

Facility Name & ID Number Lexington of Elmhurst

0037317 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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	145	Skilled (SNF)	145	52,925	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	145	TOTALS	145	52,925	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			23,402	23,402	8
9	SNF/PED					9
10	ICF	9,592	7,306		16,898	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,592	7,306	23,402	40,300	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.15%

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 11/12/91

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 142 and days of care provided 19,256

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year?

YES NO

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

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

Facility Name & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	415,410	28,043	4,911	448,364		448,364		448,364		1
2	Food Purchase		251,444		251,444		251,444	(18,555)	232,889		2
3	Housekeeping	281,985	29,038		311,023		311,023	190	311,213		3
4	Laundry	30,189	14,345		44,534		44,534		44,534		4
5	Heat and Other Utilities			219,930	219,930		219,930	5,676	225,606		5
6	Maintenance	47,694	148	162,821	210,663		210,663	55,514	266,177		6
7	Other (specify):* Mgmt Co. Alloc. Bene							7,755	7,755		7
8	TOTAL General Services	775,278	323,018	387,662	1,485,958		1,485,958	50,580	1,536,538		8
	B. Health Care and Programs										
9	Medical Director			65,800	65,800		65,800		65,800		9
10	Nursing and Medical Records	3,974,591	461,548	147,288	4,583,427		4,583,427	34,010	4,617,437		10
10a	Therapy										10a
11	Activities	126,044	12,624	5,207	143,875		143,875		143,875		11
12	Social Services	134,601		5,077	139,678		139,678		139,678		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co. Alloc. Bene							4,647	4,647		15
16	TOTAL Health Care and Programs	4,235,236	474,172	223,372	4,932,780		4,932,780	38,657	4,971,437		16
	C. General Administration										
17	Administrative	155,741		1,271,518	1,427,259		1,427,259	(1,231,884)	195,375		17
18	Directors Fees										18
19	Professional Services			250,873	250,873		250,873	4,682	255,555		19
20	Dues, Fees, Subscriptions & Promotions			34,719	34,719		34,719	2,850	37,569		20
21	Clerical & General Office Expenses	139,580	26,834	36,402	202,816		202,816	460,676	663,492		21
22	Employee Benefits & Payroll Taxes			968,230	968,230		968,230	14,649	982,879		22
23	Inservice Training & Education			7,461	7,461		7,461	571	8,032		23
24	Travel and Seminar			51	51		51	1,153	1,204		24
25	Other Admin. Staff Transportation			5,315	5,315		5,315	10,509	15,824		25
26	Insurance-Prop.Liab.Malpractice			364,988	364,988		364,988	7,706	372,694		26
27	Other (specify):* Mgmt Co. Alloc. Bene							72,620	72,620		27
28	TOTAL General Administration	295,321	26,834	2,939,557	3,261,712		3,261,712	(656,468)	2,605,244		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,305,835	824,024	3,550,591	9,680,450		9,680,450	(567,231)	9,113,219		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 Elmhurst

#0037317

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			163,325	163,325		163,325	244,349	407,674			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			930	930		930	259,385	260,315			32
33	Real Estate Taxes							86,865	86,865			33
34	Rent-Facility & Grounds			1,017,603	1,017,603		1,017,603	(1,014,419)	3,184			34
35	Rent-Equipment & Vehicles			108,514	108,514		108,514	1,805	110,319			35
36	Other (specify):*											36
37	TOTAL Ownership			1,290,372	1,290,372		1,290,372	(422,015)	868,357			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		793,065	2,373,275	3,166,340		3,166,340		3,166,340			39
40	Barber and Beauty Shops	9,543		4,139	13,682		13,682		13,682			40
41	Coffee and Gift Shops			989	989		989		989			41
42	Provider Participation Fee			219,682	219,682		219,682		219,682			42
43	Other (specify):* Non-Allowable Co	165,350		212,259	377,609		377,609	(377,609)				43
44	TOTAL Special Cost Centers	174,893	793,065	2,810,344	3,778,302		3,778,302	(377,609)	3,400,693			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,480,728	1,617,089	7,651,307	14,749,124		14,749,124	(1,366,855)	13,382,269			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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0037317

Report Period Beginning: 01/01/2014

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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	(3,906)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,185)	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	875	30		9
10	Interest and Other Investment Income	(11,999)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,028)	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	(35,322)	43		18
19	Entertainment	(21)	43		19
20	Contributions	(4,600)	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	(24,995)	43		24
25	Fund Raising, Advertising and Promotional	(43,979)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,856)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(81,080)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (231,096)		\$	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)	(1,135,759)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,135,759)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,366,855)		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 of Elmhurst

ID# 0037317

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (22,802)	43	1
2	X-Rays-Part A	(46,695)	43	2
3	Diagnostics Managed Care	(7,139)	43	3
4	Trust Fees	(120)	43	4
5	Marketing Software	(5,004)	19	5
6	Collections & Out of Period Legal Fees	(11,371)	19	6
7	Marketing Salary	(165,350)	43	7
8	Education & Seminar marketing	(20)	24	8
9	Unrealized loss on FMV swap	178,338	43	9
10	Chamber of commerce dues	(275)	20	10
11	Loss On Disposal	(642)	43	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		(81,080)	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 Elmhurst II Limited Partnership	**	\$ 300	\$ 300	1
2	V	30 Depreciation		Sambell of Elmhurst II Limited Partnership	**	192,999	192,999	2
3	V	32 Interest expense		Sambell of Elmhurst II Limited Partnership	**	255,996	255,996	3
4	V	32 Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	3,405	3,405	4
5	V	33 Property taxes		Sambell of Elmhurst II Limited Partnership	**	81,603	81,603	5
6	V	34 Rental expense	1,017,603	Sambell of Elmhurst II Limited Partnership	**		(1,017,603)	6
7	V	43 Unrealized loss on FMV swap	178,338	Sambell of Elmhurst II Limited Partnership	**		(178,338)	7
8	V	43 Trust fees		Sambell of Elmhurst II Limited Partnership	**	120	120	8
9	V	43 State Replacement Tax		Sambell of Elmhurst II Limited Partnership	**	5	5	9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				12
13	V			of Sambell of Elmhurst II Limited Partnership				13
14	Total		\$ 1,195,941			\$ 534,428	\$ * (661,513)	14

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

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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.	**	\$ 190	\$	190	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,949		4,949	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	221		221	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	506		506	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	51,019		51,019	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,472		4,472	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	23		23	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	7,755		7,755	22
23	V	10 Medical consultant		Royal Management Corp.	**	3,440		3,440	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	30,570		30,570	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	4,647		4,647	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	39,634		39,634	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	11,349		11,349	27
28	V	19 Professional fees		Royal Management Corp.	**	9,408		9,408	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,532		1,532	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	1,593		1,593	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	438,132		438,132	31
32	V	21 Bank charges		Royal Management Corp.	**	1,774		1,774	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	8,967		8,967	33
34	V	21 Postage		Royal Management Corp.	**	3,176		3,176	34
35	V	21 Telephone		Royal Management Corp.	**	8,627		8,627	35
36	V								36
37	V								37
38	V	** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 631,984	\$ *	631,984	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>	**	\$ 571	\$	571	15	
16	V	24 <u>Travel & seminar</u>		<u>Royal Management Corp.</u>	**	1,173		1,173	16	
17	V	25 <u>Auto expense</u>		<u>Royal Management Corp.</u>	**	10,509		10,509	17	
18	V	26 <u>Insurance general</u>		<u>Royal Management Corp.</u>	**	7,706		7,706	18	
19	V	27 <u>Management allocation - employee benefits</u>		<u>Royal Management Corp.</u>	**	72,620		72,620	19	
20	V	30 <u>Depreciation</u>		<u>Royal Management Corp.</u>	**	50,475		50,475	20	
21	V	32 <u>Interest</u>		<u>Royal Management Corp.</u>	**	10,227		10,227	21	
22	V	32 <u>Amortization of mortgage costs</u>		<u>Royal Management Corp.</u>	**	1,756		1,756	22	
23	V	33 <u>Property taxes</u>		<u>Royal Management Corp.</u>	**	5,262		5,262	23	
24	V	34 <u>Rent expense</u>		<u>Royal Management Corp.</u>	**	3,184		3,184	24	
25	V	35 <u>Equipment rental</u>		<u>Royal Management Corp.</u>	**	1,026		1,026	25	
26	V	17 <u>Management fees</u>	1,271,518	<u>Royal Management Corp.</u>	**			(1,271,518)	26	
27	V	35 <u>Auto Lease</u>		<u>Royal Management Corp.</u>	**	779		779	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V	** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.								36
37	V								37	
38	V								38	
39	Total		\$ 1,271,518			\$ 165,288	\$ *	(1,106,230)	39	

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

Facility Name & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

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

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

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01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Sambell of	Bloomingtondale	Real Estate	1
2					Bloomingtondale Ltd. Ptsp.		Property	2
3								3
4					Sambell of Chicago	Chicago Ridge	Real Estate	4
5					Ridge Ltd. Ptsp.		Property	5
6								6
7					Sambell of	LaGrange	Real Estate	7
8					LaGrange Ltd. Ptsp.		Property	8
9								9
10					Lexington Health	Lake Zurich	Real Estate	10
11					Care Systems of		Property	11
12					Lake Zurich Ltd. Ptsp			12
13								13
14					Lexington Health	Lombard	Real Estate	14
15					Care Systems of		Property	15
16					Lombard Ltd. Ptsp.			16
17								17
18					Lexington Health	Orland Park	Real Estate	18
19					Care Systems of		Property	19
20					Orland Park Ltd. Ptsp			20
21								21
22					Sambell of	Schaumburg	Real Estate	22
23					Schaumburg Ltd. Ptsp		Property	23
24								24
25					Sambell of	Streamwood	Real Estate	25
26					Streamwood Ltd. Ptsp		Property	26
27								27
28					Lexington Health	Wheeling	Real Estate	28
29					Care Systems of		Property	29
30					Wheeling Ltd. Ptsp.			30

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

	1 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	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 6,961	L 17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,073	L 17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,355	L 17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,259	L 17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	12,987	L 17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 39,634		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 Elmhurst

0037317 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	\$ 2,591	\$ 52,925	\$ 190	1	
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,650	52,925	4,949	2	
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	3,027	52,925	221	3	
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	6,910	52,925	506	4	
5	6	Management allocation - salaries	Bed Days Available	723,430	10	697,374	697,374	52,925	51,019	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	61,125	52,925	4,472	6	
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	320	52,925	23	7	
8	7	Management allocation - employe	Bed Days Available	723,430	10	106,001	52,925	7,755	8	
9	10	Medical consultant	Bed Days Available	723,430	10	47,016	52,925	3,440	9	
10	10	Management allocation - salaries	Bed Days Available	723,430	10	417,860	417,860	52,925	30,570	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	63,515	52,925	4,647	11	
12	17	Management allocation - salaries	Bed Days Available	723,430	10	541,757	541,757	52,925	39,634	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	155,132	52,925	11,349	13	
14	19	Professional fees	Bed Days Available	723,430	10	128,599	52,925	9,408	14	
15	20	Dues & subscriptions	Bed Days Available	723,430	10	20,945	52,925	1,532	15	
16	20	Advertising - help wanted	Bed Days Available	723,430	10	21,776	52,925	1,593	16	
17	21	Management allocation - salaries	Bed Days Available	723,430	10	5,988,811	5,988,811	52,925	438,132	17
18	21	Bank charges	Bed Days Available	723,430	10	24,252	52,925	1,774	18	
19	21	Office supplies & printing	Bed Days Available	723,430	10	122,570	52,925	8,967	19	
20	21	Postage	Bed Days Available	723,430	10	43,413	52,925	3,176	20	
21	21	Telephone	Bed Days Available	723,430	10	117,921	52,925	8,627	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 8,638,565	\$ 7,645,802	\$ 631,984	25	

Facility Name & ID Number Lexington of Elmhurst

0037317 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	\$ 7,807	\$ 52,925	\$ 571	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	16,032	52,925	1,173	2
3	25	Auto expense	Bed Days Available	723,430	10	143,653	52,925	10,509	3
4	26	Insurance general	Bed Days Available	723,430	10	105,333	52,925	7,706	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	992,646	52,925	72,620	5
6	30	Depreciation	Bed Days Available	723,430	10	689,938	52,925	50,475	6
7	32	Interest	Bed Days Available	723,430	10	139,794	52,925	10,227	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	24,007	52,925	1,756	8
9	33	Property taxes	Bed Days Available	723,430	10	71,926	52,925	5,262	9
10	34	Rent expense	Bed Days Available	723,430	10	43,516	52,925	3,184	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,023	52,925	1,026	11
12	35	Auto Lease	Bed Days Available	723,430	10	10,648	52,925	779	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,259,323	\$	\$ 165,288	25

Facility Name & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	Services II, L.L.C.	X		Mortgage	Varies	4/30/07	5,391,000	3,944,919	5/1/17	0.0650	255,996	2					
3												3					
4										Finance Charge - Insurance Policy	930	4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 5,391,000	\$ 3,944,919			\$ 256,926	9					
	B. Non-Facility Related*																
10										Amortization of Loan Cost	5,161	10					
11										Interest Income Offset	(11,999)	11					
12										Allocated from Home Office	10,227	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 3,389	14					
15	TOTALS (line 9+line14)						\$ 5,391,000	\$ 3,944,919			\$ 260,315	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 2013 report.				\$	72,000	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.)	2013			\$	75,652	2														
3. Under or (over) accrual (line 2 minus line 1).				\$	3,652	3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	78,000	4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5														
			Allocated from Management Co.		5,262															
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 \$ <u>49</u> For <u>2001</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(49)	6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	86,865	7														
Real Estate Tax History:																				
Real Estate Tax Bill for Calendar Year:	2009	<u>68,355</u>	8	<table border="1"> <tr> <td colspan="2">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																				
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																		
14	PLUS APPEAL COST FROM LINE 5 \$	14																		
15	LESS REFUND FROM LINE 6 \$	15																		
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																		
	2010	<u>68,387</u>	9																	
	2011	<u>69,831</u>	10																	
	2012	<u>73,433</u>	11																	
	2013	<u>75,652</u>	12																	
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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Elmhurst COUNTY DuPage
 FACILITY IDPH LICENSE NUMBER 0037317
 CONTACT PERSON REGARDING THIS REPORT Karen Gillis
 TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-14-317-008</u>	<u>Land & Building</u>	\$ <u>75,652.44</u>	\$ <u>75,652.44</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>282,411.00</u>	\$ <u>5,262.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>358,063.44</u></u>	\$ <u><u>80,914.44</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

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).

Lexington Square Life Care of Elmhurst, Inc.: Retirement Community: 342 units

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>55,000</u>	<u>1991</u>	<u>\$ 1,277,670</u>	1
2	<u>Management Company Allocation</u>			<u>14,998</u>	2
3	TOTALS	55,000		\$ 1,292,668	3

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

	1	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	133		1991	1991	\$ 4,110,586	\$	35	\$ 117,445	\$ 117,445	\$ 2,714,010	4
5	12		1995	1995	73,302	2,095	35	2,095		41,172	5
6			2001	2001							6
7											7
8											8
	Improvement Type**										
9		Building Improvement	1992		693	20	35	20		442	9
10		Land Improvement	1995		7,500		15			7,500	10
11		Fan Coil Units	1996		4,904	140	35	140		2,591	11
12		Patio	1996		2,322		15			2,322	12
13		Basement rehab	1997		17,151		10			17,151	13
14		Baseboards	1997		3,129		10			3,129	14
15		Wiring	1998		3,090		10			3,090	15
16		Lobby Tile	1999		19,354		10			19,354	16
17		Patio	1999		4,196	278	15	278		4,196	17
18		Automatic Door	2000		1,300		10			1,300	18
19		Wallpaper	2000		6,853		10			6,853	19
20		Patio	2000		1,242	83	15	83		1,202	20
21		Storage closet for HVAC	2000		3,745	250	15	250		3,622	21
22		Fire pump system	2001		4,140		10			4,140	22
23		Door releases	2001		4,420		10			4,420	23
24		Infrared curtains for elevators	2001		3,000		10			3,000	24
25		Parking lot	2002		2,532		10			2,532	25
26		Kitchen tile and plumbing	2002		9,661		10			9,661	26
27		Elevator upgrade	2002		2,596		5			2,596	27
28		Facility Rehab-Painting/wallpaper/carpeting	2003		175,251		10			175,251	28
29		Facility Rehab-Floor tile/room upgrade	2003		38,140	1,907	20	1,907		22,725	29
30		Facility Rehab-Carpeting	2003		7,861		10			7,861	30
31		Parking lot	2004		2,000		5			2,000	31
32		Roof	2004		15,000	750	20	750		7,813	32
33		Landscaping	2005		5,396	270	20	270		2,564	33
34		Paint for building	2005		9,000	900	10	900		8,325	34
35		Roof	2005		14,300	715	20	715		6,554	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

1	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	HVAC upgrade	2005	\$ 3,230	\$ 162	20	\$ 162	\$	\$ 1,565	37
38	Sprinkler system	2005	1,060	53	20	53		490	38
39	Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		13,685	39
40	Window treatment	2005	1,932	193	10	193		1,866	40
41	Cubicle curtains	2005	820		5			820	41
42	Countertop	2005	845		5			845	42
43	HVAC	2006	3,793	190	20	190		1,535	43
44	Automatic Door Lock	2006	2,784	139	20	139		1,112	44
45	Storeroom Door Lock	2006	1,904	95	20	95		776	45
46	Service Door	2006	2,545	127	20	127		1,016	46
47	Landscaping Enhancement-Patio	2006	2,340	156	15	156		1,313	47
48	PT Therapy Room	2006	570	14	40	14		112	48
49									49
50									50
51									51
52	Transitional Unit	2007	1,864	93	20	93		721	52
53	Employee Lunch Room	2007	2,827	141	20	141		1,058	53
54	PT Room Rehab	2007	58,628	2,941	20	2,941		21,372	54
55	Landscaping-brick pavers	2008	43,813	2,921	15	2,921		18,256	55
56	Parking Lot	2008	31,700	1,585	20	1,585		10,435	56
57	Roof Repairs	2008	4,200	280	15	280		1,867	57
58	HVAC-New Chillers	2008	118,557	5,928	20	5,928		37,544	58
59	Emergency A/C	2008	5,706	285	20	285		1,805	59
60	Building Addition	2008			27				60
61	Kitchen Upgrade	2008	7,214		27	262	262	1,616	61
62	2nd Floor Remodel-painting, flooring, electrical	2008	561,274		27	20,410	20,410	125,862	62
63	Foundation Stabilization	2008	66,195		27	2,407	2,407	14,843	63
64	Irrigation System	2009	15,485	1,032	15	1,032		5,504	64
65	Landscaping Enhancements	2009	26,798	1,787	15	1,787		9,679	65
66	Patio Fence	2009	9,319	466	20	466		2,602	66
67	Chiller	2009	82,310	4,115	20	4,115		23,662	67
68	Plumbing	2009	4,280	214	20	214		1,070	68
69	2nd floor remodel-MDS office,HR office,Nursing call system	2009	6,853	250	27	250		1,260	69
70	TOTAL (lines 4 thru 69)		\$ 5,649,111	\$ 31,955		\$ 172,479	\$ 140,524	\$ 3,391,667	70

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

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 5,649,111	\$ 31,955		\$ 172,479	\$ 140,524	\$ 3,391,667	1
2	Patio Pergola	2009	12,814	641	20	641		3,419	2
3	Tub Room carpentry, flooring, electrical	2009	5,828	212	27	212		1,060	3
4	2nd Floor remodel-Carpentry, doors, flooring, electrical	2009	455,801		7	16,575	16,575	95,306	4
5	painting, sprinkler system								5
6	Landscaping	2010	3,314	221	15	221		939	6
7	Physician office remodel-carpentry, tiling	2010	6,450	235	27	235		960	7
8	Front Entrance-door and drain tile	2010	4,418	216	27	216		911	8
9	Nurse pull cord station	2010	3,256	118	27	118		472	9
10	Remodel Pantry-shelves	2010	7,146	260	27	260		1,040	10
11	Director of Nursing office painting	2010	5,539	201	27	201		804	11
12	Cooridor remodel-flag pole, tiling	2010	13,777	550	27	550		2,264	12
13	Library/Lounge remodel-art, carpentry, electrical	2010	11,870	432	27	432		1,728	13
14	Steel frame remodel	2010	6,740	245	27	245		1,103	14
15	2nd Floor remodel-Carpentry, doors, flooring, electrical	2010	17,168	624	27	624		3,120	15
16	Tub Room carpentry, plumbing	2010	11,731	427	27	427		2,064	16
17	Pergola	2010	8,180	1,636	5	1,636		7,089	17
18	Stamped concrete	2010	17,260	628	27	628		2,721	18
19	Landscaping	2011	4,443	296	15	296		987	19
20	Offices-doors, locks, keys	2011	66,131	2,405	27	2,405		8,618	20
21	Seal and stripe parking lot	2011	3,500	127	27	127		413	21
22	Laundry room-electrical, painting	2011	6,412	233	27	233		816	22
23	Floor install	2011	10,158	369	27	369		1,415	23
24	2nd floor doors	2011	9,654	351	27	351		1,375	24
25									25
26	Front entrance door	2012	3,733	136	27	136		306	26
27	Shower-Electrical	2012	4,982	181	27	181		392	27
28	Fire Dampers	2012	7,392	269	27	269		560	28
29	Low voltage wiring	2012	5,186	189	27	189		504	29
30	EMR Wiring	2012	14,543	529	27	529		1,102	30
31	1st floor doors	2012	8,476	308	27	308		744	31
32	Back patio fence	2012	3,536	129	27	129		365	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,388,549	\$ 44,123		\$ 201,222	\$ 157,099	\$ 3,534,264	34

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

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

1	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		\$ 6,388,549	\$ 44,123		\$ 201,222	\$ 157,099	\$ 3,534,264	1
2	1st Fl. Rm. Reconfigure. - labor, electrical, drywall, plumbing	2013	39,603	1,440	27	1,440		2,760	2
3									3
4	MDS Office Millwork & Electrical	2014	15,401	233	27	233		233	4
5	Automate Front Doors (Front Entrance)	2014	9,593	87	27	87		87	5
6	Install LED Lights throughout facility	2014	44,958		27				6
7	Wiring -Fiber connection throughout facility	2014	5,597	68	27	68		68	7
8	Install Automatic Doors (Front Entrance)	2014	17,085	52	27	52		52	8
9									9
10	Building - management company	2002	207,548		40	6,050	6,050	79,743	10
11	HVAC, electrical, security system - management company	2003	1,823		30	437	437	1,337	11
12	Key card system - management company	2004	286		20	14	14	149	12
13	VAV TX controls - management company	2005	87		20	4	4	43	13
14	Interior Signs - management company	2006	63		5	4	4	35	14
15	Building improvements - management company	2008	10,022		5	328	328	3,766	15
16	Building improvements - management company	2009	1,864		15	34	34	553	16
17	Building improvements - management company	2010	1,817		15	74	74	545	17
18	Building improvements - management company	2011	1,292		15	59	59	209	18
19	Building improvements - management company	2012	4,416		15	8	8	428	19
20	Building improvements - management company	2013	3,372		15	241	241	311	20
21	Building improvements - management company	2014	1,825		15	91	91	93	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29	Reconcile to book depreciation			818			(818)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,755,201	\$ 46,821		\$ 210,447	\$ 163,626	\$ 3,624,675	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	\$ 1,110,317	\$ 114,921	\$ 152,514	\$ 37,593	5	\$ 555,635	71
72	Current Year Purchases	46,169	1,583	1,583		5	1,583	72
73	Fully Depreciated Assets	434,533				5	434,533	73
74	Allocated from Mgmt. Co.	353,972		40,402	40,402	5-7	227,839	74
75	TOTALS	\$ 1,944,991	\$ 116,504	\$ 194,499	\$ 77,995		\$ 1,219,591	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.			37,548		2,728	2,728	5	32,848	79
80	TOTALS			\$ 37,548	\$	\$ 2,728	\$ 2,728		\$ 32,848	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)	\$ 10,030,409	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 163,325	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 407,674	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 244,349	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,877,114	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 Elmhurst

0037317

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				3,184			6
7	TOTAL				\$ 3,184			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 109,540 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Management Company			779	20
21	TOTAL		\$	\$ 779	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.

Lexington of Elmhurst
ID # 0037317
Fiscal Year 12/31/2014

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

<u>Rental Description</u>	<u>Amount</u>
Copier	8,986
Mailing System	135
Printer	4,960
Medical Equipment	60,905
Oxygen Equipment	33,528
Allocated from Management Company	1,026
Total - Line 16	<u>109,540</u>

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	\$	17,080	\$	822,719	\$	17,080	\$	822,719	1		
2	Licensed Speech and Language Development Therapist	39(3)	hrs		7,098		323,520		7,098		323,520	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39(2),(3)	hrs		20,526		1,223,166		20,526		1,232,454	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					772,443			772,443	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Other (specify): <u>Ambulance</u>	39(3)					3,870				3,870	12		
13	Other (specify): <u>See Sch. 16 A</u>							11,334			11,334	13		
14	TOTAL			\$	44,704	\$	2,373,275	\$	793,065	\$	44,704	\$	3,166,340	14

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	To (Col.
			Staff		Cost	Outside Practitioner (other than consultant)							
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist		hrs	\$			\$		\$			\$	
2	Licensed Speech and Language Development Therapist		hrs										
3	Licensed Recreational Therapist		hrs										
4	Licensed Physical Therapist		hrs										
5	Physician Care		visits										
6	Dental Care		visits										
7	Work Related Program		hrs										
8	Habilitation		hrs										
9	Pharmacy		# of prescripts										
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										
11	Academic Education		hrs										
12	Other (specify): <u>Oxygen</u>	39(2)								10,478			
13	Other (specify): <u>DME</u>	39(2)								856			
14	TOTAL			\$			\$		\$	11,334		\$	

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

8

tal Cost 3 + 5 + 6)	
	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
10,478	12
856	13
11,334	14

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 01/01/2014

Ending:

12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,683,823	\$ 2,823,798	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>307,395</u>)	2,406,260	2,406,260	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,498	51,498	6
7	Other Prepaid Expenses	9,208	9,208	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>PA Interest Income</u>	3,954	3,954	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,154,743	\$ 5,294,718	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,319	6,319	12
13	Land		1,292,668	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	1,143,094	2,644,615	15
16	Equipment, at Historical Cost	721,870	1,982,540	16
17	Accumulated Depreciation (book methods)	(829,886)	(4,877,114)	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 Net Cost</u>		59,863	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,041,397	\$ 5,219,477	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,196,140	\$ 10,514,195	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 864,196	\$ 864,196	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	460,848	460,848	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,457	9,457	31
32	Accrued Real Estate Taxes(Sch.IX-B)		78,000	32
33	Accrued Interest Payable		22,241	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	715,460	1,176,437	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,049,961	\$ 2,611,179	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,944,919	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)	\$	\$ 3,944,919	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,049,961	\$ 6,556,098	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,146,179	\$ 3,958,097	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,196,140	\$ 10,514,195	48

*(See instructions.)

Facility Name: Lexington of Elmhurst
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2014

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
00-12020-0 LHCC PA AUDIT SETTLEMENT	110,765	110,765
00-13330-0 LHCC DUE TO/FROM REPUBLIC CONSTRUCTION	(2,477)	(2,477)
00-13370-0 LHCC DUE FROM LOMARD SQUARE- AR	(9,557)	(9,557)
00-14530-0 LHCC PREPAID INSURANCE	9,007	9,007
00-21030-0 COBRA	(14,439)	(14,439)
00-22030-0 LHCC ACCRUED EXPENSES	97,918	97,918
00-22040-0 LHCC ACCRUED RESIDENT TAX	19,974	19,974
00-22060-0 LHCC ACCRUED ROYL / VESTA MGMT FEES	12,697	12,697
00-22120-0 LHCC ACCRUED RENT	7,262	
00-22140-0 LHCC ACCRUED INSURANCE	26,474	26,474
00-22270-0 LHCC DUE TO PATIENT TRUST FUND	(14,349)	(14,349)
00-22330-0 LHCC ADVANCE - BIWEEKLY PART A PAYM	(61,828)	(61,828)
00-22360-0 LHCC UNCOLLECTIBLE PART A CO PVTS	(11,236)	(11,236)
00-23530-0 LHCC DUE TO - ROYAL OPERATIONS	32,468	32,468
00-23870-0 LHCC DUE TO/FROM LEXINGTON FINANCIAL SERVICES	33	33
00-24345-0 LHCC Sambel Interest Rate Swap Liability	-	468,239
00-24400-0 LHCC PROFESSIONAL LIABILITIES CLAIMS	512,748	512,748
Total - Line 36	715,460	1,176,437

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,151,847	1
2	Restatements (describe):		2
3	Post closing adjustment	(73,805)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,078,042	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	869,173	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	(801,036)	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)	\$ 68,137	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)	\$ 4,146,179	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	\$ 15,007,687	1
2	Discounts and Allowances for all Levels	(9,591,409)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,416,278	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,041,526	6
7	Oxygen	43,242	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,084,768	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		12
13	Barber and Beauty Care	22,033	13
14	Non-Patient Meals	3,906	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,236,565	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	282,987	19
20	Radiology and X-Ray	68,462	20
21	Other Medical Services	491,299	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,105,252	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,999	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,999	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)	\$ 15,618,297	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,485,958	31
32	Health Care	4,932,780	32
33	General Administration	3,261,712	33
B. Capital Expense			
34	Ownership	1,290,372	34
C. Ancillary Expense			
35	Special Cost Centers	3,558,620	35
36	Provider Participation Fee	219,682	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,749,124	40
41	Income before Income Taxes (line 30 minus line 40)**	869,173	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 869,173	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,362,307	44
45	Private Pay - Net Inpatient Revenue	2,021,591	45
46	Medicare - Net Inpatient Revenue	2,105,597	46
47	Other-(specify) <u>Managed Care</u>	(73,217)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,416,278	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 Elmhurst

0037317

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,866	2,218	\$ 120,696	\$ 54.42	1
2	Assistant Director of Nursing	28,951	35,042	981,496	28.01	2
3	Registered Nurses	26,254	32,524	986,143	30.32	3
4	Licensed Practical Nurses	23,533	28,854	753,499	26.11	4
5	CNAs & Orderlies	76,266	91,242	1,093,800	11.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,896	9,935	126,044	12.69	10
11	Social Service Workers	6,071	6,842	134,601	19.67	11
12	Dietician	2,213	2,519	56,720	22.52	12
13	Food Service Supervisor	3,137	3,520	68,346	19.42	13
14	Head Cook	1,554	1,864	30,461	16.34	14
15	Cook Helpers/Assistants	18,205	21,922	225,359	10.28	15
16	Dishwashers	3,143	3,732	34,524	9.25	16
17	Maintenance Workers	1,907	2,320	47,694	20.56	17
18	Housekeepers	23,486	28,072	281,985	10.05	18
19	Laundry	2,498	3,236	30,189	9.33	19
20	Administrator	1,886	2,429	155,741	64.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,801	10,223	139,580	13.65	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	1,896	2,293	38,957	16.99	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	4,821	5,357	174,893	32.65	33
34	TOTAL (lines 1 - 33)	243,384	294,144	\$ 5,480,728 *	\$ 18.63	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 65,800	9(3)	36
37	Medical Records Consultant	Monthly 720	10(3)	37
38	Nurse Consultant	Monthly 45,632	10(3)	38
39	Pharmacist Consultant	Monthly 8,583	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 2,347	11(3)	44
45	Social Service Consultant	Monthly 5,077	12(3)	45
46	Other(specify) <u>Pulmonary</u>	Monthly 92,353	10(3)	46
47	<u>Medical Consultant</u>	Monthly 3,440	10(7)	47
48				48
49	TOTAL (lines 35 - 48)	\$ 223,952		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: Lexington of Elmhurst
IDPH License ID Number: 0037317
Fiscal Year End: 12/31/2014

Schedule 20A

XVIII. Staffing and Salary Costs

Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Marketing	4,040	4,489	165,350	\$ 36.83
Beauty	781	868	9,543	\$ 10.99
Total - Line 33 Other (specify):	4,821	5,357	174,893	\$ 32.65

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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		
Sandra Cubas	Administrator	0	\$ 155,741	Workers' Compensation Insurance	\$ 163,323	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	96,801	Advertising: Employee Recruitment	17,895		
				FICA Taxes	418,383	Health Care Worker Background Check			
				Employee Health Insurance	242,217	(Indicate # of checks performed <u>372</u>)	4,467		
				Employee Meals	14,649	Patient Background Checks	138		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	6,831		
				401K	11,329	Miscellaneous Subscriptions & Dues	1,883		
				Other Employee Benefits	32,419	Less: Chamber of commerce dues	(275)		
				Uniform Allowance	(1,357)	Allocated from Mgmt Co.	3,125		
				Tuition	5,115				
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)			
					\$ 982,879	\$ 37,569			
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			\$ 802,886	N/A			Out-of-State Travel	\$	
Management Fees-Vesta Mgmt.			468,632						
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)			\$ 1,271,518						
C. Professional Services				TOTAL			Seminar Expense		31
Vendor/Payee	Type		Amount				Allocated from Mgmt Co.		1,173
Cassiday Schade LLP	Legal		\$ 110,256				Entertainment Expense		()
Appraisal Research Counselors	Appraisers		4,000				(agree to Sch. V, line 24, col. 8)		
McGladrey LLP	Accounting		35,331				TOTAL		\$ 1,204
Much Shelist	Legal		10,026						
North Heron Insurance	Insurance		(1,002)						
Pension Administrators	401(k) Administration		840						
Personnel Planners	U/C Consulting		1,715						
Polsinelli Shughart	Legal		1,891						
Secretary of State	Filing Fees		132						
Generation Law	Legal		4,253						
Grabowski Law Center, LLC	Collections		4,524						
See Schedule 21C			78,906						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)						\$			

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Elmhurst
 Provider #: 0037317
 1/1/13-12/31/14
 Section XIX

Schedule 21C

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Law Offices of Serpico	Legal	5,658
Duane Morris	Legal	724
Scott & Kraus	Legal	1,040
Information Controls	Computer Consulting	4,507
Ability Network	Computer Consulting	1,513
Avalere Health	Computer Consulting	2,000
Citrix	Computer Consulting	348
Corepoint	Computer Consulting	945
E-Health Data Solutions	Computer Consulting	3,450
Information Controls	Computer Consulting	3,713
National Research	Computer Consulting	513
On Shift	Computer Consulting	7,912
Relias	Computer Consulting	8,041
Salesforce.Com	Computer Consulting	5,004
Symbria	Computer Consulting	1,200
Trisis	Computer Consulting	1,716
Availity	Computer Consulting	139
Centino	Computer Consulting	750
Lintech L Lc	Computer Consulting	29
National Datacare	Computer Consulting	1,338
Rmc	Computer Consulting	44
Tympani	Computer Consulting	257
Soft Choice Corporation	Computer Consulting	1,403
Hp Commercial Paper	Computer Consulting	5
Information Control	Computer Consulting	253
Soft Choice Corporation	Computer Consulting	1,105
Touch Point /Satisfaction Survey	Computer Consulting	235
Woundrounds Care Management	Computer Consulting	1,800

Microsoft	Computer Consulting	12,433
Soft Choice Corporation	Computer Consulting	502
Health Medx	Computer Consulting	10,331
		<hr/> 78,906

Schedule V, line 19, column 3 **250,873**

Less: Collection Fees & Out of Period Legal	(11,371)
Less: Marketing Software	(5,004)

Allocated from Sambell of Elmhurst

Secretary of State	300
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Allocated from Samvest of Lombard II

Accounting	74
Filing Fees	11

Allocated from Mgmt Co.

Much Shelist	Legal	117
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	38
Duane Morris	Legal	202
McGladrey LLP	Accounting	1,057
Frost, Ruttenberg & Rothblatt, P.C	Accounting	73
Gilson Labus & Silverman	Accounting	778
Illinois Secretary of State	Filing Fees	29
LaSalle Network	Recruiting/Finance	3,894
Pension Administrators, Inc.	401K Administration	242
Gene Whitehorn	Medicaid Reimb Specialist	1,049
M. Werner Consulting	Financial Consultant	1,376
McNamara & Associates	SNF Consultants	201
Healthcents	Managed Care Consultants	267
Computer Services	Computer Consulting	11,349
		<hr/> 20,672

Schedule V, line 19, column 8 **255,555**

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 Elmhurst# 0037317Report Period Beginning: 01/01/2014 Ending: 12/31/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? 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. \$ 35,467 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. \$ 219,682
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,649 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,906
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.