,456	226,233	4,529,558		4,529,558	25,306	4,554,864		10
10a	Therapy										10a
11	Activities	84,440	15,748	6,983	107,171		107,171		107,171		11
12	Social Services	200,755		4,999	205,754		205,754		205,754		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. Mgmt Co. Bene							3,647	3,647		15
16	TOTAL Health Care and Programs	4,191,064	413,204	317,590	4,921,858		4,921,858	28,953	4,950,811		16
	C. General Administration										
17	Administrative	125,388		1,107,342	1,232,730		1,232,730	(1,071,971)	160,759		17
18	Directors Fees										18
19	Professional Services			218,099	218,099		218,099	4,850	222,949		19
20	Dues, Fees, Subscriptions & Promotions			30,691	30,691		30,691	7,974	38,665		20
21	Clerical & General Office Expenses	207,353	20,282	49,054	276,689		276,689	376,330	653,019		21
22	Employee Benefits & Payroll Taxes			902,482	902,482		902,482	13,750	916,232		22
23	Inservice Training & Education			11,270	11,270		11,270	544	11,814		23
24	Travel and Seminar			434	434		434	291	725		24
25	Other Admin. Staff Transportation			6,575	6,575		6,575	9,234	15,809		25
26	Insurance-Prop.Liab.Malpractice			335,282	335,282		335,282	3,606	338,888		26
27	Other (specify):* Alloc. Mgmt Co. Bene							59,795	59,795		27
28	TOTAL General Administration	332,741	20,282	2,661,229	3,014,252		3,014,252	(595,597)	2,418,655		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,206,045	711,159	3,291,045	9,208,249		9,208,249	(525,467)	8,682,782		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:

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Ending:

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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			117,924	117,924		117,924	272,798	390,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,104	6,104		6,104	335,899	342,003			32
33	Real Estate Taxes							337,674	337,674			33
34	Rent-Facility & Grounds			1,112,455	1,112,455		1,112,455	(1,110,004)	2,451			34
35	Rent-Equipment & Vehicles			110,669	110,669		110,669	2,576	113,245			35
36	Other (specify):*											36
37	TOTAL Ownership			1,347,152	1,347,152		1,347,152	(161,057)	1,186,095			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		725,273	2,506,297	3,231,570		3,231,570		3,231,570			39
40	Barber and Beauty Shops			18,894	18,894		18,894		18,894			40
41	Coffee and Gift Shops			120	120		120		120			41
42	Provider Participation Fee			150,816	150,816		150,816		150,816			42
43	Other (specify):* Non-Allowable Co	90,913		206,943	297,856		297,856	(297,856)				43
44	TOTAL Special Cost Centers	90,913	725,273	2,883,070	3,699,256		3,699,256	(297,856)	3,401,400			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,296,958	1,436,432	7,521,267	14,254,657		14,254,657	(984,380)	13,270,277			45

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

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0038083

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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	(5,659)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,037)	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	(42)	30		9
10	Interest and Other Investment Income	(11,971)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,850)	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				18
19	Entertainment				19
20	Contributions	(4,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,601)	43		24
25	Fund Raising, Advertising and Promotional	(46,094)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,486)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	82,595	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,645)		\$	30

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)	(962,735)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (962,735)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (984,380)		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

BHF USE ONLY						
48		49		50		51
						52

Lexington of LaGrange

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Report Period Beginning: 01/01/2013

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Reclass Repairs & Maintenance	\$ 3,721	6	1
2	Labs-Part A	(21,613)	43	2
3	X-Rays-Part A	(60,248)	43	3
4	Diagnostics Managed Care	(6,276)	43	4
5	Trust Fees	(145)	43	5
6	Collections	(1,914)	19	6
7	Out of Period legal	(3,208)	19	7
8	Marketing Salary	(90,913)	43	8
9	Education & Seminar marketing	(434)	24	9
10	Unrealized loss on FMV swap	301,018	43	10
11	Valet Services	(32,244)	43	11
12	Disallow Marketing Software	(5,149)	19	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
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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		82,595	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	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)	
1	V	19 Professional Fees	\$	Sambell of LaGrange Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	241,925	241,925	2
3	V	32 Interest Expense		Sambell of LaGrange Limited Partnership	**	336,459	336,459	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	**	332,455	332,455	5
6	V	34 Rental Expense	1,112,455	Sambell of LaGrange Limited Partnership	**		(1,112,455)	6
7	V	43 Trust Fees		Sambell of LaGrange Limited Partnership	**	145	145	7
8	V	43 Unrealized loss on FMV swap	301,018	Sambell of LaGrange Limited Partnership	**		(301,018)	8
9	V	43 State Replacement Tax		Sambell of LaGrange Limited Partnership	**	6	6	9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of La Grange, Inc. owns 100%				12
13	V			of Sambell of LaGrange Limited Partnership.				13
14	Total		\$ 1,413,473			\$ 912,529	\$ * (500,944)	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:

01/01/2013

Ending:

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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.	**	\$ 212	\$	212	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,538		3,538	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	209		209	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	546		546	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	41,185		41,185	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,680		4,680	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	201		201	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	6,294		6,294	22
23	V	10 Medical consultant		Royal Management Corp.	**	1,444		1,444	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	23,862		23,862	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,647		3,647	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	35,371		35,371	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	9,551		9,551	27
28	V	19 Professional fees		Royal Management Corp.	**	5,370		5,370	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	446		446	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	7,528		7,528	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	355,897		355,897	31
32	V	21 Bank charges		Royal Management Corp.	**	2,429		2,429	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	8,060		8,060	33
34	V	21 Postage		Royal Management Corp.	**	2,523		2,523	34
35	V	21 Telephone		Royal Management Corp.	**	7,421		7,421	35
36	V			Royal Management Corp.	**				36
37	V								37
38	V	**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 520,414	\$ *	520,414	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 Inservice Training	\$	Royal Management Corp.	**	\$ 544	\$	544	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	725		725	16	
17	V	25 Auto expense		Royal Management Corp.	**	9,234		9,234	17	
18	V	26 Insurance general		Royal Management Corp.	**	3,606		3,606	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	59,795		59,795	19	
20	V	30 Depreciation		Royal Management Corp.	**	30,915		30,915	20	
21	V	32 Interest		Royal Management Corp.	**	8,564		8,564	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	1,508		1,508	22	
23	V	33 Property taxes		Royal Management Corp.	**	5,219		5,219	23	
24	V	34 Rent expense		Royal Management Corp.	**	2,451		2,451	24	
25	V	35 Equipment rental		Royal Management Corp.	**	1,130		1,130	25	
26	V	17 Management fees	1,107,342	Royal Management Corp.	**			(1,107,342)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	1,446		1,446	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V	**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.								36
37	V								37	
38	V								38	
39	Total		\$ 1,107,342			\$ 125,137	\$ *	(982,205)	39	

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

Facility Name & ID Number

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Report Period Beginning:

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Ending:

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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 Bloomingdale, Inc.	Bloomington	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	22.34%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Vesta Mgmt.	Lombard	Mgmt. Company	3
4	Jeffrey J. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Group LLC			4
5	Lawrence W. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Sambell of	LaGrange	Real Estate	5
6	David S. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	LaGrange		Property	6
7	David S. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Ltd. Ptsp.			7
8	Jeffrey J. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Royal Mgmt.	Lombard	Mgmt. Company	8
9	Lawrence W. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Corporation			9
10					Lexington Financial	Lombard	Finance Company	10
11					Services II, LLC			11
12					Lexington Square	Lombard	Independent	12
13					Life Care of		and Assisted	13
14					Lombard, LLC		Living	14
15					Lexington Square	Elmhurst	Independent	15
16					Life Care of		Living Facility	16
17					Elmhurst, LLC			17
18					Samvest of Lombard	Lombard	Lessor	18
19					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: 01/01/2013 Ending: 12/31/2013

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	5,757	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,299	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,125	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,149	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	13,041	L17, C7	5
6		Member									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 35,371		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:

01/01/2013

Ending: 2/31/2013

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 Available	723,430	10	\$ 3,503	\$ 0	43,800	\$ 212	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	58,428	0	43,800	3,538	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	3,454	0	43,800	209	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	9,011	0	43,800	546	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	680,245	680,245	43,800	41,185	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	77,300	0	43,800	4,680	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	3,323	0	43,800	201	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	103,957	0	43,800	6,294	8
9	10	Medical consultant	Bed Days Available	723,430	10	23,850	0	43,800	1,444	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	394,114	394,114	43,800	23,862	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	60,229	0	43,800	3,647	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	584,219	584,219	43,800	35,371	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	157,743	0	43,800	9,551	13
14	19	Professional fees	Bed Days Available	723,430	10	88,700	0	43,800	5,370	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	7,368	0	43,800	446	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	124,332	0	43,800	7,528	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	5,878,235	5,878,235	43,800	355,897	17
18	21	Bank charges	Bed Days Available	723,430	10	40,121	0	43,800	2,429	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	133,126	0	43,800	8,060	19
20	21	Postage	Bed Days Available	723,430	10	41,674	0	43,800	2,523	20
21	21	Telephone	Bed Days Available	723,430	10	122,578	0	43,800	7,421	21
22										22
23										23
24										24
25	TOTALS					\$ 8,595,510	\$ 7,536,813		\$ 520,414	25

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

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 Available	723,430	10	\$ 8,988	\$ 43,800	\$ 544	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	11,975	43,800	725	2
3	25	Auto expense	Bed Days Available	723,430	10	152,523	43,800	9,234	3
4	26	Insurance general	Bed Days Available	723,430	10	59,556	43,800	3,606	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	987,607	43,800	59,795	5
6	30	Depreciation	Bed Days Available	723,430	10	510,614	43,800	30,915	6
7	32	Interest	Bed Days Available	723,430	10	141,456	43,800	8,564	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	24,914	43,800	1,508	8
9	33	Property taxes	Bed Days Available	723,430	10	86,200	43,800	5,219	9
10	34	Rent expense	Bed Days Available	723,430	10	40,490	43,800	2,451	10
11	35	Equipment rental	Bed Days Available	723,430	10	18,660	43,800	1,130	11
12	35	Auto Lease	Bed Days Available	723,430	10	23,891	43,800	1,446	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	\$	\$ 125,137	25

Facility Name & ID Number

Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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						
		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	5,243,917	5/1/17	0.0625	336,459	2					
3												3					
4												4					
5							Interest on financing insurance premium				788	5					
	Working Capital																
6	JP Morgan Chase		X	Line of Credit	Various	6/29/13	5,600,000	90,000	6/29/14	Libor +2.25%	5,316	6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 11,591,000	\$ 5,333,917			\$ 342,563	9					
	B. Non-Facility Related*																
10											1,339	10					
11											(11,971)	11					
12												12					
13											10,072	13					
14	TOTAL Non-Facility Related						\$	\$			(560)	14					
15	TOTALS (line 9+line14)						\$ 11,591,000	\$ 5,333,917			\$ 342,003	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2012 report.		\$ 342,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012	\$ 345,195	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 3,195	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 356,400	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.)	Allocated from Mgmt. Co.	5,219	
		\$ 9,280	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 36,420 For 2010 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ (36,420)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 337,674	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2008	<u>219,332</u>	8
	2009	<u>241,653</u>	9
	2010	<u>244,173</u>	10
	2011	<u>331,522</u>	11
	2012	<u>345,195</u>	12
See attached real estate accrual sheet			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 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 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>18-08-207-017-0000</u>	<u>Land & Building</u>	\$ <u>193,443.09</u>	\$ <u>193,443.09</u>
2. <u>18-08-207-018-0000</u>	<u>Land & Building</u>	\$ <u>151,751.76</u>	\$ <u>151,751.76</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
4. <u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>262,977.74</u>	\$ <u>5,219.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>608,172.59</u></u>	\$ <u><u>350,413.85</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: 50,072 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

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>40,000</u>	<u>1991</u>	<u>\$ 500,000</u>	1
2	<u>Management Company Allocation</u>			<u>11,000</u>	2
3	TOTALS	40,000		\$ 511,000	3

Facility Name & ID Number Lexington of LaGrange# 0038083

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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	120	1992	1992	\$ 2,661,448	\$	35	\$ 76,041	\$ 76,041	\$ 1,634,887	4
5		1995	1995	79,363		10			79,363	5
6		2005	2005	2,321,014		21	110,524	110,524	939,456	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	1,741	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 renovation	2002		150,083	7,505	20	7,505		83,176	21
22	Elevator upgrade	2002		5,398		10			5,398	22
23	Air conditioner compressor	2003		9,218	537	10	537		9,218	23
24	Sidewalk and fencing	2005		46,701	2,335	20	2,335		19,069	24
25	HVAC	2005		8,141	407	20	407		3,290	25
26	Wiring	2005		4,506	225	20	225		1,857	26
27	Lobby, lounge and reception renovations	2005		24,362	1,218	20	1,218		10,150	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors	2005		326,862		20	16,343	16,343	130,744	28
29	Wallcoverings	2005		10,822		5			10,822	29
30	Medical records room rehab	2006		19,739	987	20	987		6,909	30
31	Activity/PT Room Rehab	2006		1,158	58	20	58		406	31
32	Land scape enhancement	2006		8,726	582	15	582		4,268	32
33	Roof	2006		29,700	1,980	15	1,980		14,520	33
34	HVAC	2006		3,254	163	20	163		1,195	34
35	Plumbing and sprinkler system	2006		20,725	1,036	20	1,036		8,289	35
36	Laundry Combustion Air	2006		16,814	841	20	841		6,517	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:

01/01/2013 Ending: 12/31/2013

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	Lobby/Lounge/Reception rehab	2006	\$ 14,033	\$ 1,403	10	\$ 1,403	\$	\$ 10,523	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		1,935	39
40	TCU rehab	2006	2,402	120	20	120		850	40
41	First floor remodel	2006	212,084		20	10,604	10,604	74,228	41
42	Kitchen rehab	2006	8,165	408	20	408		3,061	42
43	Bath fixtures-2nd floor	2006	2,076	208	10	208		1,629	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		1,233	44
45	Landscaping	2007	3,862	257	15	257		1,692	45
46	HVAC	2007	58,326	2,916	20	2,916		18,711	46
47	Common Areas Remodel	2007	2,059	206	10	206		1,356	47
48	First Floor Remodel	2007	6,517		20	326	326	2,199	48
49	Garage	2007	16,487	824	20	824		5,013	49
50	Land Improvements	2008	3,745	250	15	250		1,271	50
51	Parking lot-paving	2008	8,720	436	20	436		2,362	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		700	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV.	2008	447,153		27	16,260	16,260	94,850	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		15,631	55
56	Irrigation System	2009	16,740	1,116	15	1,116		4,743	56
57	Landscaping	2009	10,321	688	15	688		2,924	57
58	Parking lot repairs	2009	3,500	175	20	175		802	58
59	HVAC Chiller	2009	2,594	130	20	130		574	59
60	Patio Pergola	2009	6,760	338	20	338		1,634	60
61	Stamped Concrete	2009	16,658	833	20	833		3,610	61
62	Fence	2009	4,084	204	20	204		833	62
63	Patio Wall	2009	8,212	411	20	411		1,747	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		1,237	64
65									65
66	Brick Panel Replacement	2010	16,578	603	27	603		2,211	66
67	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	17,565	641	27	641		1,923	67
68	Landscaping Enhancements	2010	15,258	1,017	15	1,017		3,560	68
69	Drain tile,sewer concrete	2010	3,221	214	15	214		688	69
70	TOTAL (lines 4 thru 69)		\$ 6,882,020	\$ 35,948		\$ 266,129	\$ 230,181	\$ 3,288,706	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:

01/01/2013

Ending:

12/31/2013

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		\$ 6,882,020	\$ 35,948		\$ 266,129	\$ 230,181	\$ 3,288,706	1
2	Retaining wall	2010	15,736	1,049	15	1,049		3,147	2
3	Canopy Installation	2010	4,466	163	27	163		516	3
4	Dining Room HVAC	2010	4,169	152	27	152		532	4
5	Pantry carpentry, flooring, plumbing	2010	2,911	106	27	106		353	5
6	Director of Nursing office painting	2010	4,245	155	27	155		465	6
7	Remodel Library/Lounge-art, painting, flooring	2010	6,477	236	27	236		708	7
8	2nd floor doors	2010	3,046	111	27	111		416	8
9	Office changes-carpentry, painting, flooring	2011	2,487	90	27	90		233	9
10	Fence	2011	2,750	183	15	183		397	10
11	Mulch and stone	2011	2,662	177	15	177		384	11
12	Laundry Room-Tile, Painting	2011	7,311	266	27	266		621	12
13	Locker Room - Installation of 6 tier box lockers	2011	2,573	94	27	94		243	13
14	Place beds back into service - Carpentry, Flooring, Electrical,	2011	117,350	4,267	27	4,267		11,023	14
15	-Painting and Plumbing								15
16									16
17									17
18	Electrical wiring for EMR	2012	13,699	498	27	498		540	18
19									19
20									20
21									21
22									22
23									23
24	Reconcile book depreciation			41			(41)		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)		\$ 7,071,902	\$ 43,536		\$ 273,676	\$ 230,140	\$ 3,308,284	34

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

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		\$ 7,071,902	\$ 43,536		\$ 273,676	\$ 230,140	\$ 3,308,284	1
2	Building - management company	2002	152,225		40	5,056	5,056	53,959	2
3	HVAC, electrical, security system - management company	2003	1,337		30	383	383	940	3
4	Key card system - management company	2004	210		20	12	12	99	4
5	VAV TX controls - management company	2005	64		20	4	4	28	5
6	Interior Signs-management company	2006	47		5	3	3	22	6
7	Building - management company	2008	7,316		5	401	401	2,427	7
8	Building - management company	2009	1,351		15	29	29	327	8
9	Building - management company	2010	1,320		15	63	63	312	9
10	Building - management company	2011	947		15	50	50	110	10
11	Building - management company	2012	3,192		15	7	7	191	11
12	Building - management company	2013	2,473		15	48	48	48	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,242,384	\$ 43,536		\$ 279,734	\$ 236,198	\$ 3,366,747	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	\$ 771,690	\$ 71,883	\$ 83,626	\$ 11,743	5	\$ 511,832	71
72	Current Year Purchases	75,353	2,505	2,505		5	2,505	72
73	Fully Depreciated Assets	209,888				5	209,888	73
74	Allocated from Mgmt. Co.	267,196		22,330	22,330	5-7	142,822	74
75	TOTALS	\$ 1,324,127	\$ 74,388	\$ 108,461	\$ 34,073		\$ 867,047	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.			26,524		2,527	2,527	5	22,522	79
80	TOTALS			\$ 26,524	\$	\$ 2,527	\$ 2,527		\$ 22,522	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)	\$ 9,104,035	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,924	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 390,722	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 272,798	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,256,316	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: 01/01/2013

Ending: 12/31/2013

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	<u>Allocated from Management Company</u>				<u>2,451</u>			6
7	TOTAL				\$ <u>2,451</u>			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: \$ 111,799 Description: Copier-\$9,168, Mail. Sys-\$135,Printer-\$5,720; Med. Equip.-\$46,362, Oxygen Equip.-\$49,284, Mgmt. Co.-\$1,1

(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	<u>Allocated from Management Company</u>			<u>1,446</u>	20
21	TOTAL		\$	\$ <u>1,446</u>	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.

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? 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>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<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	\$	22,472	\$	981,114	\$	22,472	\$	981,114	1		
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,617		169,990		3,617		169,990	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39(3)	hrs		23,710		1,358,601		23,710		1,358,601	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					709,051			709,051	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Other (specify): <u>Ambulance</u>	39(3)					(3,408)				(3,408)	12		
13	Other (specify): <u>See Sch. 16A</u>							16,222			16,222	13		
14	TOTAL			\$	49,799	\$	2,506,297	\$	725,273	\$	49,799	\$	3,231,570	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.

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		hrs	\$		\$		\$		\$		1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Oxygen</u>	39(2)						11,936			11,936	12
13	Other (specify): <u>DME</u>	39(2)						4,286			4,286	13
14	TOTAL			\$		\$		\$ 16,222		\$	16,222	14

Facility Name & ID Number Lexington of LaGrange# 0038083Report Period Beginning: 01/01/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,413,396	\$ 1,567,040	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (332,977))	2,817,864	2,817,864	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,264	106,264	6
7	Other Prepaid Expenses	3,103	1,103	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>PA Interest Income</u>	2,132	2,132	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,342,759	\$ 4,494,403	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		511,000	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	1,073,042	4,580,936	15
16	Equipment, at Historical Cost	585,409	1,350,651	16
17	Accumulated Depreciation (book methods)	(769,804)	(4,256,316)	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>		24,875	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 895,699	\$ 4,879,646	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,238,458	\$ 9,374,049	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 900,521	\$ 900,521	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	90,000	90,000	29
30	Accrued Salaries Payable	417,062	417,062	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,264	12,264	31
32	Accrued Real Estate Taxes(Sch.IX-B)		356,400	32
33	Accrued Interest Payable		28,357	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	1,585,990	2,018,042	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,005,837	\$ 3,822,646	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,243,917	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)	\$	\$ 5,243,917	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,005,837	\$ 9,066,563	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,232,621	\$ 307,486	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,238,458	\$ 9,374,049	48

*(See instructions.)

Lexington Health Care Center of LaGrange
 FYE 12/31/13
 Provider # 0038083

Schedule 17A

XV. Balance Sheet

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due from Lexington Fin Serv	103	103
Prepaid Insurance	9,362	9,362
Accrued Expenses	49,971	49,971
Accrued Resident Tax	23,442	23,442
Accrued Royl/Vesta Mgmt	(3,016)	(3,016)
Accrued Rent	289,498	
Accrued Insurance	46,191	46,191
Due to Patient Trust Fund	(4,914)	(4,914)
Advance bi-weekly part A payments	4,149	4,149
Uncollectible part A Co. Pvts	(29,253)	(29,253)
Due to Royal Operating	24,998	24,998
Due to Republic Construction of Illinois, Inc	(6,319)	(6,319)
Due to Chicago Ridge	888	888
Due to LaGrange	(2,000)	(2,000)
Due to Lake Zurich	(439)	(439)
Interest Rate Swap Liability	-	721,550
Professional Liabilities Claims	1,183,329	1,183,329
	<u>1,585,990</u>	<u>2,018,042</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,862,753	1
2	Restatements (describe):		2
3	Post closing adjustment	(104,192)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,758,561	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	484,794	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	(10,734)	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)	\$ 474,060	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,232,621	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of LaGrange# 0038083Report Period Beginning: 01/01/2013Ending: 12/31/2013

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	\$ 13,540,422	1	
2	Discounts and Allowances for all Levels	(9,591,615)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,948,807	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	8,839,083	6	
7	Oxygen	75,574	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,914,657	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	1,422	12	
13	Barber and Beauty Care	23,691	13	
14	Non-Patient Meals	5,659	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	993,514	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	319,525	19	
20	Radiology and X-Ray	73,866	20	
21	Other Medical Services	446,339	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,864,016	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	11,971	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,971	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,739,451	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,272,139	31	
32	Health Care	4,921,858	32	
33	General Administration	3,014,252	33	
B. Capital Expense				
34	Ownership	1,347,152	34	
C. Ancillary Expense				
35	Special Cost Centers	3,548,440	35	
36	Provider Participation Fee	150,816	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,254,657	40	
41	Income before Income Taxes (line 30 minus line 40)**	484,794	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 484,794	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 808,138	44
45	Private Pay - Net Inpatient Revenue	837,321	45
46	Medicare - Net Inpatient Revenue	2,224,208	46
47	Other-(specify) <u>Managed Care</u>	79,140	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,948,807	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: 01/01/2013

Ending: 12/31/2013

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	2,170	2,517	\$ 131,291	\$ 52.16	1
2	Assistant Director of Nursing	32,876	39,757	1,105,052	27.80	2
3	Registered Nurses	22,948	29,966	875,803	29.23	3
4	Licensed Practical Nurses	26,887	33,266	850,903	25.58	4
5	CNAs & Orderlies	64,828	78,807	903,020	11.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,824	6,298	84,123	13.36	10
11	Social Service Workers	8,803	9,693	200,755	20.71	11
12	Dietician	2,713	3,140	62,062	19.76	12
13	Food Service Supervisor	1,238	1,427	31,444	22.04	13
14	Head Cook	1,690	2,041	30,930	15.15	14
15	Cook Helpers/Assistants	9,556	11,718	115,459	9.85	15
16	Dishwashers	10,085	12,274	104,854	8.54	16
17	Maintenance Workers	1,486	1,920	35,135	18.30	17
18	Housekeepers	20,429	24,676	251,468	10.19	18
19	Laundry	5,073	5,677	50,888	8.96	19
20	Administrator	1,663	2,319	125,388	54.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,153	12,769	207,353	16.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,078	2,516	40,117	15.94	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	3,480	3,867	90,913	23.51	33
34	TOTAL (lines 1 - 33)	231,980	284,648	\$ 5,296,958 *	\$ 18.61	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	\$	1(3)	35
36	Medical Director	Monthly 79,375	9(3)	36
37	Medical Records Consultant	25 1,348	10(3)	37
38	Nurse Consultant	Monthly 124,324	10(3)	38
39	Pharmacist Consultant	Monthly 6,984	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly 3,918	11(3)	44
45	Social Service Consultant	96 4,999	12(3)	45
46	Other(specify)			46
47	<u>Pulmonary</u>	Monthly 93,577	10(3)	47
48	<u>Medical Consultant</u>	Monthly 1,444	10(7)	48
49	TOTAL (lines 35 - 48)	121 \$ 315,969		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Renee Mills	Administrator	0	\$ 125,388	Workers' Compensation Insurance	\$ 152,957	IDPH License Fee	\$ 2,035	
				Unemployment Compensation Insurance	138,971	Advertising: Employee Recruitment	14,101	
				FICA Taxes	387,561	Health Care Worker Background Check		
				Employee Health Insurance	171,436	(Indicate # of checks performed <u>239</u>)	2,872	
				Employee Meals	13,750	Patient Background Checks	799	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,818	
				401K	11,346	Miscellaneous Dues & Subscriptions	283	
				Other Employee Benefits	25,279			
				Unifrom Expense	1,141			
				Tuition	11,996	Management Company Allocation	7,974	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,388	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 914,437		\$ 38,665		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-Royal Operating			\$ 665,196	N/A		\$	Out-of-State Travel	\$
Management Fees-Vesta Mgmt.			442,146					
Management Fees (Eliminated in Column 7)							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,107,342				Seminar Expense	
							Management Company Allocation	725
							Entertainment Expense	()
C. Professional Services				TOTAL			(agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount	\$			TOTAL	\$
Andrew Williams	401(k) Administration		\$ 250					725
Cassiday Schade	Legal		92,033					
Grabowski Law Center, LLC	Collections		1,914					
Law Offices of Serpico	Legal		11,913					
McCracken & Frank	Legal		(24)					
McGladrey LLP	Accounting		35,776					
Much Shelist	Legal		8,563					
Partridge IP Law P.C.	Legal		168					
Pension Administrators	401(k) Administration		632					
Personnel Planners	U/C Consulting		1,665					
Secretary of State	Filing Fees		36					
See Schedule 21C			65,173					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 218,099					

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of LaGrange

Provider #: 0038083

1/1/13-12/31/13

Section XIX.

C. Professional Fees

Schedule 21C

Vendor/Payee	Type	Amount
Ability Network	Computer Consulting	1,115
Availity	Computer Consulting	50
Avalere Health	Computer Consulting	2,000
Bank of America (EMR Lease Credit)	Computer Consulting	(1,373)
Compaq Commercial Repair	Computer Consulting	48
Corepoint	Computer Consulting	974
Efax Corp	Computer Consulting	480
E-health Data Solutions	Computer Consulting	2,925
Esnf	Computer Consulting	700
Health Medx	Computer Consulting	9,494
Information Controls	Computer Consulting	883
Kronos	Computer Consulting	280
Lintech LLC	Computer Consulting	4,169
MNJ Technologies	Computer Consulting	215
MS Licensing	Computer Consulting	8,565
My Innerview	Computer Consulting	5,630
National Datacare	Computer Consulting	1,014
On Shift	Computer Consulting	8,317
Paragon Clinical	Computer Consulting	400
Realmed	Computer Consulting	280
Relias	Computer Consulting	5,796
Salesforce.com	Computer Consulting	5,149
SoftChoice Corporation	Computer Consulting	816
Telemedicine	Computer Consulting	5,406
Trisis	Computer Consulting	128
Tympani	Computer Consulting	1,711
		<u>65,173</u>

Lexington Health Care Center of LaGrange
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Section XIX.

C. Professional Fees	Schedule 21C	
Total Schedule V, line 19, column 3		218,099

Lexington Health Care Center of LaGrange

Provider #: 0038083

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Section XIX.

C. Professional Fees

Schedule 21C

Less: Collection Fees	(1,914)
Less: Out of Period Legal	(3,208)
Less: Marketing Software	(5,149)

Allocated from Sambell of LaGrange James Samatas	200
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Samvest of Lombard II Accounting	97
Filing Fees	9

208,134

Allocated from Mgmt Co.

Much Shelist	Legal	296
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	268
McGladrey LLP	Accounting	1,042
Illinois Secretary of State	Filing Fees	24
Gilson Labus & Silverman	KEP	26
Personnel Planners	U/C Consultant	26
LaSalle Network	Recruiting/Finance	1,359
Pension Administrators, Inc.	401K Administration	172
Katten, Muchin, Rosenman	KEP	172
Gene Whitehorn	Medicaid Reimb Specialist	392
Burlington Group	Recruitment	57
M Werner Consulting	Financial Consultant	1,372
Bussey Environment, Inc	Environmental Consulting	58
Computer Services	Computer Consulting	9,551

14,815

Total Schedule V, line 19 column 8

222,949

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 of LaGrange# 0038083Report Period Beginning: 01/01/2013 Ending: 12/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,350 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. \$ 150,816
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. \$ 13,750 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,659
- (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? 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) 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.