



Facility Name & ID Number Lexington of Orland Park

# 0041855 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	<u>278</u>	Skilled (SNF)	<u>278</u>	<u>101,470</u>	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	<u>278</u>	TOTALS	<u>278</u>	<u>101,470</u>	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			<u>22,916</u>	<u>22,916</u>	8
9	SNF/PED	<u>54,271</u>	<u>3,725</u>		<u>57,996</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>54,271</u>	<u>3,725</u>	<u>22,916</u>	<u>80,912</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.74%

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 7/8/96

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 278 and days of care provided 18,943

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

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

Facility Name &amp; ID Number

Lexington of Orland Park

# 0041855

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
	<b>A. General Services</b>										
1	Dietary	461,233	59,471	3,555	524,259		524,259		524,259		1
2	Food Purchase		497,217		497,217		497,217	(27,069)	470,148		2
3	Housekeeping	422,604	56,671		479,275		479,275	363	479,638		3
4	Laundry	67,175	33,803		100,978		100,978		100,978		4
5	Heat and Other Utilities			272,241	272,241		272,241	10,882	283,123		5
6	Maintenance	80,628		225,377	306,005		306,005	95,848	401,853		6
7	Other (specify):* Alloc. From Mgmt. C							14,867	14,867		7
8	<b>TOTAL General Services</b>	<b>1,031,640</b>	<b>647,162</b>	<b>501,173</b>	<b>2,179,975</b>		<b>2,179,975</b>	<b>94,891</b>	<b>2,274,866</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			56,125	56,125		56,125		56,125		9
10	Nursing and Medical Records	6,154,605	639,066	179,595	6,973,266		6,973,266	65,206	7,038,472		10
10a	Therapy										10a
11	Activities	295,662	26,642	12,499	334,803		334,803		334,803		11
12	Social Services	143,195		3,817	147,012		147,012		147,012		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. From Mgmt. C							8,908	8,908		15
16	<b>TOTAL Health Care and Programs</b>	<b>6,593,462</b>	<b>665,708</b>	<b>252,036</b>	<b>7,511,206</b>		<b>7,511,206</b>	<b>74,114</b>	<b>7,585,320</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	180,760		2,135,752	2,316,512		2,316,512	(2,059,764)	256,748		17
18	Directors Fees										18
19	Professional Services			574,898	574,898		574,898	27,168	602,066		19
20	Dues, Fees, Subscriptions & Promotions			67,537	67,537		67,537	5,713	73,250		20
21	Clerical & General Office Expenses	183,226	34,336	81,481	299,043		299,043	880,159	1,179,202		21
22	Employee Benefits & Payroll Taxes			1,631,832	1,631,832		1,631,832	24,264	1,656,096		22
23	Inservice Training & Education			6,727	6,727		6,727	1,094	7,821		23
24	Travel and Seminar			1,167	1,167		1,167	1,081	2,248		24
25	Other Admin. Staff Transportation			7,149	7,149		7,149	20,152	27,301		25
26	Insurance-Prop.Liab.Malpractice			605,891	605,891		605,891	14,776	620,667		26
27	Other (specify):* Alloc. From Mgmt. C							139,229	139,229		27
28	<b>TOTAL General Administration</b>	<b>363,986</b>	<b>34,336</b>	<b>5,112,434</b>	<b>5,510,756</b>		<b>5,510,756</b>	<b>(946,128)</b>	<b>4,564,628</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>7,989,088</b>	<b>1,347,206</b>	<b>5,865,643</b>	<b>15,201,937</b>		<b>15,201,937</b>	<b>(777,123)</b>	<b>14,424,814</b>		<b>29</b>

\*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 &amp; ID Number

Lexington of Orland Park

#0041855

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	
	<b>D. Ownership</b>											
30	Depreciation			197,480	197,480		197,480	498,735	696,215			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			176,904	176,904		176,904	438,484	615,388			32
33	Real Estate Taxes							607,007	607,007			33
34	Rent-Facility & Grounds			2,407,319	2,407,319		2,407,319	(2,390,815)	16,504			34
35	Rent-Equipment & Vehicles			117,760	117,760		117,760	3,460	121,220			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,899,463	2,899,463		2,899,463	(843,129)	2,056,334			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		762,318	2,366,422	3,128,740		3,128,740		3,128,740			39
40	Barber and Beauty Shops	9,485		11,568	21,053		21,053		21,053			40
41	Coffee and Gift Shops			841	841		841		841			41
42	Provider Participation Fee			529,990	529,990		529,990		529,990			42
43	Other (specify):* <b>Non-Allowable Co</b>	119,033		206,465	325,498		325,498	(325,498)				43
44	<b>TOTAL Special Cost Centers</b>	128,518	762,318	3,115,286	4,006,122		4,006,122	(325,498)	3,680,624			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,117,606	2,109,524	11,880,392	22,107,522		22,107,522	(1,945,750)	20,161,772			45

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

Facility Name & ID Number Lexington of Orland Park

# 0041855

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	(2,805)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,687)	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	(283)	30		9
10	Interest and Other Investment Income	(182,261)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15,261)	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	(2,860)	43		18
19	Entertainment				19
20	Contributions	(3,900)	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	(52,679)	43		24
25	Fund Raising, Advertising and Promotional	(32,197)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,326)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	32,685	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (270,574)		\$	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)	(1,675,176)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,675,176)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (1,945,750)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Lexington of Orland Park

ID# 0041855

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Trust Fees	\$ (75)	43	1
2	Labs - Part A	(29,409)	43	2
3	X-Rays - Part A	(39,824)	43	3
4	Diagnostics Managed Care	(9,793)	43	4
5	Misc. Income	(3,069)	21	5
6	Marketing Salary	(119,033)	43	6
7	Collections	(6,849)	19	7
8	Out of period legal	(976)	19	8
9	Education and training marketing	(1,167)	24	9
10	Unrealized loss on FMV swap	258,750	43	10
11	Salesforce.com	(5,004)	19	11
12	Capitalize improvements over \$2,500	(10,583)	6	12
13	Disallow Lobbying	(283)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		32,685	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	30 Depreciation	\$	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	\$ 402,247	\$ 402,247	1
2	V	32 Interest Expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	593,904	593,904	2
3	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	3,866	3,866	3
4	V	33 Property Taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	596,919	596,919	4
5	V	34 Rental Expense	2,396,919	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(2,396,919)	5
6	V	43 Unrealized loss on FMV swap	268,279	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(268,279)	6
7	V	43 Trust Fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	75	75	7
8	V	19 Professional Fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	200	200	8
9	V							9
10	V							10
11	V			** The owners of Lexington Health Care Center of Orland Park, Inc. own 100%				11
12	V			of Lexington Health Care Systems of Orland Park Ltd. Ptsp.				12
13	V							13
14	Total		\$ 2,665,198			\$ 1,597,211	\$ * (1,067,987)	14

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

Facility Name & ID Number Lexington of Orland Park# 0041855Report 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.	**	\$ 363	\$	363	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	9,489		9,489	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	425		425	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	968		968	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	97,815		97,815	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	8,572		8,572	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	44		44	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	14,867		14,867	22
23	V	10 Medical consultant		Royal Management Corp.	**	6,595		6,595	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	58,611		58,611	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	8,908		8,908	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	75,988		75,988	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	21,759		21,759	27
28	V	19 Professional fees		Royal Management Corp.	**	18,038		18,038	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	2,940		2,940	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	3,056		3,056	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	840,005		840,005	31
32	V	21 Bank charges		Royal Management Corp.	**	3,401		3,401	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	17,191		17,191	33
34	V	21 Postage		Royal Management Corp.	**	6,092		6,092	34
35	V	21 Telephone		Royal Management Corp.	**	16,539		16,539	35
36	V								36
37	V								37
38	V	** The owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 1,211,666	\$ *	1,211,666	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>	**	\$ 1,094	\$ 1,094
16	V	24 <u>Travel &amp; seminar</u>		<u>Royal Management Corp.</u>	**	2,248	2,248
17	V	25 <u>Auto expense</u>		<u>Royal Management Corp.</u>	**	20,152	20,152
18	V	26 <u>Insurance general</u>		<u>Royal Management Corp.</u>	**	14,776	14,776
19	V	27 <u>Management allocation - employee benefits</u>		<u>Royal Management Corp.</u>	**	139,229	139,229
20	V	30 <u>Depreciation</u>		<u>Royal Management Corp.</u>	**	96,771	96,771
21	V	32 <u>Interest</u>		<u>Royal Management Corp.</u>	**	19,608	19,608
22	V	32 <u>Amortization of mortgage costs</u>		<u>Royal Management Corp.</u>	**	3,367	3,367
23	V	33 <u>Property taxes</u>		<u>Royal Management Corp.</u>	**	10,088	10,088
24	V	34 <u>Rent expense</u>		<u>Royal Management Corp.</u>	**	6,104	6,104
25	V	35 <u>Equipment rental</u>		<u>Royal Management Corp.</u>	**	1,968	1,968
26	V	17 <u>Management fees</u>	2,135,752	<u>Royal Management Corp.</u>	**		(2,135,752)
27	V	35 <u>Auto Lease</u>		<u>Royal Management Corp.</u>	**	1,492	1,492
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** The owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 2,135,752			\$ 316,897	\$ * (1,818,855)

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

Facility Name & ID Number

Lexington of Orland Park

# 0041855

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	30%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	30%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	30%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Lexington Square	Lombard	Independent and	3
4	Dean Sweitzer	10%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Life Care of		Assisted Living	4
5			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lombard, LLC		Facility	5
6			Lexington HC Ctr. of Lombard, Inc.	Lombard	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Life Care of		Living Facility	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Vesta Mgmt	Lombard	Mgmt. Company	8
9			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Group, LLC			9
10					Lexington Health	Orland Park	Real Estate	10
11					Care Systems of		Property	11
12					Orland Park Ltd. Ptsp.			12
13					Royal Management	Lombard	Mgmt. Company	13
14					Corporation			14
15					Lexington Financial	Lombard	Finance Company	15
16					Services, 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

Facility Name & ID Number

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# 0041855

Report Period Beginning:

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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	Elmhurst	Real Estate	7
8					Elmhurst II Ltd. Ptsp.		Property	8
9								9
10					Sambell of	LaGrange	Real Estate	10
11					LaGrange Ltd. Ptsp.		Property	11
12								12
13					Lexington Health	Lake Zurich	Real Estate	13
14					Care Systems of		Property	14
15					Lake Zurich Ltd. Ptsp.			15
16								16
17					Lexington Health	Lombard	Real Estate	17
18					Care Systems of		Property	18
19					Lombard Ltd. Ptsp.			19
20								20
21					Sambell of	Schaumburg	Real Estate	21
22					Schaumburg Ltd. Ptsp.		Property	22
23								23
24					Sambell of	Streamwood	Real Estate	24
25					Streamwood Ltd. Ptsp.		Property	25
26								26
27					Lexington Health	Wheeling	Real Estate	27
28					Care Systems of		Property	28
29					Wheeling Ltd. Ptsp.			29
30								30

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

## VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	James Samatas	Owner/officer	Administrative	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 13,345	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,725	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	30.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	12,184	L17, C7	3
4	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	24,899	L17, C7	4
5	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	15,834	L17, C7	5
6											6
7	Dean Sweitzer	Owner*	Administrative	10.00	190,776	5	10.00	Salary	31,124	L21, C7	7
8											8
9											9
10	* Dean Sweitzer is an owner only in Lexington Health Care Center of Orland Park, Inc. He is an employee										10
11	of Royal Management Corp. and provides administrative services to Royal Management Corp. His compensation										11
12	has been allocated to all 10 Lexington facilities.										12
13								TOTAL	\$ 107,112		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 Orland Park

# 0041855 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	\$ 101,470	\$ 363	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,650	101,470	9,489	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	3,027	101,470	425	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	6,910	101,470	968	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	697,374	697,374	97,815	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	61,125	101,470	8,572	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	320	101,470	44	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	106,001	101,470	14,867	8
9	10	Medical consultant	Bed Days Available	723,430	10	47,016	101,470	6,595	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	417,860	417,860	58,611	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	63,515	101,470	8,908	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	541,757	541,757	75,988	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	155,132	101,470	21,759	13
14	19	Professional fees	Bed Days Available	723,430	10	128,599	101,470	18,038	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	20,945	101,470	2,940	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	21,776	101,470	3,056	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	5,988,811	5,988,811	840,005	17
18	21	Bank charges	Bed Days Available	723,430	10	24,252	101,470	3,401	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	122,570	101,470	17,191	19
20	21	Postage	Bed Days Available	723,430	10	43,413	101,470	6,092	20
21	21	Telephone	Bed Days Available	723,430	10	117,921	101,470	16,539	21
22									22
23									23
24									24
25	TOTALS					\$ 8,638,565	\$ 7,645,802	\$ 1,211,666	25

Facility Name & ID Number Lexington of Orland Park

# 0041855 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	\$ 101,470	\$ 1,094	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	16,032	101,470	2,248	2
3	25	Auto expense	Bed Days Available	723,430	10	143,653	101,470	20,152	3
4	26	Insurance general	Bed Days Available	723,430	10	105,333	101,470	14,776	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	992,646	101,470	139,229	5
6	30	Depreciation	Bed Days Available	723,430	10	689,938	101,470	96,771	6
7	32	Interest	Bed Days Available	723,430	10	139,794	101,470	19,608	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	24,007	101,470	3,367	8
9	33	Property taxes	Bed Days Available	723,430	10	71,926	101,470	10,088	9
10	34	Rent expense	Bed Days Available	723,430	10	43,516	101,470	6,104	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,023	101,470	1,968	11
12	35	Auto Lease	Bed Days Available	723,430	10	10,648	101,470	1,492	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	\$	\$ 316,897	25

Facility Name &amp; ID Number

Lexington of Orland Park

# 0041855

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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Lexington Financial Services						\$	\$		\$	1						
2	L.L.C.	X		Mortgage	Varies	5/22/08	11,354,000	9,668,806	1/1/2033	Variable	593,904	2					
3												3					
4										Finance Charge - Insurance Policy	1,716	4					
5												5					
	<b>Working Capital</b>																
6	Bank of America		X	Line of Credit	Varies	9/30/13	13,700,000	300,000	9/30/15	Prime/Libor	13,073	6					
7	Shareholder loan	X		Working capital	Varies	5/3/12	1,200,000	1,199,000	Demand	Prime	97,578	7					
8	Shareholder loan	X		Working capital	Varies	9/30/13	750,000	750,000	Demand	0.0800	64,537	8					
9	<b>TOTAL Facility Related</b>						\$ 27,004,000	\$ 11,917,806			\$ 770,808	9					
	<b>B. Non-Facility Related*</b>																
10										Amortization of Mortgage Cost	7,233	10					
11										Interest Income Offset	(20,146)	11					
12										Shareholder Interest	(162,115)	12					
13										Allocated from Management Co.	19,608	13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(155,420)	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 27,004,000	\$ 11,917,806			\$ 615,388	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.			\$ <b>642,000</b>	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		\$ <b>623,620</b>	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(18,380)</b>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>634,800</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$ <b>29,988</b>	5	
		Allocated from Management Co.	<b>10,088</b>		
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. <b>TOTAL REFUND \$ <u>49,490</u> For <u>03/11</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$ <b>(49,490)</b>	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>607,007</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>549,706</u>	8		
	2010	<u>559,216</u>	9		
	2011	<u>595,423</u>	10		
	2012	<u>623,105</u>	11		
	2013	<u>623,620</u>	12		
<a href="#">See attached real estate accrual sheet</a>					
				<b>FOR BHF USE ONLY</b>	
				13	13
				14	14
				15	15
				16	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Orland Park COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0041855  
 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>27-10-100-099-0000</u>	<u>Land &amp; Building</u>	\$ <u>623,620.00</u>	\$ <u>623,620.00</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land &amp; Building</u>	\$ <u>282,411.22</u>	\$ <u>10,088.00</u>
4. _____		\$ _____	\$ _____
5. _____		\$ _____	\$ _____
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>906,031.22</u></u>	\$ <u><u>633,708.00</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.**

Facility Name & ID Number Lexington of Orland Park

# 0041855 Report Period Beginning:

01/01/2014 Ending:

12/31/2014

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block & 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).

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>152,460</u>	<u>1995</u>	<u>\$ 776,408</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>26,996</u>	<u>2</u>
3	<b>TOTALS</b>	<b>152,460</b>		<b>\$ 803,404</b>	<b>3</b>

**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	250	1996	1996	\$ 8,569,286	\$	40	\$ 214,232	\$ 214,232	\$ 3,960,720	4
5	10	1998	1998	63,790	1,595	40	1,595		25,517	5
6	18	2001	2001							6
7										7
8										8
	<b>Improvement Type**</b>									
9	Electrical wiring	1996		2,304	58	40	58		1,049	9
10	Paving	1997		11,589		40			11,589	10
11	Wiring	1998		3,932		40			3,932	11
12	Additional building costs - 10 bed addition	1999		1,808	45	10	45		722	12
13	Seal/restrip parking lot	1999		3,450	115	40	115		3,450	13
14	Wiring	1999		1,798	45	15	45		697	14
15	Roof repairs	2000		23,201	1,547	40	1,547		22,430	15
16	Electrical wiring	2000		5,732	164	15	164		2,376	16
17	Ceiling mount curtain rod hardware	2000		6,952	199	35	199		2,883	17
18	Automatic door closer/sensors	2000		3,624	242	35	242		3,506	18
19	Seal and restripe parking lot	2001		2,277		15			2,277	19
20	HVAC control	2001		2,548		10			2,548	20
21	Infrared curtains for elevator doors	2001		4,500		10			4,500	21
22	Fire alarm panel	2002		5,120		10			5,120	22
23	Parking lot lights	2002		9,975		10			9,975	23
24	Chiller room compressor	2002		8,879		10			8,879	24
25	Carpeting	2002		7,038		5			7,038	25
26	Pave and seal parking lot	2005		4,180	209	5	209		1,951	26
27	HVAC	2005		6,143	307	20	307		2,789	27
28	Electrical wiring	2005		3,637	182	20	182		1,668	28
29	Kitchen rehab	2005		6,360	318	20	318		3,100	29
30	Elevator rehab	2005		8,948	447	20	447		4,322	30
31	Lounge, lobby, and reception area rehab	2005		27,662	1,383	20	1,383		12,678	31
32	Landscaping enhancements	2006		5,795	386	20	386		3,217	32
33	HVAC	2006		9,300	465	15	465		3,759	33
34	LHI-therapy room rehab LL TCU/main therapy	2006		33,184	1,659	20	1,659		13,825	34
35										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 &amp; ID Number Lexington of Orland Park

# 0041855

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	Landscaping	2007	\$ 17,383	\$ 1,159	15	\$ 1,159	\$	\$ 8,596	37
38	Parking lot	2007	1,120	56	20	56		411	38
39	Plumbing-Fine Dining	2007	2,068	103	20	103		816	39
40	Laundry Room Rehab	2007	37,283	1,864	20	1,864		14,446	40
41	Employee lunch room	2007	2,865	143	20	143		1,108	41
42	Basement Renovation	2007	1,148	57	20	57		423	42
43	Patio Improvements	2007	7,000	350	20	350		2,538	43
44	1st floor remodel-carpentry, flooring, plumbing, electrical-fixtures, painting	2007	1,481,886		40	37,426	37,426	277,577	44
45		2007							45
46									46
47	Basement Renovation	2007	20,191	1,010	20	1,010		7,066	47
48	Therapy Room Renovation	2007	978	49	20	49		343	48
49	Landscaping	2008	4,300	287	15	287		1,746	49
50	Spot Coolers	2008	3,790	189	20	189		1,134	50
51	Emergency A/C	2008	32,295	807	40	807		5,178	51
52	Plumbing & Sprinkler-Showers	2008	5,047	126	40	126		756	52
53	Parking lot repairs	2008	5,285	264	20	264		1,738	53
54	Phone closet	2008	5,954	149	40	149		981	54
55	Landscaping	2009	4,190	279	15	279		1,418	55
56	1st floor admin room-heating, fire protection	2009	16,422	821	20	821		4,652	56
57	Quick connectors	2009	7,091	355	20	355		1,893	57
58	Electrical Room	2009	4,692	235	20	235		1,175	58
59	Glass and Mirrors Med Room	2009	4,954	142	35	142		781	59
60	Key pad common areas	2009	3,757	107	35	107		616	60
61	2nd Floor remodel-Doors and Locks	2009	32,130	803	40	803		4,617	61
62	Patio Pergola	2009	7,930	529	15	529		2,777	62
63	Patio Fence	2009	11,293	712	15	712		3,619	63
64	2nd floor remodel-carpentry, flooring, electrical, painting	2009	1,014,056		27	36,875	36,875	221,250	64
65	2nd floor remodel-carpentry	2009	17,258		27	628	628	3,715	65
66	Office carpentry, flooring, electrical, painting, plumbing	2010	70,270	3,806	27	3,806		15,224	66
67	Landscaping	2010	11,399	760	15	760		3,230	67
68	Physican office carpentry	2010	2,926	106	27	106		424	68
69	Repave/Seal Cracks in parking lot	2010	21,817	1,091	20	1,091		4,727	69
70	TOTAL (lines 4 thru 69)		\$ 11,701,790	\$ 25,725		\$ 314,886	\$ 289,161	\$ 4,721,492	70

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

Facility Name &amp; ID Number Lexington of Orland Park

# 0041855

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 11,701,790	\$ 25,725		\$ 314,886	\$ 289,161	\$ 4,721,492	1
2	Roof	2010	74,000	2,691	27	2,691		12,334	2
3	HVAC-Exhaust Modification	2010	4,202	153	27	153		637	3
4	Nurse pull cord station	2010	3,933	143	27	143		572	4
5	Paint lights over bed	2010	7,738	281	27	281		1,148	5
6	Trench/Awning	2010	11,666	424	27	424		1,786	6
7	Remodel Library/Lounge-art, flooring, carpentry	2010	4,120	150	27	150		600	7
8	3rd floor remodel-carpentry, electrical, plumbing	2010	868,783		27	67,183	67,183	296,725	8
9									9
10	Office-carpentry, flooring, electrical, painting, plumbing and signs	2011	6,710	244	27	244		854	10
11	Office Remodel- Doors and Locks	2011	31,324	1,139	27	1,139		5,410	11
12	Office Remodel- Doors and Locks	2011	5,282	192	27	192		736	12
13	Additional parking spaces	2011	196,376	7,141	27	7,141		23,208	13
14	Roof Repairs	2011	58,800	2,138	27	2,138		7,483	14
15	Fire Dampers	2011	5,586	203	27	203		626	15
16	Pantry Remodel - Millwork and Flooring	2011	3,730	136	27	136		431	16
17	Laundry Room Remodel - Flooring, Painting and Electrical	2011	9,172	334	27	334		1,085	17
18	2nd Floor Remodel - Doors	2011	12,612	459	27	459		1,530	18
19									19
20	Parking lot	2012	12,906	469	27	469		977	20
21	Chiller replacement kitchen	2012	108,732	3,954	27	3,954		9,555	21
22									22
23	Fire Pump- Basement	2013	5,000	125	40	125		240	23
24	EMR Wiring- Entire Facility	2013	19,542	711	27	711		770	24
25	New Countertop, wall, tile- Kitchen	2013	3,026	110	27	110		119	25
26	Stairway Access Control- Entire Facility (1st-3rd floor stairs)	2013	6,463	235	27	235		255	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,161,493	\$ 47,157		\$ 403,501	\$ 356,344	\$ 5,088,573	34

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

Facility Name &amp; ID Number Lexington of Orland Park

# 0041855

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	<b>Totals from Page 12B, Carried Forward</b>		\$ 13,161,493	\$ 47,157		\$ 403,501	\$ 356,344	\$ 5,088,573	1
2									2
3	Planting Roses Daylillies (Front Entrance)	2014	5,492	122	15	122		122	3
4	Parking lot paving	2014	119,164		27				4
5	Kitchen Chiller Replacement	2014	126,990	2,694	27	2,694		2,694	5
6	Kitchen sink, drywall, tile	2014	15,968	339	27	339		339	6
7	Install Privacy Curtains - Resident Rooms	2014	6,938	147	27	147		147	7
8	1st Floor Replacement of Interior Doors	2014	12,049	219	27	219		219	8
9	Create Workspace in 1st floor library	2014	16,429	348	27	348		348	9
10									10
11	R/M Repair Concrete Walk (Front Entrance)	2014	3,393		15	113	113	113	11
12	R/M Replace Radiator/Thermostat	2014	7,190		10	360	360	360	12
13									13
14	Reconcile to book depreciation			756			(756)		14
15									15
16									16
17									17
18									18
19	Building - management company	2002	373,584		40	11,599	11,599	143,538	19
20	HVAC, electrical, security system - management company	2003	3,282		30	838	838	2,408	20
21	Key card system - management company	2004	515		20	27	27	268	21
22	VAV TX controls - management company	2005	159		20	8	8	78	22
23	Interior Signs - Management Company	2006	114		20	8	8	60	23
24	Building improvements - management company	2008	18,043		20	628	628	6,782	24
25	Building improvements - management company	2009	3,355		15	65	65	994	25
26	Building improvements - management company	2010	3,272		15	142	142	982	26
27	Building improvements - management company	2011	2,323		15	113	113	381	27
28	Building improvements - management company	2012	7,949		15	16	16	766	28
29	Building improvements - management company	2013	6,070		15	462	462	559	29
30	Building improvements - management company	2014	3,284		15	175	175	165	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,897,056	\$ 51,782		\$ 421,923	\$ 370,141	\$ 5,249,896	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	\$ 1,173,009	\$ 144,275	\$ 190,178	\$ 45,903	5	\$ 771,627	71
72	Current Year Purchases	34,196	1,423	1,423		5	1,423	72
73	Fully Depreciated Assets	428,356				5	428,356	73
74	Allocated from Mgmt. Co.	637,150		77,460	77,460	5-7	410,110	74
75	TOTALS	\$ 2,272,711	\$ 145,698	\$ 269,061	\$ 123,363		\$ 1,611,515	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.			67,587		5,231	5,231	5	59,128	79
80	TOTALS			\$ 67,587	\$	\$ 5,231	\$ 5,231		\$ 59,128	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)	\$ 17,040,757	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 197,480	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 696,215	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 498,735	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,920,539	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 Orland Park

# 0041855

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	<u>Parking space lease</u>				<u>10,400</u>			5
6	<u>Allocated from Management Company</u>				<u>6,104</u>			6
7	TOTAL				\$ <u>16,504</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. \_\_\_\_\_ /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: \$ 119,728 Description: See Sch 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	<u>Allocated from Management Company</u>			<u>1,492</u>	20
21	TOTAL		\$	\$ <u>1,492</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.

Facility Name: Lexington of Orland Park  
IDPH License ID Number: 0041855  
Fiscal Year End: 12/31/2014

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Copier	9,177
Printer	6,635
Mailing	180
Med Equip	49,721
Oxygen	52,047
Alloc. Mgmt Co.	1,968
<b>Total - Line 16</b>	<b><u>119,728</u></b>

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (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	\$	18,330	\$	860,562	\$	18,330	\$	860,562	1		
2	Licensed Speech and Language Development Therapist	39(3)	hrs		5,108		296,074		5,108		296,074	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39(3)	hrs		20,780		1,209,537		20,780		1,209,537	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39(2)	# of prescrpts					746,287			746,287	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Other (specify): <u>Ambulance</u>	39(3)					249				249	12		
13	Other (specify): <u>See Sch 16A</u>	39(2)						16,031			16,031	13		
14	<b>TOTAL</b>			\$	44,218	\$	2,366,422	\$	762,318	\$	44,218	\$	3,128,740	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 Orland Park  
IDPH License ID Number: 0041855  
Fiscal Year End: 12/31/2014

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

	<u>Description</u>	<u>Units</u>	<u>Amount</u>
39(2)	Oxygen		(488)
39(2)	DME		16,519
	<b>Total - Line 12</b>	<b>-</b>	<b>16,031</b>

Facility Name & ID Number Lexington of Orland Park# 0041855Report Period Beginning: 01/01/2014Ending: 12/31/2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 435,628	\$ 447,118	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>795,989</u> )	4,647,929	4,647,929	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,450	5,450	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest Receivable</u>	27,583	27,583	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 5,116,590	\$ 5,128,080	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	114,386	114,386	12
13	Land		803,404	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	1,463,618	5,327,770	15
16	Equipment, at Historical Cost	834,674	2,340,297	16
17	Accumulated Depreciation (book methods)	(866,503)	(6,920,539)	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>		71,079	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,546,175	\$ 10,305,683	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,662,765	\$ 15,433,763	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 908,547	\$ 908,547	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,249,000	2,249,000	29
30	Accrued Salaries Payable	483,646	483,646	30
31	Accrued Taxes Payable (excluding real estate taxes)	111,595	111,595	31
32	Accrued Real Estate Taxes(Sch.IX-B)		634,800	32
33	Accrued Interest Payable		45,420	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	8,066,833	4,756,551	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 11,819,621	\$ 9,189,559	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,668,806	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 9,668,806	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 11,819,621	\$ 18,858,365	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (5,156,856)	\$ (3,424,602)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,662,765	\$ 15,433,763	48

\*(See instructions.)

**Facility Name:** Lexington of Orland Park  
**IDPH License ID Number:** 0041855  
**Fiscal Year End:** 12/31/2014

**Schedule 17A**

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

Description	Operating	After Consolidation
DUE TO / FROM REHAB CARE THERAPY	36,121	36,121
Due to/from Republic Construction	(924)	(924)
Due from LLC	-	2,512
PREPAID INSURANCE	23,255	23,255
ESCROW - INSURANCE	(33,503)	(33,503)
401K WITHHOLDING	(499)	(499)
ACCRUED EXPENSES	206,410	206,410
ACCRUED ROYL / VESTA MGMT FEES	1,689,425	1,689,425
ACCRUED RENT	4,572,345	
ACCRUED INSURANCE	50,325	50,325
DUE TO PATIENT TRUST FUND	14,475	14,475
ADVANCE - BIWEEKLY PART A PAYM	(123,932)	(123,932)
UNCOLLECTIBLE PART A CO PVTS	(45,277)	(45,277)
DUE TO - ROYAL OPERATIONS	28,882	28,882
DUE TO REPUBLIC	(606)	(606)
Interest Rate Swap Liability	-	1,259,551
PROFESSIONAL LIABILITIES CLAIMS	1,650,336	1,650,336
<b>Total - Line 36</b>	<b>8,066,833</b>	<b>4,756,551</b>
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,267,739)	1
2	Restatements (describe):		2
3	Post closing adjustment	(370,801)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,638,540)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(518,316)	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	( )	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)	\$ (518,316)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (5,156,856)	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 27,102,409	1
2	Discounts and Allowances for all Levels	(15,816,036)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 11,286,373</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,136,131	6
7	Oxygen	(3,481)	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 8,132,650</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	582	12
13	Barber and Beauty Care	27,835	13
14	Non-Patient Meals	2,805	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,103,202	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	169,940	19
20	Radiology and X-Ray	368,765	20
21	Other Medical Services	473,839	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 2,146,968</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	20,146	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 20,146</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Misc. Income</u>	3,069	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 3,069</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 21,589,206</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,179,975	31
32	Health Care	7,511,206	32
33	General Administration	5,510,756	33
<b>B. Capital Expense</b>			
34	Ownership	2,899,463	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,476,132	35
36	Provider Participation Fee	529,990	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 22,107,522</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(518,316)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (518,316)</b>	<b>43</b>

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,667,887	44
45	Private Pay - Net Inpatient Revenue	771,999	45
46	Medicare - Net Inpatient Revenue	1,855,361	46
47	Other-(specify) <u>Managed Care</u>	(8,874)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 11,286,373</b>	<b>49</b>

\* 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 Taxpayer

Facility Name & ID Number Lexington of Orland Park

# 0041855

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	1,680	2,205	\$ 145,670	\$ 66.06	1
2	Assistant Director of Nursing	37,931	44,931	1,193,267	26.56	2
3	Registered Nurses	34,230	40,353	1,225,294	30.36	3
4	Licensed Practical Nurses	47,790	56,852	1,475,464	25.95	4
5	CNAs & Orderlies	154,557	178,667	2,079,288	11.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	15,055	17,748	200,744	11.31	10
11	Social Service Workers	6,091	6,889	143,195	20.79	11
12	Dietician	1,807	1,944	45,540	23.43	12
13	Food Service Supervisor	1,765	1,981	43,684	22.05	13
14	Head Cook	1,793	1,981	33,914	17.12	14
15	Cook Helpers/Assistants	23,277	26,474	280,351	10.59	15
16	Dishwashers	6,113	6,809	57,744	8.48	16
17	Maintenance Workers	3,965	4,546	80,628	17.74	17
18	Housekeepers	38,148	43,901	422,604	9.63	18
19	Laundry	5,964	7,274	67,175	9.23	19
20	Administrator	1,920	2,542	180,760	71.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,889	12,332	183,226	14.86	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	1,950	2,229	35,622	15.98	31
32	Other Health C: <u>Memory Care</u>	3,807	4,337	94,918	21.89	32
33	Other(specify) <u>See Sch 20A</u>	3,786	4,206	128,518	30.56	33
34	TOTAL (lines 1 - 33)	401,518	468,201	\$ 8,117,606 *	\$ 17.34	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 56,125	9(3)	36
37	Medical Records Consultant	Monthly 1,050	10(3)	37
38	Nurse Consultant	Monthly 64,046	10(3)	38
39	Pharmacist Consultant	Monthly 14,892	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly 3,115	11(3)	44
45	Social Service Consultant	Monthly 3,817	12(3)	45
46	Other(specify)			46
47	<u>Pulmonary Consulting</u>	Monthly 99,557	10(3)	47
48	<u>Medical Consultant</u>	Monthly 6,595	10(7)	48
49	TOTAL (lines 35 - 48)	\$ 249,197		49

**C. CONTRACT NURSES**

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

**Facility Name:** Lexington of Orland Park  
**IDPH License ID Number:** 0041855  
**Fiscal Year End:** 12/31/2014

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

**Line 33 Other (specify):**

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Marketing	3,010	3,344	119,033	\$ 35.60
Beauty	776	862	9,485	\$ 11.00
<b>Total - Line 33 Other (specify):</b>	<b>3,786</b>	<b>4,206</b>	<b>128,518</b>	<b>\$ 30.56</b>

Facility Name & ID Number Lexington of Orland Park

# 0041855

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	
Kimberly Saggese	Administrator	0	\$ 54,971	Workers' Compensation Insurance	\$ 273,368	IDPH License Fee	\$ 1,990	
Linda Pyfer	Administrator	0	125,789	Unemployment Compensation Insurance	352,703	Advertising: Employee Recruitment	48,594	
				FICA Taxes	620,804	Health Care Worker Background Check		
				Employee Health Insurance	303,155	(Indicate # of checks performed <u>204</u> )	2,443	
				Employee Meals	24,264	Patient Background Checks	645 7,737	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	4,258	
				401K	15,157	Miscellaneous Dues & Subscriptions	1,778	
				Tuition	19,642	IHCA	737	
				Uniform Allowance	4,111	Less non-allowable dues	(283)	
				Other Employee Benefits	42,892	Management Company Allocation	5,996	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 180,760	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 1,656,096		\$ 73,250		
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 OPERATNS			\$ 1,489,555	N/A		\$	Out-of-State Travel	\$
MANAGEMENT FEES- VESTA MGMT			646,197					
Eliminated in col. 7							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,135,752				Seminar Expense	
(Attach a copy of any management service agreement)							Management Company Allocation	2,248
							Entertainment Expense	( )
C. Professional Services				TOTAL			(agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount			\$	TOTAL	\$
Cassiday Schade, LLP	Legal		\$ 188,746					
Johnson & Bell	Legal		823					
Generation Law	Legal		507					
Grabowski Law Center, LLC	Collections		6,850					
Law Offices of Serpico	Legal		300					
Duane Morris	Legal		594					
McGladrey LLP	Accounting		42,015					
Personnel Planners	U/C Consulting		3,653					
Pension Administrators	401(k) Administration		600					
Much Shelist	Legal		21,337					
Secretary of State	Filing Fees		100					
See Sch 21C			309,374					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 574,898					
(For legal fee disclosure, see page 39 of instructions)								

\* Attach copy of IMRF notifications

\*\*See instructions.

**Facility Name:** Lexington of Orland Park  
**IDPH License ID Number:** 0041855  
**Fiscal Year End:** 12/31/2014

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
Lexington Financial	Financial	\$5,555.00
Vesta Mgmt.	Consulting	1,135.20
Information Controls	Computer	11,668.73
Health Medx	Computer	18,968.28
Americorp Financial	Computer	198,932.56
Ability Network	Computer	1,918.16
Avalere Health	Computer	2,000.00
Citrix	Computer	347.83
Corepoint	Computer	945.00
E-Health Data Solutions	Computer	3,450.00
National Research	Computer	512.67
On Shift	Computer	7,911.50
Relias	Computer	8,041.17
Salesforce.Com	Computer	5,004.31
Symbria	Computer	1,200.00
Tableau	Computer	1,715.84
Availity	Computer	138.50
Centino	Computer	750.00
Lintech LLC	Computer	72.50
National Datacare	Computer	2,874.45
Tympani	Computer	456.04
Soft Choice Corp	Computer	2,494.89
Hpcommercial Repair	Computer	21.41
Genesis Technology	Computer	171.51
Information Control	Computer	839.63
Ici Time	Computer	346.40

Soft Choice Corporation	Computer	2,851.59
Touch Point /Satisfaction Survey	Computer	235.20
Woundrounds Care Management	Computer	1,800.00
Ms Licensing	Computer	27,015.66
		309,374

**Total (agree to Schedule V, line 19, column 3) 574,898**

Less: Non-Allowable Legal Fees	(7,825)
Less: Marketing Software	(5,004)

*Allocated from Sambell*

Secretary of State	Filing Fees	200
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*Allocated from Management Company*

Much Shelist	Legal	225
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	73
Duane Morris	Legal	388
McGladrey LLP	Accounting	2,024
Frost, Ruttenberg & Rothblatt, P.C	Accounting	140
Gilson Labus & Silverman	Accounting	1,492
Illinois Secretary of State	Filing Fees	55
LaSalle Network	Recruiting/Finance	7,466
Pension Administrators, Inc.	401K Administration	464
Gene Whitehorn	Medicaid Reimb Specialist	2,011
M. Werner Consulting	Financial Consultant	2,638
McNamara & Associates	SNF Consultants	386
Healthcents	Managed Care Consultants	512
Computer Services	Computer Consulting	21,759

*Allocated from SV of Lombard II*

Gilson Labus & Silverman	Accounting	142
Illinois Secretary of State	Filing Fees	22

**Total (agree to Schedule V, line 19, column 8) 602,066**

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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Lexington of Orland Park# 0041855Report Period Beginning: 01/01/2014Ending: 12/31/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$454
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 101,097 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. \$ 529,990  
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. \$ 24,264 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,805
- (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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.