

Facility Name & ID Number Lexington of LaGrange

0038083 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 _____

	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	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	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	281	273	15,677	16,231	8
9	SNF/PED					9
10	ICF	11,179	4,658	1,667	17,504	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,460	4,931	17,344	33,735	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.67%

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

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date New Construction NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 119 and days of care provided 15,651

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: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	284,529	15,495	10,904	310,928		310,928	(208)	310,720		1
2	Food Purchase		151,108		151,108		151,108	(9,372)	141,736		2
3	Housekeeping	242,511	24,658		267,169		267,169	172	267,341		3
4	Laundry	48,343	10,925		59,268		59,268		59,268		4
5	Heat and Other Utilities			189,748	189,748		189,748	3,173	192,921		5
6	Maintenance	35,747		96,721	132,468		132,468	24,708	157,176		6
7	Other (specify):* Mgmt Alloc of Benefit							3,092	3,092		7
8	TOTAL General Services	611,130	202,186	297,373	1,110,689		1,110,689	21,565	1,132,254		8
	B. Health Care and Programs										
9	Medical Director			64,500	64,500		64,500		64,500		9
10	Nursing and Medical Records	2,561,679	130,079	279,207	2,970,965		2,970,965	6,569	2,977,534		10
10a	Therapy			1,127,352	1,127,352		1,127,352		1,127,352		10a
11	Activities	207,656	17,626	6,185	231,467		231,467		231,467		11
12	Social Services	61,943		17,251	79,194		79,194	208	79,402		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Alloc of Benefit							587	587		15
16	TOTAL Health Care and Programs	2,831,278	147,705	1,494,495	4,473,478		4,473,478	7,364	4,480,842		16
	C. General Administration										
17	Administrative	114,410		680,163	794,573		794,573	(625,735)	168,838		17
18	Directors Fees										18
19	Professional Services			56,126	56,126		56,126	18,650	74,776		19
20	Dues, Fees, Subscriptions & Promotions			25,258	25,258		25,258	701	25,959		20
21	Clerical & General Office Expenses	173,850	20,553	15,933	210,336		210,336	186,083	396,419		21
22	Employee Benefits & Payroll Taxes			530,512	530,512		530,512	9,372	539,884		22
23	Inservice Training & Education			1,003	1,003		1,003		1,003		23
24	Travel and Seminar			7,216	7,216		7,216	273	7,489		24
25	Other Admin. Staff Transportation			46	46		46	9,313	9,359		25
26	Insurance-Prop.Liab.Malpractice			105,716	105,716		105,716	2,034	107,750		26
27	Other (specify):* Mgmt Alloc of Benefit							36,706	36,706		27
28	TOTAL General Administration	288,260	20,553	1,421,973	1,730,786		1,730,786	(362,603)	1,368,183		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,730,668	370,444	3,213,841	7,314,953		7,314,953	(333,674)	6,981,279		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of LaGrange

#0038083

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			117,847	117,847		117,847	224,625	342,472			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,026	45,026		45,026	240,826	285,852			32
33	Real Estate Taxes							206,688	206,688			33
34	Rent-Facility & Grounds			934,684	934,684		934,684	(932,566)	2,118			34
35	Rent-Equipment & Vehicles			7,606	7,606		7,606	2,432	10,038			35
36	Other (specify):*											36
37	TOTAL Ownership			1,105,163	1,105,163		1,105,163	(257,995)	847,168			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		570,936	8,517	579,453		579,453		579,453			39
40	Barber and Beauty Shops			23,527	23,527		23,527		23,527			40
41	Coffee and Gift Shops			316	316		316		316			41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* Non-allowable Cos			71,610	71,610		71,610	(71,610)				43
44	TOTAL Special Cost Centers		570,936	169,123	740,059		740,059	(71,610)	668,449			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,730,668	941,380	4,488,127	9,160,175		9,160,175	(663,279)	8,496,896			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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				4
5	Telephone, TV & Radio in Resident Rooms	(3,973)	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				9
10	Interest and Other Investment Income	(124,690)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(539)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(7,567)	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	(11,837)	43		24
25	Fund Raising, Advertising and Promotional	(22,314)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,310)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(152,633)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (324,863)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(338,416)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (338,416)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (663,279)		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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of LaGrange

ID# 0038083

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (9,143)	43	1
2	X-Rays Part A	(13,349)	43	2
3	Non-Allowable Collection Fees	(1,059)	19	3
4	Personal Item Replacement	(1,578)	43	4
5	Miscellaneous Income Offset	(596)	21	5
6	Trust Fees	(205)	43	6
7	Loss from Extinguishment of Debt	(88,237)	43	7
8	Offset Marketing Salaries	(38,466)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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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	(152,633)		49

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule B		See Attached Schedule B		Sambell of LaGrange		
				Limited Partnership	LaGrange	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, LLC	Lombard	Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Fees	\$	Sambell of LaGrange Limited Partnership	**	\$ 10,990	\$ 10,990	1
2	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	197,038	197,038	2
3	V	32 Interest Expense		Sambell of LaGrange Limited Partnership	**	357,238	357,238	3
4	V	32 Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	697	697	4
5	V	33 Property Taxes		Sambell of LaGrange Limited Partnership	**	204,684	204,684	5
6	V	34 Rental Expense	934,684	Sambell of LaGrange Limited Partnership	**		(934,684)	6
7	V	43 Trust Fees		Sambell of LaGrange Limited Partnership	**	205	205	7
8	V	43 Loss from Extinguishment of Debt		Sambell of LaGrange Limited Partnership	**	88,237	88,237	8
9	V				**			9
10	V							10
11	V			**The owners of Lexington Health Care Center of LaGrange, Inc. owns 100% of Sambell of LaGrange Limited Partnership.				11
12	V							12
13	V							13
14	Total		\$ 934,684			\$ 859,089	\$ * (75,595)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.	**	\$ 172	\$	172	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	2,635		2,635	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	66		66	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	472		472	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	22,586		22,586	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	2,018		2,018	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	99		99	21	
22	V	6 Security service		Royal Management Corp.	**	5		5	22	
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	3,092		3,092	23	
24	V	10 Medical consultant		Royal Management Corp.	**	2,281		2,281	24	
25	V	10 Management allocation - salaries		Royal Management Corp.	**	4,288		4,288	25	
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	587		587	26	
27	V	17 Management allocation - salaries		Royal Management Corp.	**	54,428		54,428	27	
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	6,740		6,740	28	
29	V	19 Professional fees		Royal Management Corp.	**	1,979		1,979	29	
30	V	20 Dues & subscriptions		Royal Management Corp.	**	285		285	30	
31	V	21 Communications		Royal Management Corp.	**	67		67	31	
32	V	20 Advertising - help wanted		Royal Management Corp.	**	416		416	32	
33	V	21 Management allocation - salaries		Royal Management Corp.	**	213,720		213,720	33	
34	V	21 Bank charges		Royal Management Corp.	**	605		605	34	
35	V	21 Office supplies & printing		Royal Management Corp.	**	5,382		5,382	35	
36	V	21 Postage		Royal Management Corp.	**	1,968		1,968	36	
37	V								37	
38	V	**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 323,891	\$ *	323,891	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	21 Telephone	\$	Royal Management Corp.	**	\$ 3,403	\$ 3,403	
16	V	24 Travel & seminar		Royal Management Corp.	**	273	273	
17	V	25 Auto expense		Royal Management Corp.	**	9,313	9,313	
18	V	26 Insurance general		Royal Management Corp.	**	2,034	2,034	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	36,706	36,706	
20	V	30 Depreciation		Royal Management Corp.	**	27,587	27,587	
21	V	32 Interest		Royal Management Corp.	**	7,567	7,567	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	14	14	
23	V	33 Property taxes		Royal Management Corp.	**	2,004	2,004	
24	V	34 Rent expense		Royal Management Corp.	**	2,118	2,118	
25	V	35 Equipment rental		Royal Management Corp.	**	613	613	
26	V	17 Management fees	680,163	Royal Management Corp.	**		(680,163)	
27	V	35 Auto Lease		Royal Management Corp.	**	1,819	1,819	
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V	** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						
39	Total		\$ 680,163			\$ 93,451	\$ * (586,712)	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	22.33	See Schedule 7A	2	4.00	Salary	\$ 18,350	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	2	4.00	Salary	13,107	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	2	4.00	Salary	13,107	L17, C7	3
4	Jason Samatas	VP of Operations	Administrative	0.00	See Schedule 7A	3	6.00	Salary	9,864	L17, C7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	2	4.00	Salary	2,101	L21, C7	5
6											6
7											7
8											8
9											9
10						All individuals work in excess of 40 hours per week.					10
11											11
12											12
13								TOTAL	\$ 56,529		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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

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

Name of Related Organization Royal Management Corp.
 Street Address 665 W. North Avenue, Suite 500
 City / State / Zip Code Lombard, IL 60148
 Phone Number (630) 458-4700
 Fax Number (630) 458-4796

1	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	748,545	10	\$ 2,970	\$ 43,435	\$ 172	1
2	5	Utilities - gas & electric	Bed Days	748,545	10	45,421	43,435	2,636	2
3	5	Utilities - water & sewer	Bed Days	748,545	10	1,129	43,435	66	3
4	5	Utilities - maintenance office	Bed Days	748,545	10	8,141	43,435	472	4
5	6	Management allocation - salaries	Bed Days	748,545	10	389,246	389,246	22,586	5
6	6	Repairs & maintenance	Bed Days	748,545	10	34,773	43,435	2,018	6
7	6	Scavenger & exterminating	Bed Days	748,545	10	1,705	43,435	99	7
8	6	Security service	Bed Days	748,545	10	78	43,435	5	8
9	7	Management allocation - employee	Bed Days	748,545	10	53,283	43,435	3,092	9
10	10	Medical consultant	Bed Days	748,545	10	39,304	43,435	2,281	10
11	10	Management allocation - salaries	Bed Days	748,545	10	73,905	73,905	4,288	11
12	15	Management allocation - employee	Bed Days	748,545	10	10,117	43,435	587	12
13	17	Management allocation - salaries	Bed Days	748,545	10	937,986	937,986	54,427	13
14	19	Computer consultant & supplies	Bed Days	748,545	10	116,160	43,435	6,740	14
15	19	Professional fees	Bed Days	748,545	10	34,111	43,435	1,979	15
16	20	Dues & subscriptions	Bed Days	748,545	10	4,903	43,435	285	16
17	21	Communications	Bed Days	748,545	10	1,161	43,435	67	17
18	20	Advertising - help wanted	Bed Days	748,545	10	7,177	43,435	416	18
19	21	Management allocation - salaries	Bed Days	748,545	10	3,683,186	3,683,186	213,720	19
20	21	Bank charges	Bed Days	748,545	10	10,433	43,435	605	20
21	21	Office supplies & printing	Bed Days	748,545	10	92,754	43,435	5,382	21
22	21	Postage	Bed Days	748,545	10	33,908	43,435	1,968	22
23	21	Telephone	Bed Days	748,545	10	58,647	43,435	3,403	23
24	24	Travel and Seminar	Bed Days	748,545	10	4,702	43,435	273	24
25	TOTALS					\$ 5,645,200	\$ 5,084,323	\$ 327,567	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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	25	Auto expense	Bed Days	748,545	10	\$ 160,505	\$ 43,435	\$ 9,313	1
2	26	Insurance general	Bed Days	748,545	10	35,055	43,435	2,034	2
3	27	Management allocation - employee	Bed Days	748,545	10	632,578	43,435	36,706	3
4	30	Depreciation	Bed Days	748,545	10	475,433	43,435	27,587	4
5	32	Interest	Bed Days	748,545	10	130,405	43,435	7,567	5
6	32	Amortization of mortgage costs	Bed Days	748,545	10	242	43,435	14	6
7	33	Property taxes	Bed Days	748,545	10	34,533	43,435	2,004	7
8	34	Rent expense	Bed Days	748,545	10	36,507	43,435	2,118	8
9	35	Equipment rental	Bed Days	748,545	10	10,570	43,435	613	9
10	35	Auto Lease	Bed Days	748,545	10	31,346	43,435	1,819	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,547,174	\$	\$ 89,775	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lexington Financial	X		Mortgage	\$22,735.00	12/29/98	\$ 2,990,000	\$	12/29/08	0.0675	\$ 50,463	1								
2	Services II, LLC	X		Mortgage	Varies	4/30/07	5,991,000	5,937,081	5/1/17	0.0625	257,799	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LaSalle Bank, NA		X	Line of Credit	Various	12/1/02	500,000		5/31/07	Prime/Libor	3,002	6								
7	Partner Loans	X		Working Capital	Various	11/26/03	1,330,000		Demand	Prime + 1	88,014	7								
8	JP Morgan Chase		X	Line of Credit	Various	4/30/07	600,000	100,000	5/1/10	Libor	2,986	8								
9	TOTAL Facility Related				\$22,735.00		\$ 11,411,000	\$ 6,037,081			\$ 402,264	9								
B. Non-Facility Related*																				
10							Amortization of loan costs				711	10								
11							Interest income offset				(36,676)	11								
12							Nonallowable partner loan interest				(88,014)	12								
13							Allocated from management company				7,567	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (116,412)	14								
15	TOTALS (line 9+line14)						\$ 11,411,000	\$ 6,037,081			\$ 285,852	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 2006 report.		\$	224,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	222,226	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,174)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	234,000	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.)		\$	22,576	5
	Allocated from Management Co.		2,004	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(49,718)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	206,688	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	198,271	8	
	2003	205,441	9	
	2004	217,366	10	
	2005	217,905	11	
	2006	222,226	12	
Computation of accrual, see attached schedule.				
Use:		\$234,000		
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006 \$		13
	14	PLUS APPEAL COST FROM LINE 5 \$		14
	15	LESS REFUND FROM LINE 6 \$		15
	16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Sue Rojek

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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-08-207-017-000</u>	<u>Land & Building</u>	\$ <u>118,691.49</u>	\$ <u>118,691.49</u>
2. <u>18-08-207-018-000</u>	<u>Land & Building</u>	\$ <u>103,535.11</u>	\$ <u>103,535.11</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ <u>132,281.84</u>	\$ <u>2,004.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>354,508.44</u>	\$ <u>224,230.60</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? YES NO

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>40,000</u>	<u>1991</u>	<u>\$ 500,000</u>	<u>1</u>
2	<u>Allocated from Management Co.</u>			<u>8,605</u>	<u>2</u>
3	TOTALS	40,000		\$ 508,605	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange# 0038083

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	99		1992	1992	\$ 2,661,448	\$	35	\$ 76,041	\$ 76,041	\$ 1,178,641	4
5	10		1995	1995	79,363		10			79,363	5
6	10		2005	2005	2,321,014		21	110,524	110,524	276,311	6
7											7
8											8
	Improvement Type**										
9		Land Improvements	1992	1992	1,152		20	58	58	894	9
10		Building Improvements	1992	1992	2,714		31			2,714	10
11		Building Improvements	1993	1993	2,901		35	83	83	1,201	11
12		Leasehold Improvements	1994	1994	6,402		10			6,402	12
13		Leasehold Improvements - Corner Guards	1996	1996	2,195		10			2,122	13
14		Wiring	1998	1998	3,378	338	10	338		3,209	14
15		Resurface & Restripe Parking Lot	1998	1998	3,753	375	10	375		3,565	15
16		Lobby Tile	1998	1998	19,488	1,949	10	1,949		17,864	16
17		Resurface & Restripe Parking Lot	2000	2000	1,997	200	10	200		1,498	17
18		Automatic Door	2000	2000	1,300	130	10	130		975	18
19		Kitchen Rehab	2001	2001	1,441	144	10	144		937	19
20		Infrared curtains for elevator	2001	2001	3,000	300	10	300		1,950	20
21		Dining room, resident rooms, and corridors renovations	2002	2002	150,084	7,505	20	7,505		38,146	21
22		Elevator upgrade	2002	2002	5,398	540	10	540		3,059	22
23		Air conditioner compressor	2003	2003	9,218	922	10	922		4,071	23
24		Sidewalk and fencing	2005	2005	46,701	2,335	20	2,335		5,059	24
25		HVAC	2005	2005	8,141	407	20	407		848	25
26		Wiring	2005	2005	4,506	225	20	225		507	26
27		Lobby, lounge and reception renovations	2005	2005	24,362	1,218	20	1,218		2,842	27
28		1st floor new dining room, floors, ceilings, wallcoverings, doors	2005	2005	326,862	16,343	20	16,343		32,686	28
29		Wallcoverings	2005	2005	10,822	2,164	5	2,164		5,591	29
30		Medical records room rehab	2006	2006	19,739	987	20	987		987	30
31		Activity/PT Room Rehab	2006	2006	1,158	58	20	58		58	31
32		Land scape enhancement	2006	2006	8,726	582	15	582		776	32
33		Roof	2006	2006	29,700	1,980	15	1,980		2,640	33
34		HVAC	2006	2006	3,254	163	20	163		217	34
35		Plumbing and sprinkler system	2006	2006	20,725	1,036	20	1,036		2,073	35
36			2006	2006	16,814	841	20	841		1,471	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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Lobby/Lounge/Reception rehab	2006	\$ 14,033	\$ 1,403	10	\$ 1,403	\$	\$ 2,105	37
38	Cubicle curtains/drapery	2006	6,955	1,391	5	1,391		2,605	38
39	Cabinets/counters for 2nd FI library	2006	2,665	267	10	267		333	39
40	TCU rehab	2006	2,402	120	20	120		130	40
41	First floor remodel	2006	212,084	10,604	20	10,604		10,604	41
42	Kitchen rehab	2006	8,165	408	20	408		612	42
43	Bath fixtures-2nd floor	2006	2,076	208	10	208		381	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		176	44
45	Landscaping	2007	3,862	150	15	150		150	45
46	HVAC	2007	58,326	1,215	20	1,215		1,215	46
47	Common Areas Remodel	2007	2,059	120	10	120		120	47
48	First Floor Remodel	2007	6,517	244	20	244		244	48
49	Garage	2007	16,487	69	20	69		69	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61	Land improvements - management company	2002	13,562		15	253	253	5,349	61
62	Building - management company	2002	105,510		40	651	651	15,607	62
63	HVAC, electrical, security system - management company	2003	1,046		30	73	73	318	63
64	Key card system - management company	2004	164		20	8	8	28	64
65	VAV TX controls - management company	2005	50		20	2	2	7	65
66	Interior Signs-management company	2006	36		5	3	3	3	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,257,282	\$ 57,117		\$ 244,813	\$ 187,696	\$ 1,718,733	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 398,470	\$ 58,133	\$ 68,469	\$ 10,336	3-10	\$ 164,378	71
72	Current Year Purchases	38,029	2,593	2,593		5-7	2,593	72
73	Fully Depreciated Assets	92,945					92,945	73
74	Allocated from Management Company	130,328		23,934	23,934	5-7	66,214	74
75	TOTALS	\$ 659,772	\$ 60,726	\$ 94,996	\$ 34,270		\$ 326,130	75

D. Vehicle Depreciation (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 Management Company			20,673		2,663	2,663	5-7	13,553	79
80	TOTALS			\$ 20,673	\$	\$ 2,663	\$ 2,663		\$ 13,553	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)	\$ 7,446,332	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,843	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 342,472	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 224,629	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,058,416	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	2nd Floor Remodel	\$ 271,935	92
93			93
94			94
95		\$ 271,935	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co.				2,118			6
7	TOTAL				\$ 2,118			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 8,219 Description: Copier-\$7,027, Postage Meter-\$180, Fax Machine-\$399, Mgmt Co.-\$613

(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	Allocated from Mgmt Co.		\$	\$ 1,819	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,819	21

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	8,903	\$ 450,503	\$	8,903	\$ 450,503	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		968	61,992		968	61,992	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		9,956	614,857		9,956	614,857	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				570,936		570,936	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Wound Care & Ambul</u>	L39, C3				8,517			8,517	13
14	TOTAL			\$	19,827	\$ 1,135,869	\$ 570,936	19,827	\$ 1,706,805	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0038083
 As of 12/31/2007

Report Period Beginning: 01/01/2007
 (last day of reporting year)

Ending: 12/31/2007

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 306,677	\$ 307,454	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 471,283)	1,675,002	1,675,002	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,303	80,303	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,127,704)	370,848	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 934,278	\$ 2,433,607	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,587	6,587	12
13	Land		508,605	13
14	Buildings, at Historical Cost		5,064,539	14
15	Leasehold Improvements, at Historical Cost	1,155,137	1,192,743	15
16	Equipment, at Historical Cost	400,311	680,445	16
17	Accumulated Depreciation (book methods)	(401,732)	(2,058,416)	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 (spec Construc in Progress	271,935	271,935	22
23	Other(specify): <u>Mortgage Cost</u>		32,767	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,432,238	\$ 5,699,205	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,366,516	\$ 8,132,812	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 260,560	\$ 260,560	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000	100,000	29
30	Accrued Salaries Payable	176,957	176,957	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,766	4,766	31
32	Accrued Real Estate Taxes(Sch.IX-B)		234,000	32
33	Accrued Interest Payable		38,922	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	531,214	331,836	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,073,497	\$ 1,147,041	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,937,081	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,937,081	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,073,497	\$ 7,084,122	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,293,019	\$ 1,048,690	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,366,516	\$ 8,132,812	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of La Grange
FYE 12/31/07
Provider #: 0038083
Schedule 17A

Other Current Liabilities

Due to Royal (OPS)	33,940	33,940
Due To/From Lake Zurich	247	247
Due To/From OP	2,578	2,578
Bond Withholding	257	257
401K Withholding	1,784	1,784
Accrued 401K	16,314	16,314
Due To-Republic Construction	36,527	36,527
Accrued Expenses	270,097	270,097
Accrued Royal Mgmt Fees	5,349	5,349
Accrued Rent	199,378	-
Accrued Wage Assignments	105	105
Advance-Biweekly Part A Payments	(35,362)	(35,362)
	<hr/>	<hr/>
Schedule XV Line 36	531,214	331,836

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,929,608	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(122,399)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,807,209	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	592,810	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	(1,107,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (514,190)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,293,019	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,367,779	1
2	Discounts and Allowances for all Levels	(2,863,158)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,504,621	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,082,353	6
7	Oxygen	637	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,082,990	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	203	12
13	Barber and Beauty Care	20,180	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	995,004	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,996	19
20	Radiology and X-Ray	24,942	20
21	Other Medical Services	72,378	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,158,703	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,937	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,937	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous & Investment Income</u>	734	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 734	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,752,985	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,110,689	31
32	Health Care	4,473,478	32
33	General Administration	1,730,786	33
	B. Capital Expense		
34	Ownership	1,105,163	34
	C. Ancillary Expense		
35	Special Cost Centers	674,906	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,160,175	40
41	Income before Income Taxes (line 30 minus line 40)**	592,810	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 592,810	43

* 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.
This entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	1,959	2,204	\$ 102,283	\$ 46.41	1
2	Assistant Director of Nursing	3,920	4,405	151,264	34.34	2
3	Registered Nurses	28,537	31,836	985,036	30.94	3
4	Licensed Practical Nurses	13,810	15,194	377,305	24.83	4
5	CNAs & Orderlies	63,499	68,913	785,643	11.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,823	11,384	160,148	14.07	8
9	Activity Director	2,042	2,107	30,422	14.44	9
10	Activity Assistants	15,271	16,458	177,234	10.77	10
11	Social Service Workers	2,987	3,354	61,943	18.47	11
12	Dietician	849	876	11,021	12.58	12
13	Food Service Supervisor	1,988	2,209	49,421	22.37	13
14	Head Cook	2,127	2,209	30,796	13.94	14
15	Cook Helpers/Assistants	13,432	14,410	121,815	8.45	15
16	Dishwashers	9,176	9,721	71,476	7.35	16
17	Maintenance Workers	2,172	2,348	35,747	15.22	17
18	Housekeepers	26,961	29,566	242,511	8.20	18
19	Laundry	5,821	6,334	48,343	7.63	19
20	Administrator	1,788	2,184	114,410	52.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,546	12,772	173,850	13.61	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	217,708	238,484	\$ 3,730,668 *	\$ 15.64	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	192	\$ 10,904	L1, C3	35
36	Medical Director	Monthly	64,500	L9, C3	36
37	Medical Records Consultant	19	1,128	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	4,512	L11, C3	44
45	Social Service Consultant	96	4,800	L12, C3	45
46	Other(specify) <u>PA Applic Consult</u>	Monthly	24,501	L10, C3	46
47	<u>See Schedule 20A</u>	250	12,659		47
48	<u>Medical Consultant</u>	Monthly	2,281	L10, C3	48
49	TOTAL (lines 35 - 48)	653	\$ 127,685		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	185	\$ 9,671	L10, C3	50
51	Licensed Practical Nurses	5,449	210,840	L10, C3	51
52	Certified Nurse Assistants/Aides	8	144	L10, C3	52
53	TOTAL (lines 50 - 52)	5,642	\$ 220,655		53

SEE ACCOUNTANTS' COMPILATION REPORT

LHCC of La Grange
FYE 12/31/07
Provider #: 0038083
Summary of Consultants

	# of Hours	Total Consultant Cost	Schedule V Line # & Column
Psychosocial Consultant	40	1,984	L12, C3
MDS Consultant	210	10,675	L12, C3
	<u>250</u>	<u>12,659</u>	

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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		
<u>Kathryn Dyhouse</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 114,410</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 57,310</u>	<u>IDPH License Fee</u>	<u>\$ 16,673</u>		
				<u>Unemployment Compensation Insurance</u>	<u>39,172</u>	<u>Advertising: Employee Recruitment</u>	<u>16,673</u>		
				<u>FICA Taxes</u>	<u>275,061</u>	<u>Health Care Worker Background Check</u>	<u>6,000</u>		
				<u>Employee Health Insurance</u>	<u>115,940</u>	(Indicate # of checks performed <u>600</u>)			
				<u>Employee Meals</u>	<u>9,372</u>	<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Permits</u>	<u>2,550</u>		
				<u>401 (K) Contributions</u>	<u>16,315</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>35</u>		
				<u>Life Insurance</u>	<u>3,103</u>	<u>Allocated from Home Office</u>	<u>701</u>		
				<u>Other Employee Benefits</u>	<u>23,611</u>				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 114,410	TOTAL (agree to Schedule V, line 22, col.8)			\$ 539,884		
(List each licensed administrator separately.)				(agree to Sch. V, line 20, col. 8)			\$ 25,959		
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	
<u>Management Fees-Royal Operating</u>			<u>\$ 388,677</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>	
<u>Management Fees-Royal General</u>			<u>291,486</u>				<u>In-State Travel</u>		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 680,163	TOTAL			\$	<u>Seminar Expense</u>	<u>7,216</u>
(Attach a copy of any management service agreement)							<u>Allocated from Home Office</u>	<u>273</u>	
C. Professional Services									
Vendor/Payee	Type	Amount							
<u>McGladrey & Pullen, LLP</u>	<u>Accounting</u>	<u>\$ 17,844</u>					<u>Entertainment Expense</u>	<u>()</u>	
<u>RSM McGladrey, Inc.</u>	<u>Accounting</u>	<u>6,450</u>					(agree to Sch. V, line 24, col. 8)		
<u>Adam Stern</u>	<u>Other Consulting</u>	<u>470</u>					TOTAL	\$ 7,489	
<u>Cassiday Schade & Gloor, LLP</u>	<u>Legal</u>	<u>4,361</u>							
<u>Chicago Legal Clinic</u>	<u>Other Consulting</u>	<u>470</u>							
<u>James Samatas, Atty at Law</u>	<u>Legal</u>	<u>100</u>							
<u>Reed Smith LLP</u>	<u>Legal</u>	<u>1,350</u>							
<u>Sachnoff & Weaver</u>	<u>Legal</u>	<u>1,980</u>							
<u>Personnel Planners</u>	<u>U/C Consulting</u>	<u>1,530</u>							
<u>Grabowski Law Center</u>	<u>Collections</u>	<u>1,059</u>							
<u>Systematic Management System</u>	<u>Billing Fees</u>	<u>595</u>							
<u>See Attached Schedule F</u>		<u>19,917</u>							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 56,126						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of LaGrange, Inc.
 FYE: 12/31/06
 Medicaid Cost Report Workpapers
 Provider Number - 0038083

Schedule F

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
ING	401K Audit	826
National Datacare Corporation	Computer Consulting	1,305
Information Controls, Inc.	Computer Consulting	434
AAOD	Computer Consulting	512
eHealth Solutions	Computer Consulting	2,400
Microsoft	Computer Consulting	5,207
Action Computer Service	Computer Consulting	324
Krakau Business	Computer Consulting	617
Alperian Technology	Computer Consulting	215
Visual Click	Computer Consulting	97
CDW	Computer Consulting	490
Lanac	Computer Consulting	3,337
Lintech	Computer Consulting	3,137
Campbell	Computer Consulting	55
Andrew Campbell Photography	Computer Consulting	125
O'Donnell & Associates	Computer Consulting	186
Other	Computer Consulting	650

Total, Other Professional Services 19,917
 Plus Professional Services from Page 21 36,209

Total Professional Services Col 3 56,126
 Allocated from management co.

Lintech	Computer Consulting	2,359
Lanac Technology	Computer Consulting	2,022
Lifecare Software, Inc.	Computer Consulting	1,348
CDW Direct	Computer Consulting	1,012
James Samatas	Legal	4
Sachnoff & Weaver	Legal	87
McGladrey & Pullen, LLP	Accounting	200
RSM McGladrey, Inc.	Accounting	292
Aronberg, Goldgehn, Davis	Accounting	165
Gilson, Labus & Silverman	Accounting	268
ING Administration Fee	Pension Consultation	3
Elizabeth Schwarz	Physician Credentialing Consultant	97
Pension Administrators, Inc.	401K Administration	272
Addison Search	Billing Consulting	27
Gene Whitehorn	Medicaid Reim Specialist	488
		<u>8,644</u>

Allocated from Samvest of Lombard II
 Gilson, Labus & Silverman Accounting 75

Allocated from building partnership
 James Samatas Filing and recording fees 100
 RSM McGladrey Accounting 10,890

Less Collection Fees disallowed (1,059)

Total, Agrees to Schedule V, Line 19, Column 8 74,776

See accountants' compilation report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange# 0038083Report Period Beginning: 01/01/2007Ending: 12/31/2007**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. \$ 26,845 Line 10
- (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. \$ 65,153
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 9,372 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees