



Facility Name & ID Number Lexington of Chicago Ridge

# 0042739 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 8/28/09

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>214</u>	Skilled (SNF)	<u>203</u>	<u>75,440</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>214</u>	TOTALS	<u>203</u>	<u>75,440</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF			<u>17,268</u>	<u>17,268</u>	8
9	SNF/PED					9
10	ICF	<u>44,136</u>	<u>6,861</u>		<u>50,997</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,136</u>	<u>6,861</u>	<u>17,268</u>	<u>68,265</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.49%

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 removed on 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 6/4/91

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 203 and days of care provided 11,085

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

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

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 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
	<b>A. General Services</b>										
1	Dietary	392,378	29,937	31,946	454,261		454,261		454,261		1
2	Food Purchase		311,016		311,016		311,016	(15,429)	295,587		2
3	Housekeeping	397,210	39,931		437,141		437,141	523	437,664		3
4	Laundry	87,396	25,947		113,343		113,343		113,343		4
5	Heat and Other Utilities			253,728	253,728		253,728	8,644	262,372		5
6	Maintenance	40,230		162,660	202,890		202,890	55,918	258,808		6
7	Other (specify):* <b>Alloc. From Mgmt. C</b>							5,868	5,868		7
8	<b>TOTAL General Services</b>	917,214	406,831	448,334	1,772,379		1,772,379	55,524	1,827,903		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			31,800	31,800		31,800		31,800		9
10	Nursing and Medical Records	4,106,660	339,826	38,329	4,484,815		4,484,815	47,774	4,532,589		10
10a	Therapy			1,308,059	1,308,059		1,308,059		1,308,059		10a
11	Activities	227,469	32,879	6,438	266,786		266,786		266,786		11
12	Social Services	199,614		7,139	206,753		206,753		206,753		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Alloc. From Mgmt. C</b>							5,768	5,768		15
16	<b>TOTAL Health Care and Programs</b>	4,533,743	372,705	1,391,765	6,298,213		6,298,213	53,542	6,351,755		16
	<b>C. General Administration</b>										
17	Administrative	127,052		1,341,747	1,468,799		1,468,799	(1,295,529)	173,270		17
18	Directors Fees										18
19	Professional Services			190,692	190,692		190,692	29,277	219,969		19
20	Dues, Fees, Subscriptions & Promotions			36,495	36,495		36,495	749	37,244		20
21	Clerical & General Office Expenses	330,961	40,476	24,324	395,761		395,761	412,108	807,869		21
22	Employee Benefits & Payroll Taxes			825,346	825,346		825,346	15,415	840,761		22
23	Inservice Training & Education			5,143	5,143		5,143	21	5,164		23
24	Travel and Seminar			7,243	7,243		7,243	1,148	8,391		24
25	Other Admin. Staff Transportation			661	661		661	18,833	19,494		25
26	Insurance-Prop.Liab.Malpractice			231,044	231,044		231,044	6,641	237,685		26
27	Other (specify):* <b>Alloc. From Mgmt. C</b>							66,140	66,140		27
28	<b>TOTAL General Administration</b>	458,013	40,476	2,662,695	3,161,184		3,161,184	(745,197)	2,415,987		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,908,970	820,012	4,502,794	11,231,776		11,231,776	(636,131)	10,595,645		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 Chicago Ridge

#0042739

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	
	<b>D. Ownership</b>											
30	Depreciation			148,799	148,799		148,799	334,961	483,760			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,807	17,807		17,807	411,958	429,765			32
33	Real Estate Taxes							700,100	700,100			33
34	Rent-Facility & Grounds			2,086,599	2,086,599		2,086,599	(2,082,474)	4,125			34
35	Rent-Equipment & Vehicles			67,930	67,930		67,930	4,049	71,979			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,321,135	2,321,135		2,321,135	(631,406)	1,689,729			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		507,204	1,954	509,158		509,158		509,158			39
40	Barber and Beauty Shops			21,688	21,688		21,688		21,688			40
41	Coffee and Gift Shops			1,893	1,893		1,893		1,893			41
42	Provider Participation Fee			115,086	115,086		115,086		115,086			42
43	Other (specify):* <b>Non-allowable cost</b>			171,305	171,305		171,305	(171,305)				43
44	<b>TOTAL Special Cost Centers</b>		507,204	311,926	819,130		819,130	(171,305)	647,825			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,908,970	1,327,216	7,135,855	14,372,041		14,372,041	(1,438,842)	12,933,199			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

# 0042739

Report Period Beginning:

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**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,123)	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	(3)	30		9
10	Interest and Other Investment Income	(5,775)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(886)	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	(10,850)	43		18
19	Entertainment	(3,509)	43		19
20	Contributions	(5,423)	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	(38,820)	43		24
25	Fund Raising, Advertising and Promotional	(29,625)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,225)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(167,528)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (271,781)		\$	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)	(1,167,061)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,167,061)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,438,842)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (30,908)	43	1
2	X-Rays-Part A	(32,191)	43	2
3	Diagnostics Managed Care	(9,745)	43	3
4	Marketing Salary	(94,238)	43	4
5	Trust Fees	(75)	43	5
6	Collection Fees	(2,517)	19	6
7	Out of period legal	(328)	19	7
8	Reclass LHI under 2500	2,474	6	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
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(167,528)		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		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 Chicago Ridge Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation		Sambell of Chicago Ridge Limited Partnership	**	276,508	276,508	2
3	V	32 Interest expense		Sambell of Chicago Ridge Limited Partnership	**	400,117	400,117	3
4	V	32 Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	1,288	1,288	4
5	V	33 Real estate tax		Sambell of Chicago Ridge Limited Partnership	**	694,599	694,599	5
6	V	34 Rental expense	2,086,599	Sambell of Chicago Ridge Limited Partnership	**		(2,086,599)	6
7	V	43 Trust fees		Sambell of Chicago Ridge Limited Partnership	**	75	75	7
8	V							8
9	V							9
10	V							10
11	V			** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Sambell of Chicago Ridge Limited Partnership				11
12	V							12
13	V							13
14	Total		\$ 2,086,599			\$ 1,372,787	\$ * (713,812)	14

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

Facility Name & ID Number Lexington of Chicago Ridge# 0042739Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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.	**	\$ 523	\$	523	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,441		7,441	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	202		202	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,001		1,001	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	45,488		45,488	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	7,564		7,564	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	392		392	21	
22	V	6 Security service		Royal Management Corp.	**				22	
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,868		5,868	23	
24	V	10 Medical consultant		Royal Management Corp.	**	3,062		3,062	24	
25	V	10 Management allocation - salaries		Royal Management Corp.	**	44,712		44,712	25	
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	5,768		5,768	26	
27	V	17 Management allocation - salaries		Royal Management Corp.	**	46,218		46,218	27	
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	21,150		21,150	28	
29	V	19 Professional fees		Royal Management Corp.	**	10,772		10,772	29	
30	V	20 Dues & subscriptions		Royal Management Corp.	**	418		418	30	
31	V	23 Inservice Training		Royal Management Corp.	**	21		21	31	
32	V	20 Advertising - help wanted		Royal Management Corp.	**	331		331	32	
33	V	21 Management allocation - salaries		Royal Management Corp.	**	466,481		466,481	33	
34	V	21 Bank charges		Royal Management Corp.	**	9,374		9,374	34	
35	V	21 Office supplies & printing		Royal Management Corp.	**	13,228		13,228	35	
36	V	21 Postage		Royal Management Corp.	**	4,325		4,325	36	
37	V								37	
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 694,339	\$ *	694,339	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 12,938	\$ 12,938	
16	V	24 Travel & seminar		Royal Management Corp.	**	1,148	1,148	
17	V	25 Auto expense		Royal Management Corp.	**	18,833	18,833	
18	V	26 Insurance general		Royal Management Corp.	**	6,641	6,641	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	66,140	66,140	
20	V	30 Depreciation		Royal Management Corp.	**	58,456	58,456	
21	V	32 Interest		Royal Management Corp.	**	16,294	16,294	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	34	34	
23	V	33 Property taxes		Royal Management Corp.	**	5,501	5,501	
24	V	34 Rent expense		Royal Management Corp.	**	4,125	4,125	
25	V	35 Equipment rental		Royal Management Corp.	**	951	951	
26	V	17 Management fees	1,341,747	Royal Management Corp.	**		(1,341,747)	
27	V	35 Auto Lease		Royal Management Corp.	**	3,098	3,098	
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 Chicago Ridge, Inc. own 100% of Royal Management Corp.						
39	Total		\$ 1,341,747			\$ 194,159	\$ * (1,147,588)	

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Chicago Ridge, Inc.**  
**Provider #0036996**  
**1/1/09-12/31/09**

**Schedule 6B**

VII. Related Parties  
 Related Nursing Homes  
 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%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%
David S. 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 Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Orland Park, Inc.	Orland Park

Other Related Business Entities

Eastgate Manor	Algonquin	Supportive Living Facility
Vesta Management Group LLC	Lombard	Management Company
Sambell of Chicago Ridge Ltd. Ptsp.	Chicago Ridge	Real Estate Property
Royal Management Corporation	Lombard	Management Company
Lexington Financial Services, LLC	Lombard	Finance Company

**See Accountants' Compilation Report**

Facility Name &amp; ID Number

Lexington of Chicago Ridge

# 0042739

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	3.41	8.52	Salary	\$ 11,242	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33	See Schedule 7A	3.73	7.45	Salary	18,173	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34	See Schedule 7A	3.41	8.52	Salary	8,547	L17, C7	3
4											4
5	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	5.32	10.65	Salary	8,256	L17,C7	5
6											6
7											7
8					Certain individuals work in excess of 40 hours per week						8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 46,218		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

# 0042739

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	3	Housekeeping supplies	Bed Days	720,658	10	\$ 4,909	\$ 76,724	\$ 523	1	
2	5	Utilities - gas & electric	Bed Days	720,658	10	69,894	76,724	7,441	2	
3	5	Utilities - water & sewer	Bed Days	720,658	10	1,894	76,724	202	3	
4	5	Utilities - maintenance office	Bed Days	720,658	10	9,406	76,724	1,001	4	
5	6	Management allocation - salaries	Bed Days	720,658	10	427,259	427,259	76,724	45,488	5
6	6	Repairs & maintenance	Bed Days	720,658	10	71,047	76,724	7,564	6	
7	6	Scavenger & exterminating	Bed Days	720,658	10	3,681	76,724	392	7	
8	6	Security service	Bed Days	720,658	10		76,724	0	8	
9	7	Management allocation - employee	Bed Days	720,658	10	55,118	76,724	5,868	9	
10	10	Medical consultant	Bed Days	720,658	10	28,762	76,724	3,062	10	
11	10	Management allocation - salaries	Bed Days	720,658	10	419,975	419,975	76,724	44,712	11
12	15	Management allocation - employee	Bed Days	720,658	10	54,178	76,724	5,768	12	
13	17	Management allocation - salaries	Bed Days	720,658	10	434,122	434,122	76,724	46,218	13
14	19	Computer consultant & supplies	Bed Days	720,658	10	198,663	76,724	21,150	14	
15	19	Professional fees	Bed Days	720,658	10	101,182	76,724	10,772	15	
16	20	Dues & subscriptions	Bed Days	720,658	10	3,923	76,724	418	16	
17	23	Inservice Training	Bed Days	720,658	10	193	76,724	21	17	
18	20	Advertising - help wanted	Bed Days	720,658	10	3,108	76,724	331	18	
19	21	Management allocation - salaries	Bed Days	720,658	10	4,381,596	4,381,596	76,724	466,481	19
20	21	Bank charges	Bed Days	720,658	10	88,048	76,724	9,374	20	
21	21	Office supplies & printing	Bed Days	720,658	10	124,253	76,724	13,228	21	
22	21	Postage	Bed Days	720,658	10	40,624	76,724	4,325	22	
23	21	Telephone	Bed Days	720,658	10	121,527	76,724	12,938	23	
24	24	Travel and Seminar	Bed Days	720,658	10	10,782	76,724	1,148	24	
25	TOTALS					\$ 6,654,144	\$ 5,662,952	\$ 708,425	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

# 0042739

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 Ave.  
 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	\$ 76,724	\$ 18,833	1
2	26	Insurance general	Bed Days	720,658	10	62,379	76,724	6,641	2
3	27	Management allocation - employees	Bed Days	720,658	10	621,243	76,724	66,140	3
4	30	Depreciation	Bed Days	720,658	10	549,069	76,724	58,456	4
5	32	Interest	Bed Days	720,658	10	153,050	76,724	16,294	5
6	32	Amortization of mortgage costs	Bed Days	720,658	10	321	76,724	34	6
7	33	Property taxes	Bed Days	720,658	10	51,670	76,724	5,501	7
8	34	Rent expense	Bed Days	720,658	10	38,747	76,724	4,125	8
9	35	Equipment rental	Bed Days	720,658	10	8,933	76,724	951	9
10	35	Auto Lease	Bed Days	720,658	10	29,103	76,724	3,098	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					\$ 1,691,413	\$	\$ 180,073	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Lexington of Chicago Ridge

# 0042739

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		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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Lexington Financial	X		Mortgage	Varies	4/30/07	\$ 6,908,000	\$ 6,617,523	5/1/17	0.0625	\$ 400,117	1								
2	Services II, L.L.C.											2								
3												3								
4												4								
5							Interest on Financing insurance premium				728	5								
	<b>Working Capital</b>																			
6	JP Morgan Chase		X	Line of Credit	Varies	4/30/07	1,400,000		5/1/10	Libor +1	17,079	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 8,308,000	\$ 6,617,523			\$ 417,924	9								
	<b>B. Non-Facility Related*</b>																			
10											Amortization of mortgage costs	1,322	10							
11											Interest income offset	(5,775)	11							
12											Allocated from Management Co.	16,294	12							
13													13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 11,841	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 8,308,000	\$ 6,617,523			\$ 429,765	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: 85,551 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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>31,000</u>	<u>1989</u>	<u>\$ 505,000</u>	<u>1</u>
2	<u>Allocation from Management company</u>			<u>20,006</u>	<u>2</u>
3	<b>TOTALS</b>	<b>31,000</b>		<b>\$ 525,006</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Chicago Ridge

# 0042739

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	203		1991	1991	\$ 5,143,342	\$	35	\$ 146,951	\$ 146,951	\$ 2,730,863	4
5			1995	1995	97,352	2,781	35	2,781		40,331	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Leasehold Improvements	1993		2,694	77	35	77		1,271	9
10		Leasehold Improvements	1994		6,581	188	35	188		2,915	10
11		Dishwasher hood	1996		2,480		10			2,480	11
12		Lobby repairs	1996		8,698		10			8,698	12
13		Basement rehab	1997		24,477		10			24,477	13
14		Wiring	1998		3,429		10			3,429	14
15		Handrails	1998		895	60	15	60		687	15
16		Resurface & restripe parking lot	1998		4,450		10			4,451	16
17		Fire wall	1998		2,169	62	35	62		713	17
18		Foyer floor tile	1999		32,379	540	10	540		32,379	18
19		Wallpapering / painting / decorating	1999		8,833	662	10	662		8,832	19
20		Rebuild garage area	1999		1,762	50	35	50		511	20
21		Roof repairs	2000		6,240	624	10	624		5,928	21
22		Electrical wiring	2000		3,986	114	35	114		1,082	22
23		Electrical wiring	2000		2,536	72	35	72		688	23
24		Kitchen rehab	2000		6,623	221	35	221		2,098	24
25		Automatic doors	2000		1,300	130	10	130		1,235	25
26		Elevator eye sensors	2000		4,500	300	15	300		2,850	26
27		Resurface & restripe parking lot	2001		3,319	332	10	332		2,821	27
28		Door releases	2001		5,200	520	10	520		4,420	28
29		Carpeting	2001		10,022	1,002	10	1,002		8,519	29
30		Roof repairs	2002		25,600	1,280	20	1,280		10,027	30
31		Elevator upgrade	2002		9,865	986	10	986		7,480	31
32		Painting/decorating/carpet/wallpaper	2003		38,165	1,908	20	1,908		13,357	32
33		Rehab/new office	2003		26,733	1,337	20	1,337		9,357	33
34		Facility rehab - construction costs, painting & decorating	2003		257,174	12,859	20	12,859		83,582	34
35		Facility rehab - electrical	2003		12,840	642	20	642		4,173	35
36		Facility rehab - carpeting	2003		7,800	780	10	780		5,070	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 Chicago Ridge# 0042739

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	Facility rehab - floor tile	2003	\$ 3,548	\$ 177	20	\$ 177		\$ 1,152	37
38									38
39	Kickplates/Door protectors	2004	4,095	410	10	410		2,322	39
40	Kitchen Fire Protection Upgrade	2004	1,427	143	10	143		809	40
41	Parking Lot - Paving and Sealcoating	2005	4,375	219	20	219		948	41
42	Kitchen Rehab	2005	19,228	961	20	961		4,005	42
43	Lobby/Lounge Reception Area	2005	36,503	1,825	20	1,825		8,365	43
44	Sidewalk - Raise and Support	2005	1,330	67	20	67		284	44
45	Lower Level Therapy Rehab	2005	52,525	2,626	20	2,626		11,380	45
46	Transitional Unit	2005	1,020	51	20	51		208	46
47	Basement Renovation	2005	3,754	188	20	188		783	47
48	Landscaping Enhancement	2006	6,463	431	15	431		1,401	48
49	Lhi-Hvac	2006	4,333	217	20	217		669	49
50	Rehab Common Areas	2006	7,661	383	20	383		1,341	50
51	Modular Units attached to wall	2006	10,316	516	20	516		1,720	51
52	Cubical Curtains	2006	1,578	316	5	316		1,210	52
53	Landscaping	2007	5,000	333	15	333		805	53
54	Parking lot	2007	35,969		20	1,819	1,819	3,638	54
55	HVAC	2007	4,580	229	20	229		611	55
56	Emergency A/C	2007	30,293	1,515	20	1,515		3,535	56
57	Portable A/C	2007	3,768	188	20	188		455	57
58	Employee Lunch Room	2007	3,671	184	20	184		399	58
59	Painting	2007	16,150	808	20	808		1,885	59
60	1st floor remodel-carpentry, flooring, plumbing, electrical fixtures	2007	641,616		40	16,225	16,225	32,450	60
61	painting,								61
62	Create first floor therapy	2007	185	9	20	9		27	62
63	Landscaping	2008	19,600	1,307	15	1,307		1,851	63
64	Parking Lot-paving,sealcoating and repairs	2008	44,050	2,203	20	2,203		2,754	64
65	HVAC Sport Coolers	2008	3,790	95	40	95		95	65
66	Plumbing & Sprinkler Shower room	2008	9,668	483	20	483		483	66
67	Common areas-doors and locks	2008	3,162	158	20	158		290	67
68	Basement Renovation	2008	7,569	189	40	189		347	68
69	2nd Floor Remodel-Carpentry, Flooring, Electrical, painting	2008	578,270		27	21,028	21,028	22,780	69
70	TOTAL (lines 4 thru 69)		\$ 7,326,941	\$ 43,758		\$ 229,781	\$ 186,023	\$ 3,133,726	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 of Chicago Ridge# 0042739

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 7,326,941	\$ 43,758		\$ 229,781	\$ 186,023	\$ 3,133,726	1
2	Land improvements	2009	15,180	253	15	253		253	2
3	Landscaping	2009	3,693	103	15	103		103	3
4	Chiller	2009	178,462	5,205	20	5,205		5,205	4
5	Quick connectors/spot cooler	2009	10,244	333	20	333		333	5
6	Plumbing & Sprinkler	2009	6,172	39	40	39		39	6
7	Chiller Fence	2009	5,350						7
8	Land improvements-patio pergola	2009	7,930	132	20	132		132	8
9	Land improvements patio fence	2009	14,308	60	20	60		60	9
10	3rd floor remodel-Carpentry, flooring, electrical, painting, sprinkler system	2009	670,689		27	2,032	2,032	2,032	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	Land improvements - management company	2002	276,840		40	7,910	7,910	65,192	21
22									22
23	HVAC, electrical, security system - management company	2003	2,432		30	162	162	1,077	23
24	Key card system - management company	2004	382		20	18	18	104	24
25	VAV TX controls - management company	2005	116		20	6	6	28	25
26	Interior Signs- management company	2006	85		5	5	5	18	26
27	Building - management company	2008	9,194		5	676	676	867	27
28	Building - management company	2009	691		15	12	12	12	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,528,709	\$ 49,883		\$ 246,727	\$ 196,844	\$ 3,209,181	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	\$ 569,711	\$ 85,629	\$ 85,629	\$		\$ 348,283	71
72	Current Year Purchases	768,772	13,287	101,738	88,451		150,218	72
73	Fully Depreciated Assets	16,189					16,189	73
74		304,420		43,641	43,641		221,422	74
75	TOTALS	\$ 1,659,092	\$ 98,916	\$ 231,008	\$ 132,092		\$ 736,112	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	Alloc. From Mgmt Co.			44,945		6,025	6,025		28,354	79
80	TOTALS			\$ 44,945	\$	\$ 6,025	\$ 6,025		\$ 28,354	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,757,752	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 148,799	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 483,760	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 334,961	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,973,647	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		\$	\$	\$	86
87	N/A				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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co.				4,125			6
7	TOTAL				\$ 4,125			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: \$ 68,881 Description: Copier-\$9,046;Postage-\$189;Med Equip-\$22,777;Oxygen-\$35,918;Alloc. Mgmt Co.-951

(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.			3,098	20
21	TOTAL		\$	\$ 3,098	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8				
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service			Units	Cost								
1	Licensed Occupational Therapist	10A(3)	hrs	\$	8,468	\$	504,466	\$	8,468	\$	504,466	1			
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,229		114,872		2,229		114,872	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist	10A(3)	hrs		13,471		688,721		13,471		688,721	4			
5	Physician Care		visits									5			
6	Dental Care		visits									6			
7	Work Related Program		hrs									7			
8	Habilitation		hrs									8			
9	Pharmacy	39(2)	# of prescripts					507,204			507,204	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10			
11	Academic Education		hrs									11			
12	Other (specify): <u>Dentist</u>	39(3)					1,954				1,954	12			
13	Other (specify): _____											13			
14	<b>TOTAL</b>			\$			24,168	\$	1,310,013	\$	507,204	24,168	\$	1,817,217	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 Chicago Ridge# 0042739Report 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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 365,849	\$ 454,161	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>470,490</u> )	2,653,798	2,653,798	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,073	29,073	6
7	Other Prepaid Expenses	71,705	71,705	7
8	Accounts Receivable (owners or related parties)	(14,683)	161,814	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,105,742	\$ 3,370,551	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,545	6,545	12
13	Land		525,006	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	1,171,556	3,385,367	15
16	Equipment, at Historical Cost	759,400	1,704,037	16
17	Accumulated Depreciation (book methods)	(711,718)	(3,973,647)	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>		29,078	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,225,783	\$ 6,819,728	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,331,525	\$ 10,190,279	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 595,585	\$ 595,585	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,503	2,503	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	426,796	426,796	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,481	4,481	31
32	Accrued Real Estate Taxes(Sch.IX-B)		666,000	32
33	Accrued Interest Payable		37,026	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	1,739,390	1,211,618	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,768,755	\$ 2,944,009	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,617,523	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,617,523	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,768,755	\$ 9,561,532	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,562,770	\$ 628,747	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,331,525	\$ 10,190,279	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington Health Care Center of Chicago Ridge, Inc.  
Provider # 0036996  
1/1/09-12/31/09

Schedule 17A  
XV. Balance Sheet

B. Long Term Assets  
23. Other Assets

C. Current Liabilities  
36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to/from Royal	21,573	21,573
Due to/from Orland Park	288	288
Accrued 401K	22,181	22,181
Due to Republic Construction	224	224
Accrued expenses	77,695	77,695
Accrued royal genl mgmt fees	54,279	54,279
Accrued rent	1,297,947	-
Deferred income	265,203	265,203
Interest Rate Swap Liability		770,175
	<u>1,739,390</u>	<u>1,211,618</u>

**See Accountants' Compilation**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,783,629</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post closing adjustment</b>	<b>(354,902)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,428,727</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>134,043</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>134,043</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,562,770</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 18,758,177	1
2	Discounts and Allowances for all Levels	(7,952,177)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 10,806,000</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,929,385	6
7	Oxygen	(280)	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,929,105</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,792	12
13	Barber and Beauty Care	23,415	13
14	Non-Patient Meals	14	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	477,932	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	53,158	19
20	Radiology and X-Ray	20,049	20
21	Other Medical Services	195,137	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 771,497</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	420	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 420</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income/Investment Income</u>	(938)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ (938)</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 14,506,084</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,772,379	31
32	Health Care	6,298,213	32
33	General Administration	3,161,184	33
<b>B. Capital Expense</b>			
34	Ownership	2,321,135	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	704,044	35
36	Provider Participation Fee	115,086	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 14,372,041</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>134,043</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 134,043</b>	<b>43</b>

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
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 Chicago Ridge**

# **0042739**

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	2,151	2,259	\$ 115,536	\$ 51.14	1
2	Assistant Director of Nursing	9,260	10,045	350,982	34.94	2
3	Registered Nurses	36,279	40,018	1,288,018	32.19	3
4	Licensed Practical Nurses	33,915	35,472	857,918	24.19	4
5	CNAs & Orderlies	105,257	112,407	1,284,352	11.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,498	14,496	181,670	12.53	8
9	Activity Director					9
10	Activity Assistants	16,104	17,595	227,469	12.93	10
11	Social Service Workers	13,014	13,664	199,614	14.61	11
12	Dietician	5,837	6,260	65,426	10.45	12
13	Food Service Supervisor	1,971	2,083	41,762	20.05	13
14	Head Cook	1,971	2,084	33,199	15.93	14
15	Cook Helpers/Assistants	7,787	8,645	88,948	10.29	15
16	Dishwashers	19,163	20,068	163,043	8.12	16
17	Maintenance Workers	2,157	2,291	40,230	17.56	17
18	Housekeepers	39,888	43,572	397,210	9.12	18
19	Laundry	8,854	9,633	87,396	9.07	19
20	Administrator	1,847	1,941	127,052	65.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,222	22,483	330,961	14.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,577	1,775	28,184	15.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	341,752	366,791	\$ 5,908,970 *	\$ 16.11	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	636	\$ 31,946	1(3)	35
36	Medical Director	Monthly	31,800	9(3)	36
37	Medical Records Consultant	18	1,004	10(3)	37
38	Nurse Consultant	Monthly	16,930	10(3)	38
39	Pharmacist Consultant	Monthly	12,180	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	92	4,594	11(3)	44
45	Social Service Consultant	96	4,835	12(3)	45
46	Other(specify) <u>Psychosocial</u>	48	2,304	12(3)	46
47	<u>Clinical Consultant</u>	Monthly	8,215	10(3)	47
48	<u>Medical Consultant</u>	Monthly	3,062	10(7)	48
49	TOTAL (lines 35 - 48)	890	\$ 116,870		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



C. Professional Fees

Schedule 21C

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Reed Smith/Sachnoff & Weaver	Legal	19,641
RSM McGladrey	Accounting	10,120
Serpivo, Petrosino & Depiero	Legal	2,425
Action Computer Service	Computer Consulting	842
ASG Staffing	Computer Consulting	1,661
Lintech LLC	Computer Consulting	4,311
National Datacare	Computer Consulting	2,619
E-Health Solutions	Computer Consulting	2,400
C.D.W. Direct	Computer Consulting	606
Krakau Business	Computer Consulting	353
Healthware Consulting	Computer Consulting	1,415
Information Control	Computer Consulting	1,445
Silver Chair Learning Systems	Computer Consulting	4,200
Microsoft2	Computer Consulting	4,820
Lanac Technology	Computer Consulting	3,055
Vision Share, Inc.	Computer Consulting	863
Visual Click Software	Computer Consulting	124
MNJ Technology	Computer Consulting	158
B2B Computer	Computer Consulting	46
Conrac Healthcare	Computer Consulting	2,187
		<u>63,291</u>

**Schedule V, line 19 column 7** 190,692

To disallow collection fees (2,517)  
 Out of period legal (328)

Legal allocated from Real Estate  
 James Samatas 200

Samvest of Lombard  
 Legal 227  
 Accounting 97  
 Total 324

Allocated from Mgmt Co.  
 James Samatas Legal 62  
 Reed Smith Legal 2,527  
 Much Shelist Legal 1,591  
 Serpico, Petrosino, Dipiero Legal 11  
 McGladrey & Pullen Accounting 775  
 RSM McGladrey Accounting 596  
 Aronberg, Goldgehn Davis 401K Administration 1  
 LaSalle Network Accounting 1,008  
 Gilson Labus & Silverman Accounting 503  
 KMZ Rosenmann Legal 1,842  
 ING Life Annutiy 401K Administration 121  
 Pension Administrators, Inc. 401K Administration 537  
 Personnel Planners Unemployment Consulting 32  
 Gene Whitehorn Medicaid Reimb Specialist 842  
 Computer Consulting Computer Services 21,150  
31,598

**Schedule V, line 19, column 8** 219,969

**See Accountants' Compilation Report**

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 69,342 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 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. \$ 115,086  
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. \$ 15,415 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 14
- (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**