

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0035188</u></p> <p>Facility Name: <u>Lexington Health Care Center-Bloomingtondale</u></p> <p>Address: <u>165 South Bloomingtondale Road</u> <u>Bloomingtondale</u> <u>60108</u> Number City Zip Code</p> <p>County: <u>Dupage</u></p> <p>Telephone Number: <u>(630)980-8700</u> Fax # <u>(630)980-6170</u></p> <p>HFS ID Number: <u>363635151001</u></p> <p>Date of Initial License for Current Owners: <u>5/1/89</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>		(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																							
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	166	Skilled (SNF)	166	60,590	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	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			11,917	11,917	8
9	SNF/PED					9
10	ICF	32,933	6,749	6	39,688	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,933	6,749	11,923	51,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.17%

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 expenses have been eliminated in Schedule V, col. 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 05/01/89

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 166 and days of care provided 8,013

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	348,842	32,307	18,360	399,509		399,509		399,509		1
2	Food Purchase		245,851		245,851		245,851	(13,090)	232,761		2
3	Housekeeping	290,885	29,649		320,534		320,534	413	320,947		3
4	Laundry	69,387	18,050		87,437		87,437		87,437		4
5	Heat and Other Utilities			207,046	207,046		207,046	6,826	213,872		5
6	Maintenance	36,368		154,078	190,446		190,446	42,204	232,650		6
7	Other (specify):* Mgmt Co.-Allocated B							4,634	4,634		7
8	TOTAL General Services	745,482	325,857	379,484	1,450,823		1,450,823	40,987	1,491,810		8
	B. Health Care and Programs										
9	Medical Director			33,800	33,800		33,800		33,800		9
10	Nursing and Medical Records	3,144,697	247,821	29,429	3,421,947		3,421,947	37,728	3,459,675		10
10a	Therapy			946,109	946,109		946,109		946,109		10a
11	Activities	258,553	22,714	7,915	289,182		289,182		289,182		11
12	Social Services	204,993		6,571	211,564		211,564		211,564		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co.-Allocated B							4,555	4,555		15
16	TOTAL Health Care and Programs	3,608,243	270,535	1,023,824	4,902,602		4,902,602	42,283	4,944,885		16
	C. General Administration										
17	Administrative	98,924		992,590	1,091,514		1,091,514	(956,091)	135,423		17
18	Directors Fees										18
19	Professional Services			113,032	113,032		113,032	13,073	126,105		19
20	Dues, Fees, Subscriptions & Promotions			26,426	26,426		26,426	591	27,017		20
21	Clerical & General Office Expenses	326,378	33,856	21,563	381,797		381,797	316,889	698,686		21
22	Employee Benefits & Payroll Taxes			689,034	689,034		689,034	13,090	702,124		22
23	Inservice Training & Education			6,706	6,706		6,706	16	6,722		23
24	Travel and Seminar			4,729	4,729		4,729	907	5,636		24
25	Other Admin. Staff Transportation			1,041	1,041		1,041	14,873	15,914		25
26	Insurance-Prop.Liab.Malpractice			171,111	171,111		171,111	5,245	176,356		26
27	Other (specify):* Mgmt Co.-Allocated B							52,232	52,232		27
28	TOTAL General Administration	425,302	33,856	2,026,232	2,485,390		2,485,390	(539,175)	1,946,215		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,779,027	630,248	3,429,540	8,838,815		8,838,815	(455,905)	8,382,910		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 Health Care Center-Bloomington #0035188 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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			145,377	145,377		145,377	288,544	433,921			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,941	5,941		5,941	401,124	407,065			32
33	Real Estate Taxes							145,026	145,026			33
34	Rent-Facility & Grounds			1,220,682	1,220,682		1,220,682	(1,217,424)	3,258			34
35	Rent-Equipment & Vehicles			52,871	52,871		52,871	3,198	56,069			35
36	Other (specify):*											36
37	TOTAL Ownership			1,424,871	1,424,871		1,424,871	(379,532)	1,045,339			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		259,765	912	260,677		260,677		260,677			39
40	Barber and Beauty Shops			19,764	19,764		19,764		19,764			40
41	Coffee and Gift Shops			3,416	3,416		3,416		3,416			41
42	Provider Participation Fee			90,885	90,885		90,885		90,885			42
43	Other (specify):* Non-allowable cost			82,922	82,922		82,922	(82,922)				43
44	TOTAL Special Cost Centers		259,765	197,899	457,664		457,664	(82,922)	374,742			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,779,027	890,013	5,052,310	10,721,350		10,721,350	(918,359)	9,802,991			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	(4,886)	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	(13,923)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,593)	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	(3,921)	43		18
19	Entertainment	(2,597)	43		19
20	Contributions	(2,153)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,951)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,720)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(140,411)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (195,155)		\$	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)	(723,204)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (723,204)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (918,359)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center-Bloomington

ID# 0035188

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Radiology	\$ (10,472)	43	1
2	Laboratory	(12,969)	43	2
3	Personal Item Replacement	(2,942)	43	3
4	Trust Fees	(50)	43	4
5	Collection Fees	(12,312)	19	5
6	Nonallowable Marketing Salaries	(82,981)	21	6
7	Nonallowable Marketing Expenses	(18,660)	43	7
8	Out of period legal	(25)	19	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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44				44
45				45
46				46
47				47
48				48
49	Total	(140,411)		49

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		See Attached Schedule B		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Fees	\$	Sambell of Bloomingtondale Limited Partnership	**	\$ 200	\$ 200	1
2	V							2
3	V	30 Depreciation Expense		Sambell of Bloomingtondale Limited Partnership	**	242,381	242,381	3
4	V	32 Interest		Sambell of Bloomingtondale Limited Partnership	**	399,981	399,981	4
5	V	32 Amortization of Mortgage Cost		Sambell of Bloomingtondale Limited Partnership	**	2,171	2,171	5
6	V	33 Property Tax		Sambell of Bloomingtondale Limited Partnership	**	140,682	140,682	6
7	V	34 Rent	1,220,682	Sambell of Bloomingtondale Limited Partnership	**		(1,220,682)	7
8	V	43 Trust Fees		Sambell of Bloomingtondale Limited Partnership	**	50	50	8
9	V	43 State Replacement Tax		Sambell of Bloomingtondale Limited Partnership	**	2,942	2,942	9
10	V							10
11	V							11
12	V			** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc. own 100% of Sambell of Bloomingtondale Limited Partnership				12
13	V							13
14	Total		\$ 1,220,682			\$ 788,407	\$ * (432,275)	14

* 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	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 413	\$	413	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	5,876		5,876	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	159		159	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	791		791	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	35,922		35,922	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,973		5,973	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	309		309	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	4,634		4,634	22
23	V	10 Medical consultant		Royal Management Corp.	**	2,418		2,418	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	35,310		35,310	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	4,555		4,555	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	36,499		36,499	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	16,703		16,703	27
28	V	19 Professional fees		Royal Management Corp.	**	8,507		8,507	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	330		330	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	261		261	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	368,387		368,387	31
32	V	21 Bank charges		Royal Management Corp.	**	7,403		7,403	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,447		10,447	33
34	V	21 Postage		Royal Management Corp.	**	3,416		3,416	34
35	V								35
36	V								36
37	V			** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc.					37
38	V			own 100% of Sambell of Bloomingtondale Limited Partnership					38
39	Total		\$			\$ 548,313	\$ *	548,313	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.	**	\$ 10,217	\$	10,217	15
16	V	24 Travel & seminar		Royal Management Corp.	**	907		907	16
17	V	25 Auto expense		Royal Management Corp.	**	14,873		14,873	17
18	V	26 Insurance general		Royal Management Corp.	**	5,245		5,245	18
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	52,232		52,232	19
20	V	30 Depreciation		Royal Management Corp.	**	46,163		46,163	20
21	V	32 Interest		Royal Management Corp.	**	12,868		12,868	21
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	27		27	22
23	V	33 Property taxes		Royal Management Corp.	**	4,344		4,344	23
24	V	34 Rent expense		Royal Management Corp.	**	3,258		3,258	24
25	V	35 Equipment rental		Royal Management Corp.	**	751		751	25
26	V	17 Management fees	992,590	Royal Management Corp.	**			(992,590)	26
27	V	35 Auto Lease		Royal Management Corp.	**	2,447		2,447	27
28	V	23 Inservice Training		Royal Management Corp.	**	16		16	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V			** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc.					37
38	V			own 100% of Sambell of Bloomingtondale Limited Partnership					38
39	Total		\$ 992,590			\$ 153,348	\$ *	(839,242)	39

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

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/09-12/31/09

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%

VII. Related Parties
Related Nursing Homes

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

Other Business Related Entities

Eastgate Manor	Algonquin	Supportive Living Facility
Vesta Management Group LLC	Lombard	Management Company
Lexington Health Care System of Orland Park Ltd. Ptsp.	Orland Park	Real Estate Property
Royal Management Corporation	Lombard	Management Company
Lexington Financial Services, LLC	Lombard	Finance Company

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	2.69	6.73	Salary	\$ 14,352	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	2.94	5.89	Salary	8,878	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	2.69	6.73	Salary	6,750	L17, C7	3
4	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	4.2	8.41	Salary	6,520	L17, C7	4
5											5
6											6
7											7
8											8
9		Certain individuals work in excess of 40 hours per week.									9
10											10
11											11
12											12
13								TOTAL	\$ 36,500		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 Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	720,658	10	\$ 4,909	\$ 60,590	\$ 413	1
2	5	Utilities - gas & electric	Bed Days	720,658	10	69,894	60,590	5,876	2
3	5	Utilities - water & sewer	Bed Days	720,658	10	1,894	60,590	159	3
4	5	Utilities - maintenance office	Bed Days	720,658	10	9,406	60,590	791	4
5	6	Management allocation - salaries	Bed Days	720,658	10	427,259	427,259	35,922	5
6	6	Repairs & maintenance	Bed Days	720,658	10	71,047	60,590	5,973	6
7	6	Scavenger & exterminating	Bed Days	720,658	10	3,681	60,590	309	7
8	7	Management allocation - employees	Bed Days	720,658	10	55,118	60,590	4,634	8
9	10	Medical consultant	Bed Days	720,658	10	28,762	60,590	2,418	9
10	10	Management allocation - salaries	Bed Days	720,658	10	419,975	419,975	35,310	10
11	15	Management allocation - employees	Bed Days	720,658	10	54,178	60,590	4,555	11
12	17	Management allocation - salaries	Bed Days	720,658	10	434,122	434,122	36,499	12
13	19	Computer consultant & supplies	Bed Days	720,658	10	198,663	60,590	16,703	13
14	19	Professional fees	Bed Days	720,658	10	101,182	60,590	8,507	14
15	20	Dues & subscriptions	Bed Days	720,658	10	3,923	60,590	330	15
16	20	Advertising - help wanted	Bed Days	720,658	10	3,108	60,590	261	16
17	21	Management allocation - salaries	Bed Days	720,658	10	4,381,596	4,381,596	368,387	17
18	21	Bank charges	Bed Days	720,658	10	88,048	60,590	7,403	18
19	21	Office supplies & printing	Bed Days	720,658	10	124,253	60,590	10,447	19
20	21	Postage	Bed Days	720,658	10	40,624	60,590	3,416	20
21	21	Telephone	Bed Days	720,658	10	121,527	60,590	10,217	21
22	24	Travel and Seminar	Bed Days	720,658	10	10,782	60,590	907	22
23									23
24									24
25	TOTALS					\$ 6,653,951	\$ 5,662,952	\$ 559,437	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	720,658	10	\$ 176,898	\$ 60,590	\$ 14,873	1
2	26	Insurance general	Bed Days	720,658	10	62,379	60,590	5,245	2
3	27	Management allocation - employees	Bed Days	720,658	10	621,243	60,590	52,232	3
4	30	Depreciation	Bed Days	720,658	10	549,069	60,590	46,163	4
5	32	Interest	Bed Days	720,658	10	153,050	60,590	12,868	5
6	32	Amortization of mortgage costs	Bed Days	720,658	10	321	60,590	27	6
7	33	Property taxes	Bed Days	720,658	10	51,670	60,590	4,344	7
8	34	Rent expense	Bed Days	720,658	10	38,747	60,590	3,258	8
9	35	Equipment rental	Bed Days	720,658	10	8,933	60,590	751	9
10	35	Auto Lease	Bed Days	720,658	10	29,103	60,590	2,447	10
11	23	Inservice Training	Bed Days	720,658	10	193	60,590	16	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					\$ 1,691,606	\$	\$ 142,224	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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						\$	\$			\$	1								
2	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,375,000	6,179,205	1/1/2033	Variable	399,981	2								
3												3								
4												4								
5							Interest on financing insurance premium				513	5								
	Working Capital																			
6	Bank of America		X	Working Capital	Varies	4/6/02	1,300,000	200,000	06/30/10	Prime/Libor	5,427	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 7,675,000	\$ 6,379,205			\$ 405,922	9								
	B. Non-Facility Related*																			
10										Amortization of mortgage costs	2,198	10								
11										Interest Income offset	(13,923)	11								
12										Management company allocation	12,868	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 1,143	14								
15	TOTALS (line 9+line14)						\$ 7,675,000	\$ 6,379,205			\$ 407,065	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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

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>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>15,362</u>	<u>2</u>
3	TOTALS	43,000		\$ 417,910	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	82		1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 1,760,635	4
5	9		1992	1992	178,974		35	5,114	5,114	92,046	5
6	75		1994	1994	2,022,894		35	57,797	57,797	895,852	6
7											7
8											8
	Improvement Type**										
9		Capitalized repairs	1989		9,080		10			9,080	9
10		Building Improvements	1990		3,674		10			3,674	10
11		Building Improvements	1991		2,586		10			2,586	11
12		Building Improvements	1992		3,154		10			2,997	12
13		Building Improvements	1993		1,582		10			1,503	13
14		Building Improvements	1994		15,734		10			15,734	14
15		Land Improvements	1994		1,381		10			1,381	15
16		Land Improvements	1995		1,074		15	72	72	1,039	16
17		Building Improvements	1995		1,288		35	37	37	551	17
18		Building Improvements	1995		9,433	270	35	270		3,915	18
19		Building Improvements	1995		43,839	1,252	35	1,252		18,155	19
20		Concrete flooring, fire doors, tile, sprinkler heads, and basement renovation	1996		8,706		10-35			3,606	20
21		Land improvements	1996		7,858		15	524	524	7,073	21
22											22
23											23
24		Resident room heaters	1997		3,563	102	35	102		1,324	24
25		Automatic doors	1997		12,950	370	35	370		4,471	25
26		Basement renovation	1997		59,358		10			59,358	26
27		Land Improvement - outdoor flagpoles	1997		1,574	105	15	105		1,311	27
28		1st Floor Remodel (Nurses Station/Lounge)	1998		76,487		10			76,487	28
29		Wiring for MDS	1998		4,506		10			4,506	29
30		Flag Pole	1998		787		10			787	30
31		Resurface/Stripe Parking Lot	1998		9,777		10			9,777	31
32		Kitchen tile/paint	1999		718	36	10	36		718	32
33		1st Floor Remodel	1999		3,296		10			3,296	33
34		Roof repairs	2000		5,748	383	15	383		3,640	34
35		Sump pump	2000		2,534	253	10	253		2,407	35
36		Sump pump basin repair	2000		6,307	631	10	631		5,992	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 Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	Automatic door closers	2000	\$ 1,300	\$ 87	15	\$ 87		\$ 824	37
38	Infrared curtains for elevator doors	2001	3,000	300	10	300		2,550	38
39	Ejector pump	2002	3,050		5			3,050	39
40	Lift station pump	2002	3,359		5			3,359	40
41	New asphalt parking lot	2003	16,450	1,645	10	1,645		10,144	41
42	Roof repairs	2003	2,900	290	10	290		1,764	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		1,285	43
44	Kitchen remodel	2003	7,188	359	20	359		2,306	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		20,830	45
46	Floor tile	2003	16,305	815	20	815		5,707	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		23,048	47
48	Rehab-floor tile	2003	8,117	406	20	406		2,469	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		12,988	49
50	Foundation repair	2003	4,800	240	20	240		1,540	50
51	Parking lot	2004	24,550	2,455	10	2,455		13,298	51
52	Kitchen walk-in cooler floor	2004	7,161	716	10	716		3,819	52
53	Old Towne rehab	2004	13,967	698	20	698		3,666	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		53,105	54
55	Create first floor therapy room	2004	185	9	20	9		27	55
56	Transitional unit	2005	213	11	20	11		32	56
57	Landscaping	2005	8,814	441	20	441		1,837	57
58	Roof repairs	2005	3,250	163	20	163		678	58
59	HVAC upgrade	2005	7,048	352	20	352		1,527	59
60	Kitchen repair	2005	1,631	82	20	82		367	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		3,980	61
62	Window treatments	2005	3,606	721	5	721		3,127	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		1,791	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		8,429	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		7,497	65
66	Basement renovation	2005	14,176	709	20	709		2,835	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,126,921	\$ 38,707		\$ 187,443	\$ 148,736	\$ 3,191,780	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	
1	Totals from Page 12A, Carried Forward		\$ 6,126,921	\$ 38,707		\$ 187,443	\$ 148,736	\$ 3,191,780	1
2	Landscaping Enhancement	2006	7,084	472	15	472		1,574	2
3	Install Kitchen Sink	2006	2,915	146	20	146		547	3
4	Common area rehab	2006	2,382	119	20	119		437	4
5	Paint Building Exterior	2006	19,500	3,900	5	3,900		13,325	5
6	Patio	2006	53,305	3,554	15	3,554		10,957	6
7	Retaining Wall	2007	2,950	197	15	197		525	7
8	Roof Repair	2007	17,050	853	20	853		2,345	8
9	Air Conditioning units	2007	4,338	217	20	217		633	9
10	Paver walk and stairway	2007	10,500	525	20	525		1,400	10
11	Fire exit stairways	2007	9,379	469	20	469		1,016	11
12	Landscaping	2008	35,147	2,343	15	2,343		2,538	12
13	Parking Lot - Seal & Striping	2008	6,460	323	20	323		485	13
14	Roof	2008	15,300	765	20	765		1,275	14
15	HVAC - Spot Coolers	2008	5,589	140	40	140		140	15
16	Electrical - Storage Room	2008	4,768	238	20	238		337	16
17	Electrical - Fire Alarm Panel	2008	118,395	5,920	20	5,920		6,413	17
18	1st floor remodel-Carpentry,Flooring,Electrical,Parking fixtures	2008	557,202		27	20,262	20,262	33,770	18
19	Lawn Irrigation	2009	14,435	321	15	321		321	19
20	Landscaping	2009	12,950	144	15	144		144	20
21	Roof	2009	49,330	411	20	411		411	21
22	Front Entrance	2009	19,392	81	40	81		81	22
23	HVAC-Window unit	2009	41,315	3,099	10	3,099		3,099	23
24	HVAC Quick connectors	2009	7,058	529	10	529		529	24
25	Lift pump	2009	14,783	246	10	246		246	25
26	Fire alarm panel	2009	93,279	389	20	389		389	26
27	Pantry Cabinets	2009	3,523	59	10	59		59	27
28	Therapy Room counter tops-carpentry	2009	2,500	188	10	188		188	28
29	Patio Pergola	2009	7,930	132	20	132		132	29
30	Patio Stamped Concrete	2009	13,901	386	15	386		386	30
31	Lobby 1st floor remodel-Carpentry,doors frames,electrical	2009	52,018		27				31
32	painting,wallpaper								32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,331,599	\$ 64,873		\$ 233,871	\$ 168,998	\$ 3,275,482	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,331,599	\$ 64,873		\$ 233,871	\$ 168,998	\$ 3,275,482	1
2									2
3									3
4									4
5									5
6	Building - management company	2002	212,574		40	6,247	6,247	50,058	6
7	HVAC, electrical, security system - management company	2003	1,867		30	128	128	827	7
8	Key card system - management company	2004	293		20	14	14	79	8
9	VAV TX controls - management company	2005	89		20	4	4	22	9
10	Interior Signs - management company	2006	65		5	4	4	14	10
11	Building improvements - management company	2008	7,059		5	534	534	666	11
12	Building improvements - management company	2009	531		15	9	9	10	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,554,077	\$ 64,873		\$ 240,811	\$ 175,938	\$ 3,327,158	34

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	\$ 646,688	\$ 75,201	\$ 148,585	\$ 73,384	5-7 years	\$ 491,088	71
72	Current Year Purchases	416,649	5,303	5,303		5-7 years	5,303	72
73	Fully Depreciated Assets	20,595					20,595	73
74	Allocated from Mgmt Co.	233,751		34,464	34,464		170,021	74
75	TOTALS	\$ 1,317,683	\$ 80,504	\$ 188,352	\$ 107,848		\$ 687,007	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 Mgmt Co.			34,511		4,758	4,758		21,722	79
80	TOTALS			\$ 34,511	\$	\$ 4,758	\$ 4,758		\$ 21,722	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,324,181	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 145,377	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 433,921	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 288,544	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,035,887	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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? YES NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	Allocated from Management Company			3,258			6
7	TOTAL			\$ 3,258			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: \$ 53,622 Description: Copier-\$7,797; Mailing-\$82; Medical Equip-\$29,941; Oxygen Equip-\$15,051; Alloc from Mgmt Co-\$751

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Management Company			2,447	20
21	TOTAL		\$	\$ 2,447	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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* 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?</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	10A(3)	hrs	\$	4,343	\$ 292,659	\$	4,343	\$ 292,659	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,895	144,378		1,895	144,378	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,572	509,072		9,572	509,072	4
5	Physician Care		visits							5
6	Dental Care	39(3)	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(3)	# of prescripts				259,765		259,765	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Dentist</u>	39(3)				912			912	13
14	TOTAL			\$	15,810	\$ 947,021	\$ 259,765	15,810	\$ 1,206,786	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 Health Care Center-Bloomingtondale# 0035188Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 214,912	\$ 226,804	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>303,488</u>)	1,528,215	1,528,215	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,685	32,685	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	33,867	1,719,040	8
9	Other(specify): <u>Advance Bi Wkly Part A Pmts</u>	21,066	21,066	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,830,745	\$ 3,527,810	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,261	64,261	12
13	Land		417,910	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	1,512,471	2,371,346	15
16	Equipment, at Historical Cost	676,961	1,352,194	16
17	Accumulated Depreciation (book methods)	(866,463)	(4,035,887)	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>Mort Cost / Accum Amort Mort C</u>		50,770	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,387,230	\$ 5,403,325	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,217,975	\$ 8,931,135	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 339,343	\$ 339,343	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,919	34,919	28
29	Short-Term Notes Payable	200,000	200,000	29
30	Accrued Salaries Payable	241,189	241,189	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,655	1,655	31
32	Accrued Real Estate Taxes(Sch.IX-B)		136,800	32
33	Accrued Interest Payable		40,061	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	1,057,489	1,313,719	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,874,595	\$ 2,307,686	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,179,205	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)	\$	\$ 6,179,205	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,874,595	\$ 8,486,891	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,343,380	\$ 444,244	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,217,975	\$ 8,931,135	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Bloomington, Inc.
Provider # 0035188
1/1/09-12/31/09

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to Royal Excess Earnings		143,558
Due to Royal	13,660	13,660
Accrued PTP	127,843	127,843
Accrued 401K	24,223	24,223
Due to Republic Construction	122	122
Accrued Expenses	79,457	79,457
Accrued Royl Genl Mgmt Fees	36,659	36,659
Accrued Rent	530,117	
Deferred Income	245,408	245,408
Interest Rate Swap		642,789
	<u>1,057,489</u>	<u>1,313,719</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,496,330	1
2	Restatements (describe):		2
3	Post closing adjustment	(143,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,353,330	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(9,950)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (9,950)	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)	\$ 1,343,380	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington# 0035188Report Period Beginning: 01/01/2009Ending: 12/31/2009

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	\$ 13,610,576	1
2	Discounts and Allowances for all Levels	(5,592,180)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,018,396	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,241,223	6
7	Oxygen	8,291	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,249,514	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	2,505	12
13	Barber and Beauty Care	21,944	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	268,103	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,615	19
20	Radiology and X-Ray	10,754	20
21	Other Medical Services	88,234	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 431,155	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,047	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,047	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	288	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 288	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,711,400	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,450,823	31
32	Health Care	4,902,602	32
33	General Administration	2,485,390	33
B. Capital Expense			
34	Ownership	1,424,871	34
C. Ancillary Expense			
35	Special Cost Centers	366,779	35
36	Provider Participation Fee	90,885	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,721,350	40
41	Income before Income Taxes (line 30 minus line 40)**	(9,950)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (9,950)	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.
The 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 Health Care Center-Bloomington**

0035188

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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	1,904	2,213	\$ 106,228	\$ 48.00	1
2	Assistant Director of Nursing	6,142	6,871	227,550	33.12	2
3	Registered Nurses	35,054	38,635	1,216,488	31.49	3
4	Licensed Practical Nurses	13,752	14,312	343,977	24.03	4
5	CNAs & Orderlies	89,582	94,864	1,114,784	11.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,058	8,605	121,258	14.09	8
9	Activity Director					9
10	Activity Assistants	18,223	20,274	258,553	12.75	10
11	Social Service Workers	11,995	12,634	204,993	16.23	11
12	Dietician	5,935	5,987	60,992	10.19	12
13	Food Service Supervisor	2,055	2,219	43,555	19.63	13
14	Head Cook	2,120	2,219	32,851	14.80	14
15	Cook Helpers/Assistants	5,799	6,196	63,814	10.30	15
16	Dishwashers	16,558	17,630	147,630	8.37	16
17	Maintenance Workers	2,131	2,237	36,368	16.26	17
18	Housekeepers	30,711	32,834	290,885	8.86	18
19	Laundry	7,197	7,780	69,387	8.92	19
20	Administrator	1,497	1,871	98,924	52.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,049	21,304	326,378	15.32	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	853	883	14,412	16.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	278,615	299,568	\$ 4,779,027 *	\$ 15.95	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	240	\$ 18,360	1(3)	35
36	Medical Director	Monthly	33,800	9(3)	36
37	Medical Records Consultant	Monthly	1,031	10(3)	37
38	Nurse Consultant	Monthly	10,417	10(3)	38
39	Pharmacist Consultant	Monthly	9,000	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	112	5,554	11(3)	44
45	Social Service Consultant	100	5,035	12(3)	45
46	Other(specify) <u>Psychosocial</u>	32	1,536	12(3)	46
47	<u>Pulmonary Consultant</u>	Monthly	8,981	10(3)	47
48	<u>Medical Consultant</u>	Monthly	2,418	10(7)	48
49	TOTAL (lines 35 - 48)	484	\$ 96,132		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Jeffrey Baker	Administrator	0	\$ 8,767	Workers' Compensation Insurance	\$ 66,681	IDPH License Fee	\$	
Brian Celerio	Administrator	0%	90,157	Unemployment Compensation Insurance	22,678	Advertising: Employee Recruitment	17,590	
				FICA Taxes	352,636	Health Care Worker Background Check		
				Employee Health Insurance	181,283	(Indicate # of checks performed <u>19</u>)	227	
				Employee Meals	13,090	Patient Background Checks <u>64</u>	773	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	7,214	
				401(k) Contributions	24,223	Miscellaneous Dues & Subscriptions	622	
				Other Employee Benefits	41,533			
TOTAL (agree to Schedule V, line 17, col. 1)						Management Company Allocation	591	
(List each licensed administrator separately.)			\$ 98,924			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-Royal Operating			\$ 672,040					
Management Fees-Royal General			320,550					
Management Fees (Eliminated in Column 7)								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 992,590					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Action Computer Service	Computer Consulting		\$ 540	N/A			Out-of-State Travel	\$
Lintech LLC	Computer Consulting		4,463					
National Datacare	Computer Consulting		1,621				In-State Travel	
E-Health Data Solutions	Computer Consulting		2,400					
C.D.W. Direct	Computer Consulting		945					
Krakau Business	Computer Consulting		365				Seminar Expense	4,729
Healthware Consulting	Computer Consulting		1,346					
MNJ Technology	Computer Consulting		213				Management Company Allocation	907
Information Control	Computer Consulting		1,084				Entertainment Expense	()
Visual Click	Computer Consulting		123					
See attached Schedule 21C			99,931					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 113,032				TOTAL	\$ 5,636

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Bloomingdale, Inc.

Provider # 0035188

1/1/09 - 12/31/09

Schedule 21C

XIX. Support Schedules

C. Professional Services

Vendor/Payee

Silverchair Learning Systems	Computer Consulting	4,200
Micrsoft License	Computer Consulting	4,102
Vision Share	Computer Consulting	863
B2B Computer Products	Computer Consulting	46
Micro Center	Computer Consulting	-
Lanac/GP	Computer Consulting	1,835
Grabowski Law Center	Collections	12,312
Cassidy Schade LLP	Legal	36,501
Much Shelist	Legal	1,575
Lexington Financial Services	Financial Services	4,978
James Samatas, Atty. At Law	Legal	238
Pension Administrators	Bond Consulting	722
McGladrey & Pullen	Accounting	22,802
Personnel Planners	U/C Consulting	1,040
Reed Smith/Sachnoff & Weaver	Legal	2,539
ING Life Insurance & Annuity	401k Consulting	-
RSM McGladrey	Accounting	5,850
Gene Whitehorn	Medicaid Reimb. Specialist	328
		<u>99,931</u>

Total, Agrees to Schedule V, Line 19, Column 3

113,032

Allocated from Management Co.

James Samatas	Legal-filing fees	49
ReedSmith	Legal	1,996
Much Shelist	Legal	1,256
Serpico, Petrosino, Dipiero	Legal	9
KMZ Rosenmann	Legal	1,455
McGladrey & Pullen LLP	Accounting	612
RSM McGladrey	Accounting	470
LaSalle Network	Accounting	796
Gilson Labus & Silverman	Accounting	397
Aronberg, Goldgehn Davis	401(k) Administration	1
ING Life & Annuity	401(k) Administration	96
Pension Administrators, Inc.	401(k) Administration	424
Personnel Planners, Inc.	Unemployment Consultant	26
Gene Whitehorn	Medicaid Reimb. Specialist	665
Computer Services	Computer Consultant	16,703

Allocated from Samvest of Lombard II

Accounting	76
Legal	179

Allocated from Sambell

Legal	200
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Nonallowable legal fees (25)

Nonallowable collection fees (12,312)

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

126,105**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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. \$ 45,942 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 90,885
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,090 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? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.

SEE ACCOUNTANTS' COMPILATION REPORT