

Facility Name & ID Number Lexington of LaGrange

0038083 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	119	Skilled (SNF)	119	43,554	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	43,554	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	661	1,352	17,253	19,266	8
9	SNF/PED					9
10	ICF	8,329	6,358	359	15,046	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,990	7,710	17,612	34,312	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.78%

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 17,244

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	329,334	17,181	11,191	357,706		357,706		357,706		1
2	Food Purchase		166,404		166,404		166,404	(10,696)	155,708		2
3	Housekeeping	259,124	21,987		281,111		281,111	272	281,383		3
4	Laundry	51,756	10,960		62,716		62,716		62,716		4
5	Heat and Other Utilities			211,701	211,701		211,701	4,016	215,717		5
6	Maintenance	35,929		103,713	139,642		139,642	27,538	167,180		6
7	Other (specify):* Mgmt Alloc Employee							2,991	2,991		7
8	TOTAL General Services	676,143	216,532	326,605	1,219,280		1,219,280	24,121	1,243,401		8
	B. Health Care and Programs										
9	Medical Director			62,000	62,000		62,000		62,000		9
10	Nursing and Medical Records	2,660,363	216,896	20,008	2,897,267		2,897,267	10,602	2,907,869		10
10a	Therapy			1,314,780	1,314,780		1,314,780		1,314,780		10a
11	Activities	232,637	21,033	7,090	260,760		260,760		260,760		11
12	Social Services	112,182		6,934	119,116		119,116		119,116		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Alloc Employee							1,785	1,785		15
16	TOTAL Health Care and Programs	3,005,182	237,929	1,410,812	4,653,923		4,653,923	12,387	4,666,310		16
	C. General Administration										
17	Administrative	106,027		773,390	879,417		879,417	(740,228)	139,189		17
18	Directors Fees										18
19	Professional Services			84,878	84,878		84,878	10,425	95,303		19
20	Dues, Fees, Subscriptions & Promotions			38,221	38,221		38,221	2,805	41,026		20
21	Clerical & General Office Expenses	279,074	26,868	18,186	324,128		324,128	195,229	519,357		21
22	Employee Benefits & Payroll Taxes			568,481	568,481		568,481	10,696	579,177		22
23	Inservice Training & Education			3,733	3,733		3,733		3,733		23
24	Travel and Seminar			7,229	7,229		7,229	347	7,576		24
25	Other Admin. Staff Transportation			3,881	3,881		3,881	11,844	15,725		25
26	Insurance-Prop.Liab.Malpractice			91,884	91,884		91,884	1,824	93,708		26
27	Other (specify):* Mgmt Alloc Employee							35,864	35,864		27
28	TOTAL General Administration	385,101	26,868	1,589,883	2,001,852		2,001,852	(471,194)	1,530,658		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,066,426	481,329	3,327,300	7,875,055		7,875,055	(434,686)	7,440,369		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:

01/01/2008

Ending:

12/31/2008

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			97,831	97,831		97,831	320,463	418,294			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,158	7,158		7,158	374,139	381,297			32
33	Real Estate Taxes							283,821	283,821			33
34	Rent-Facility & Grounds			1,049,930	1,049,930		1,049,930	(1,047,703)	2,227			34
35	Rent-Equipment & Vehicles			32,562	32,562		32,562	2,492	35,054			35
36	Other (specify):*											36
37	TOTAL Ownership			1,187,481	1,187,481		1,187,481	(66,788)	1,120,693			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		563,571	12,323	575,894		575,894		575,894			39
40	Barber and Beauty Shops			25,286	25,286		25,286		25,286			40
41	Coffee and Gift Shops			5,014	5,014		5,014		5,014			41
42	Provider Participation Fee			65,332	65,332		65,332		65,332			42
43	Other (specify):* Non-allowable cost			71,151	71,151		71,151	(71,151)				43
44	TOTAL Special Cost Centers		563,571	179,106	742,677		742,677	(71,151)	671,526			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,066,426	1,044,900	4,693,887	9,805,213		9,805,213	(572,625)	9,232,588			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

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	(4,166)	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	(83)	30		9
10	Interest and Other Investment Income	(4,947)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(850)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,137)	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	(2,426)	43		24
25	Fund Raising, Advertising and Promotional	(15,603)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,269)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(130,271)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (164,752)		\$	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)	(407,873)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (407,873)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (572,625)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

Lexington of LaGrange

ID# 0038083

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salary	\$ (76,444)	21	1
2	Labs-Part A	(20,652)	43	2
3	X-Rays Part A	(21,032)	43	3
4	Trust Fees	(75)	43	4
5	Collections	(1,498)	19	5
6	Out of period legal	(3,230)	19	6
7	Additional Marketing Salary	(6,622)	10	7
8	Non-allowable accounting	(718)	19	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
21				21
22				22
23				23
24				24
25				25
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34				34
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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	(130,271)		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	**	\$ 200	\$	200	1
2	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	291,083		291,083	2
3	V	32 Interest Expense		Sambell of LaGrange Limited Partnership	**	366,912		366,912	3
4	V	32 Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	1,199		1,199	4
5	V	33 Property Taxes		Sambell of LaGrange Limited Partnership	**	281,930		281,930	5
6	V	34 Rental Expense	1,049,932	Sambell of LaGrange Limited Partnership	**			(1,049,932)	6
7	V	43 Trust Fees		Sambell of LaGrange Limited Partnership	**	75		75	7
8	V	43 State Replacement Taxes		Sambell of LaGrange Limited Partnership	**	(16)		(16)	8
9	V	21 Office Supplies		Sambell of LaGrange Limited Partnership	**	105		105	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		\$ 1,049,932			\$ 941,488	\$ *	(108,444)	14

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

Lexington Health Care Center of LaGrange, Inc.

Provider # 0038083

FYE 1/1/08 - 12/31/08

Schedule B

VII. Related Parties

Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

<u>Name of Facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

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.	**	\$ 272	\$	272	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,341		3,341	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	85		85	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	590		590	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	24,484		24,484	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	2,905		2,905	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	149		149	21	
22	V	6 Security service		Royal Management Corp.	**				22	
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	2,991		2,991	23	
24	V	10 Medical consultant		Royal Management Corp.	**	2,609		2,609	24	
25	V	10 Management allocation - salaries		Royal Management Corp.	**	14,615		14,615	25	
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	1,785		1,785	26	
27	V	17 Management allocation - salaries		Royal Management Corp.	**	33,162		33,162	27	
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	12,509		12,509	28	
29	V	19 Professional fees		Royal Management Corp.	**	3,162		3,162	29	
30	V	20 Dues & subscriptions		Royal Management Corp.	**	2,137		2,137	30	
31	V	21 Communications		Royal Management Corp.	**				31	
32	V	20 Advertising - help wanted		Royal Management Corp.	**	668		668	32	
33	V	21 Management allocation - salaries		Royal Management Corp.	**	256,647		256,647	33	
34	V	21 Bank charges		Royal Management Corp.	**	3,024		3,024	34	
35	V	21 Office supplies & printing		Royal Management Corp.	**	5,715		5,715	35	
36	V	21 Postage		Royal Management Corp.	**	1,822		1,822	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		\$			\$ 372,672	\$ *	372,672	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	21 Telephone	\$	Royal Management Corp.	**	\$ 4,360	\$ 4,360	
16	V	24 Travel & seminar		Royal Management Corp.	**	347	347	
17	V	25 Auto expense		Royal Management Corp.	**	11,844	11,844	
18	V	26 Insurance general		Royal Management Corp.	**	1,824	1,824	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	35,864	35,864	
20	V	30 Depreciation		Royal Management Corp.	**	29,463	29,463	
21	V	32 Interest		Royal Management Corp.	**	10,958	10,958	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	17	17	
23	V	33 Property taxes		Royal Management Corp.	**	1,891	1,891	
24	V	34 Rent expense		Royal Management Corp.	**	2,229	2,229	
25	V	35 Equipment rental		Royal Management Corp.	**	537	537	
26	V	17 Management fees	773,390	Royal Management Corp.	**		(773,390)	
27	V	35 Auto Lease		Royal Management Corp.	**	1,955	1,955	
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		\$ 773,390			\$ 101,289	\$ * (672,101)	

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

Facility Name & ID Number

Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	2.08	4.20	Salary	\$ 11,054	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	2.08	4.20	Salary	11,054	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	2.08	4.20	Salary	11,054	L17, C7	3
4	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	0.37	0.74	Salary	769	L21, C7	4
5	Jason Samatas	Officer	Admin/SNF ops	0.00	See Schedule 7A	2.98	6.00	Salary	10,880	L17,21,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	\$ 44,811		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

Royal Management Corp.
Related Party Compensation
Period: 01/01/08 - 12/31/08

Schedule 7A

VII. Related Parties

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

Compensation Received From Other Nursing Homes

<u>Facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>Daniel Thiem</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Lombard, Inc.	20,808	20,808	20,808	1,447	20,481	84,352
Lexington Health Care Center of Bloomingdale, Inc.	15,420	15,420	15,420	1,072	15,178	62,510
Lexington Health Care Center of Schaumburg, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Chicago Ridge, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Streamwood, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Elmhurst, Inc.	13,469	13,469	13,469	936	13,257	54,600
Lexington Health Care Center of Lake Zurich, Inc.	19,415	19,415	19,415	1,350	19,109	78,704
Lexington Health Care Center of Orland Park, Inc.	25,825	25,825	25,825	1,795	25,418	104,688
Lexington Health Care Center of Wheeling, Inc.	19,972	19,972	19,972	1,389	19,658	80,963
Lexington Health Care Center of LaGrange, Inc.	11,054	11,054	11,054	769	10,880	44,811
Total	185,600	185,600	185,600	12,904	182,679	752,383

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	731,268	10	\$ 4,564	\$ 43,554	\$ 272	1
2	5	Utilities - gas & electric	Bed Days	731,268	10	56,094	43,554	3,341	2
3	5	Utilities - water & sewer	Bed Days	731,268	10	1,425	43,554	85	3
4	5	Utilities - maintenance office	Bed Days	731,268	10	9,903	43,554	590	4
5	6	Management allocation - salaries	Bed Days	731,268	10	411,084	411,084	24,484	5
6	6	Repairs & maintenance	Bed Days	731,268	10	48,773	43,554	2,905	6
7	6	Scavenger & exterminating	Bed Days	731,268	10	2,504	43,554	149	7
8	6	Security service	Bed Days	731,268	10		43,554	0	8
9	7	Management allocation - employee	Bed Days	731,268	10	50,217	43,554	2,991	9
10	10	Medical consultant	Bed Days	731,268	10	43,800	43,554	2,609	10
11	10	Management allocation - salaries	Bed Days	731,268	10	245,385	245,385	14,615	11
12	15	Management allocation - employee	Bed Days	731,268	10	29,975	43,554	1,785	12
13	17	Management allocation - salaries	Bed Days	731,268	10	556,800	556,800	33,163	13
14	19	Computer consultant & supplies	Bed Days	731,268	10	210,020	43,554	12,509	14
15	19	Professional fees	Bed Days	731,268	10	53,093	43,554	3,162	15
16	20	Dues & subscriptions	Bed Days	731,268	10	35,880	43,554	2,137	16
17	21	Communications	Bed Days	731,268	10		43,554	0	17
18	20	Advertising - help wanted	Bed Days	731,268	10	11,214	43,554	668	18
19	21	Management allocation - salaries	Bed Days	731,268	10	4,309,068	4,309,068	256,646	19
20	21	Bank charges	Bed Days	731,268	10	50,778	43,554	3,024	20
21	21	Office supplies & printing	Bed Days	731,268	10	95,951	43,554	5,715	21
22	21	Postage	Bed Days	731,268	10	30,589	43,554	1,822	22
23	21	Telephone	Bed Days	731,268	10	73,204	43,554	4,360	23
24	24	Travel and Seminar	Bed Days	731,268	10	5,826	43,554	347	24
25	TOTALS					\$ 6,336,147	\$ 5,522,337	\$ 377,379	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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	25	Auto expense	Bed Days	731,268	10	\$ 198,854	\$ 43,554	\$ 11,844	1
2	26	Insurance general	Bed Days	731,268	10	30,619	43,554	1,824	2
3	27	Management allocation - employee	Bed Days	731,268	10	602,157	43,554	35,864	3
4	30	Depreciation	Bed Days	731,268	10	494,680	43,554	29,463	4
5	32	Interest	Bed Days	731,268	10	183,980	43,554	10,958	5
6	32	Amortization of mortgage costs	Bed Days	731,268	10	283	43,554	17	6
7	33	Property taxes	Bed Days	731,268	10	31,746	43,554	1,891	7
8	34	Rent expense	Bed Days	731,268	10	37,431	43,554	2,229	8
9	35	Equipment rental	Bed Days	731,268	10	9,010	43,554	537	9
10	35	Auto Lease	Bed Days	731,268	10	32,828	43,554	1,955	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					\$ 1,621,588	\$	\$ 96,582	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Lexington Financial	X		Mortgage	Varies	4/30/07	\$ 5,991,000	\$ 5,866,829	5/1/17	0.0625	\$ 366,912	1						
2	Services II, LLC											2						
3												3						
4												4						
5							Interest on financing insurance premium				1,200	5						
	Working Capital																	
6												6						
7												7						
8	JP Morgan Chase		X	Line of Credit	Various	4/30/07	600,000	245,000	5/1/10	Libor +1	5,958	8						
9	TOTAL Facility Related						\$ 6,591,000	\$ 6,111,829			\$ 374,070	9						
	B. Non-Facility Related*																	
10											1,216	10						
11											(4,947)	11						
12												12						
13											10,958	13						
14	TOTAL Non-Facility Related						\$	\$			\$ 7,227	14						
15	TOTALS (line 9+line14)						\$ 6,591,000	\$ 6,111,829			\$ 381,297	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Susan 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 2007 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 2007.

(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>121,221.73</u>	\$ <u>121,221.73</u>
2. <u>18-08-207-018-000</u>	<u>Land & Building</u>	\$ <u>105,607.80</u>	\$ <u>105,607.80</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ <u>174,993.86</u>	\$ <u>1,891.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>401,823.39</u>	\$ <u>228,720.53</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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	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>8,568</u>	<u>2</u>
3	TOTALS	40,000		\$ 508,568	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$ 1,254,682	4
5	10	1995	1995	79,363		10			79,363	5
6	10	2005	2005	2,321,014		21	110,524	110,524	386,836	6
7										7
8										8
	Improvement Type**									
9	Land Improvements		1992	1,152		20	58	58	951	9
10	Building Improvements		1992	2,714		31			2,714	10
11	Building Improvements		1993	2,901		35	83	83	1,289	11
12	Leasehold Improvements		1994	6,402		10			6,402	12
13	Leasehold Improvements - Corner Guards		1996	2,195		10			2,122	13
14	Wiring		1998	3,378	169	10	169		3,378	14
15	Resurface & Restripe Parking Lot		1998	3,753	188	10	188		3,753	15
16	Lobby Tile		1998	19,488	1,624	10	1,624		19,488	16
17	Resurface & Restripe Parking Lot		2000	1,997	200	10	200		1,698	17
18	Automatic Door		2000	1,300	130	10	130		1,105	18
19	Kitchen Rehab		2001	1,441	144	10	144		1,081	19
20	Infrared curtains for elevator		2001	3,000	300	10	300		2,250	20
21	Dining room, resident rooms, and corridors renovations		2002	150,084	7,505	20	7,505		45,651	21
22	Elevator upgrade		2002	5,398	540	10	540		3,599	22
23	Air conditioner compressor		2003	9,218	922	10	922		4,993	23
24	Sidewalk and fencing		2005	46,701	2,335	20	2,335		7,394	24
25	HVAC		2005	8,141	407	20	407		1,255	25
26	Wiring		2005	4,506	225	20	225		732	26
27	Lobby, lounge and reception renovations		2005	24,362	1,218	20	1,218		4,060	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors		2005	326,862		20	16,343	16,343	49,029	28
29	Wallcoverings		2005	10,822		5	2,164	2,164	7,755	29
30	Medical records room rehab		2006	19,739	987	20	987		1,974	30
31	Activity/PT Room Rehab		2006	1,158	58	20	58		116	31
32	Land scape enhancement		2006	8,726	582	15	582		1,358	32
33	Roof		2006	29,700	1,980	15	1,980		4,620	33
34	HVAC		2006	3,254	163	20	163		380	34
35	Plumbing and sprinkler system		2006	20,725	1,036	20	1,036		3,109	35
36	Laundry Combustion Air		2006	16,814	841	20	841		2,312	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

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	
	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	\$	\$ 3,508	37
38	Cubicle curtains/drapery	2006	6,955	1,391	5	1,391		3,996	38
39	Cabinets/counters for 2nd FI library	2006	2,665	267	10	267		600	39
40	TCU rehab	2006	2,402	120	20	120		250	40
41	First floor remodel	2006	212,084		20	10,604	10,604	21,208	41
42	Kitchen rehab	2006	8,165	408	20	408		1,020	42
43	Bath fixtures-2nd floor	2006	2,076	208	10	208		589	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		352	44
45	Landscaping	2007	3,862	257	15	257		407	45
46	HVAC	2007	58,326	2,916	20	2,916		4,131	46
47	Common Areas Remodel	2007	2,059	206	10	206		326	47
48	First Floor Remodel	2007	6,517		20	326	326	570	48
49	Garage	2007	16,487	824	20	824		893	49
50	Land Improvements	2008	3,745	21	15	21		21	50
51	Parking lot-paving	2008	8,720	182	20	182		182	51
52	HVAC-Spot Coolers	2008	5,589		40				52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	13,550	13,550	13,550	53
54	Plumbing, Electrical,painting.								54
55									55
56									56
57									57
58									58
59									59
60									60
61	Land improvements - management company	2002	13,503		15	1,091	1,091	1,326	61
62	Building - management company	2002	105,054		40	23,030	23,030	23,030	62
63	HVAC, electrical, security system - management company	2003	1,041		30	25	25	437	63
64	Key card system - management company	2004	164		20	3	3	39	64
65	VAV TX controls - management company	2005	50		20	1	1	10	65
66	Interior Signs-management company	2006	36		5	2	2	4	66
67	Building - management company	2008	22		5	2	2	2	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,721,991	\$ 29,933		\$ 283,780	\$ 253,847	\$ 1,981,900	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	\$ 422,987	\$ 64,641	\$ 74,891	\$ 10,250	10-Mar	\$ 228,429	71
72	Current Year Purchases	390,794	3,257	54,315	51,058	7-May	54,315	72
73	Fully Depreciated Assets	206,753					206,753	73
74	Allocated from Management Company	134,525		2,481	2,481		82,367	74
75	TOTALS	\$ 1,155,060	\$ 67,898	\$ 131,686	\$ 63,788		\$ 571,864	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			19,228		2,828	2,828		12,606	79
80	TOTALS			\$ 19,228	\$	\$ 2,828	\$ 2,828		\$ 12,606	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)	\$ 8,404,846	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,831	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 418,294	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 320,463	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,566,369	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		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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.				2,227			6
7	TOTAL				\$ 2,227			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: \$ 33,099 Description: Copier-\$ 4,570; Fax Machine-\$ 2,409; Medical Equip-\$7,060; Oxygen-\$18,523 Alloc Mgmt Co.-537

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20	Allocated from Mgmt. Co.			1,955	20
21	TOTAL		\$ _____	\$ 1,955	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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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.

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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	\$	8,446	\$ 566,740	\$	8,446	\$ 566,740	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		1,432	111,127		1,432	111,127	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		7,043	636,913		7,043	636,913	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 prescripts				563,571		563,571	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Wound Care & Ambul</u>	L39,C3				12,323			12,323	13
14	TOTAL			\$	16,921	\$ 1,327,103	\$ 563,571	16,921	\$ 1,890,674	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 12/31/2008

Report Period Beginning: 01/01/2008
 (last day of reporting year)

Ending: 12/31/2008

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 590,770	\$ 632,142	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 240,291)	1,534,942	1,534,942	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	81,094	81,094	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,402	31,700	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,213,208	\$ 2,279,878	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,783	6,783	12
13	Land		508,568	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	609,453	4,060,543	15
16	Equipment, at Historical Cost	458,145	1,174,288	16
17	Accumulated Depreciation (book methods)	(420,048)	(2,566,369)	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>		31,568	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 654,333	\$ 5,876,829	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,867,541	\$ 8,156,707	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 515,991	\$ 515,991	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	245,000	245,000	29
30	Accrued Salaries Payable	227,721	227,721	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,401	6,401	31
32	Accrued Real Estate Taxes(Sch.IX-B)		285,600	32
33	Accrued Interest Payable		30,872	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See schedule 17A</u>	704,900	617,656	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,700,013	\$ 1,929,241	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,866,829	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)	\$	\$ 5,866,829	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,700,013	\$ 7,796,070	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,167,528	\$ 360,637	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,867,541	\$ 8,156,707	48

Lexington Health Care Center of La Grange

FYE 12/31/08

Provider #: 0038083

Schedule 17A

Other Current Liabilities

Due from SB LG Remodel	(125,346)	(125,346)
Due to from Lex Financial		125,346
Due to Royal (OPS)	(20,106)	(20,106)
Due To/From Lake Zurich	7,364	7,364
Accrued 401K	(13,663)	(13,663)
Due To-Republic Construction	(12,609)	(12,609)
Accrued Expenses	(136,663)	(136,663)
Accrued Royal Mgmt Fees	(30,630)	(30,630)
Accrued Rent	(288,624)	-
Accrued Wage Assignments	80	80
Deferred Income	(127,793)	(127,793)
Advance-Biweekly Part A Payments	43,090	43,090
Interest Rate Swap Liability		(326,726)
		<hr/>
Schedule XV Line 36	(704,900)	(617,656)
		<hr/> <hr/>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,293,019	1
2	Restatements (describe):		2
3	Post closing adjustment	26,296	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,319,315	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,342,213	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	(1,494,000)	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)	\$ (151,787)	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)	\$ 1,167,528	24 *

* 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	\$ 10,351,045	1
2	Discounts and Allowances for all Levels	(2,975,364)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,375,681	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,774,576	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,774,576	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	5,567	12
13	Barber and Beauty Care	17,524	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	754,728	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	66,554	19
20	Radiology and X-Ray	16,276	20
21	Other Medical Services	133,017	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 993,666	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,307	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,307	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Investment Income</u>	196	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 196	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,147,426	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,219,280	31
32	Health Care	4,653,923	32
33	General Administration	2,001,852	33
	B. Capital Expense		
34	Ownership	1,187,481	34
	C. Ancillary Expense		
35	Special Cost Centers	677,345	35
36	Provider Participation Fee	65,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,805,213	40
41	Income before Income Taxes (line 30 minus line 40)**	1,342,213	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,342,213	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 is a cash basis tax payer

*** 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:

01/01/2008

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,072	2,093	\$ 93,547	\$ 44.70	1
2	Assistant Director of Nursing	5,382	6,109	209,126	34.23	2
3	Registered Nurses	30,417	33,935	1,045,727	30.82	3
4	Licensed Practical Nurses	14,813	16,514	415,734	25.17	4
5	CNAs & Orderlies	59,465	64,266	751,351	11.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,686	9,562	135,395	14.16	8
9	Activity Director	1,981	2,157	33,751	15.65	9
10	Activity Assistants	16,822	18,275	198,886	10.88	10
11	Social Service Workers	5,112	5,630	112,182	19.93	11
12	Dietician	1,037	1,119	19,375	17.31	12
13	Food Service Supervisor	2,032	2,239	55,586	24.83	13
14	Head Cook	2,073	2,239	36,595	16.34	14
15	Cook Helpers/Assistants	12,551	13,721	125,139	9.12	15
16	Dishwashers	11,291	11,930	92,639	7.77	16
17	Maintenance Workers	2,095	2,303	35,929	15.60	17
18	Housekeepers	27,281	29,505	259,124	8.78	18
19	Laundry	5,691	6,231	51,756	8.31	19
20	Administrator	2,264	2,264	106,027	46.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,346	16,294	230,518	14.15	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	582	590	9,483	16.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Financial Coordin</u>	2,905	2,957	48,556	16.42	33
34	TOTAL (lines 1 - 33)	228,898	249,933	\$ 4,066,426 *	\$ 16.27	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	\$ 11,191	L1,C3	35
36	Medical Director	Monthly	62,000	L9,C3	36
37	Medical Records Consultant	26	1,468	L10,C3	37
38	Nurse Consultant	16	1,015	L10,C3	38
39	Pharmacist Consultant	Monthly	3,435	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	100	4,918	L11,C3	44
45	Social Service Consultant	96	4,822	L12,C3	45
46	Other(specify) <u>Psychosocial</u>	44	2,112	L12,C3	46
47	<u>PA Applicant</u>		500	L10,C3	47
48	<u>MDS Consultant</u>	160	8,176	L10,C3	48
49	TOTAL (lines 35 - 48)	634	\$ 99,637		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	127	5,404	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	127	\$ 5,404		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	
Nicolas Papp	Administrator	0%	\$ 106,027	Workers' Compensation Insurance	\$ 59,928	IDPH License Fee	\$	
				Unemployment Compensation Insurance	41,509	Advertising: Employee Recruitment	31,739	
				FICA Taxes	295,833	Health Care Worker Background Check	738	
				Employee Health Insurance	117,697	(Indicate # of checks performed <u>105</u>)		
				Employee Meals	10,696	Patient Background Checks	4,262	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,030	
				401K	13,870	Miscellaneous Dues & Subscriptions	452	
				Other Employee Benefits	39,644	Allocated from Mgmt Co.	2,805	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,027	TOTAL (agree to Schedule V, line 22, col.8)		\$ 579,177	TOTAL (agree to Sch. V, line 20, col. 8)	
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 Fess-Royal Operating			\$ 440,415				Out-of-State Travel	\$
Management Fess-Royal General			332,975				In-State Travel	
Will be eliminated on P3,C7,L17							Seminar Expense	7,229
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 773,390	TOTAL		\$	Allocated from Mgmt Co.	347
C. Professional Services							Entertainment Expense ()	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Grabowski Law Center	Collections		\$ 2,442				TOTAL	
Cassiday Schade & Gloor LLP	Legal		22,359				\$ 7,576	
Freedman Anselmo Lindberg	Legal		116					
ING	401K Audit		660					
James Samatas	Legal		100					
McGladrey & Pullen, LLP	Accounting		19,262					
Pension Administrators, Inc.	401K Administration		633					
Personnel Planners	U/C Consulting		1,130					
Reed Smith/Sachnoff & Weaver	Legal		2,749					
RSM McGladrey, Inc.	Accounting		8,643					
Gene Whitehorn	Medicaid Reimbursement Specia		957					
See attached schedule 21C			25,828					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 84,878					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of LaGrange, Inc.
 FYE 12/31/08
 Medicaid Cost Report Workpapers
 Provider Number - 0038083

Schedule 21C

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Action Computer Service	Computer Consulting	259
B2B Computer	Computer Consulting	1,665
Converged Comm	Computer Consulting	140
Lintech LLC	Computer Consulting	5,468
National Datacare	Computer Consulting	863
E-Health Data Solutions	Computer Consulting	2,400
C.D.W. Direct	Computer Consulting	382
Krakau Business	Computer Consulting	140
Healthware Consulting	Computer Consulting	2,060
Alperian Technology	Computer Consulting	215
Information Control	Computer Consulting	1,044
Microsoft2	Computer Consulting	4,389
Silver Chair Learning Systems	Computer Consulting	4,300
Lanac Technology	Computer Consulting	1,924
Vision Share, Inc	Computer Consulting	580

Total, Other Professional Services 25,828
 Plus Professional Services from Page 21 84,878

Total Professional Services Col 3 84,878
 Allocated from management co.

Computer-See attached schedule	Computer Consulting	12,508
James Samatas	Legal	16
Sachnoff & Weaver	Legal	841
Duane Morris	Legal	7
McGladrey & Pullen, LLP	Accounting	228
RSM McGladrey, Inc.	Accounting	242
Gilson, Labus & Silverman	Accounting	902
Pension Administrators, Inc.	401K Administration	254
Personnel Planners, Inc.	Unemployment Consultant	18
Beth Schwartz	Operations Consultant	10
Gene Whitehorn	Medicaid Reim Specialist	466

15,492

Gilson, Labus & Silverman-Non Allowable Accounting (718)

Allocated from Samvest of Lombard II
 Gilson, Labus & Silverman Accounting 179

Allocated from building partnership
 James Samatas Filing and recording fees 200

Less Collection Fees disallowed (1,498)

Less out of period legal (3,230)

Total, Agrees to Schedule V, Line 19, Column 8 95,303

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	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
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: 01/01/2008Ending: 12/31/2008**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. \$ 30,203 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. \$ 65,332
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. \$ 10,696 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