

Facility Name & ID Number Lexington of Elmhurst

0037317 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	138	Skilled (SNF)	138	50,370	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	138	TOTALS	138	50,370	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			12,358	12,358	8
9	SNF/PED					9
10	ICF	21,500	4,990	7,211	33,701	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,500	4,990	19,569	46,059	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.44%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/12/91

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 138 and days of care provided 10,583

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 of Elmhurst # 0037317 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	342,451	24,706	14,811	381,968		381,968		381,968		1
2	Food Purchase		231,668		231,668		231,668	(12,826)	218,842		2
3	Housekeeping	286,637	27,553		314,190		314,190	343	314,533		3
4	Laundry	36,805	15,694		52,499		52,499		52,499		4
5	Heat and Other Utilities			215,360	215,360		215,360	5,674	221,034		5
6	Maintenance	40,410		110,673	151,083		151,083	35,086	186,169		6
7	Other (specify):* Mgmt Co. Alloc. Bene							3,852	3,852		7
8	TOTAL General Services	706,303	299,621	340,844	1,346,768		1,346,768	32,129	1,378,897		8
	B. Health Care and Programs										
9	Medical Director			48,375	48,375		48,375		48,375		9
10	Nursing and Medical Records	3,003,460	182,362	65,237	3,251,059		3,251,059	31,364	3,282,423		10
10a	Therapy			1,094,691	1,094,691		1,094,691		1,094,691		10a
11	Activities	205,789	23,895	8,804	238,488		238,488		238,488		11
12	Social Services	179,210		12,022	191,232		191,232		191,232		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co. Alloc. Bene							3,787	3,787		15
16	TOTAL Health Care and Programs	3,388,459	206,257	1,229,129	4,823,845		4,823,845	35,151	4,858,996		16
	C. General Administration										
17	Administrative	86,134		963,432	1,049,566		1,049,566	(933,089)	116,477		17
18	Directors Fees										18
19	Professional Services			110,001	110,001		110,001	19,868	129,869		19
20	Dues, Fees, Subscriptions & Promotions			54,851	54,851		54,851	491	55,342		20
21	Clerical & General Office Expenses	272,811	31,311	20,700	324,822		324,822	332,013	656,835		21
22	Employee Benefits & Payroll Taxes			638,088	638,088		638,088	12,826	650,914		22
23	Inservice Training & Education			4,497	4,497		4,497	13	4,510		23
24	Travel and Seminar			6,149	6,149		6,149	754	6,903		24
25	Other Admin. Staff Transportation			866	866		866	12,364	13,230		25
26	Insurance-Prop.Liab.Malpractice			182,055	182,055		182,055	4,360	186,415		26
27	Other (specify):* Mgmt Co. Alloc. Bene							43,421	43,421		27
28	TOTAL General Administration	358,945	31,311	1,980,639	2,370,895		2,370,895	(506,979)	1,863,916		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,453,707	537,189	3,550,612	8,541,508		8,541,508	(439,699)	8,101,809		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 Elmhurst

#0037317

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			119,223	119,223		119,223	292,148	411,371			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,716	9,716		9,716	773,477	783,193			32
33	Real Estate Taxes							66,571	66,571			33
34	Rent-Facility & Grounds			998,960	998,960		998,960	(996,252)	2,708			34
35	Rent-Equipment & Vehicles			37,290	37,290		37,290	2,658	39,948			35
36	Other (specify):*											36
37	TOTAL Ownership			1,165,189	1,165,189		1,165,189	138,602	1,303,791			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		276,961	804	277,765		277,765		277,765			39
40	Barber and Beauty Shops			27,406	27,406		27,406		27,406			40
41	Coffee and Gift Shops			1,421	1,421		1,421		1,421			41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):* Non-allowable cost			103,632	103,632		103,632	(103,632)				43
44	TOTAL Special Cost Centers		276,961	212,651	489,612		489,612	(103,632)	385,980			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,453,707	814,150	4,928,452	10,196,309		10,196,309	(404,729)	9,791,580			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	(6,422)	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	1,701	30		9
10	Interest and Other Investment Income	(84,061)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(805)	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	(13,850)	43		18
19	Entertainment	(2,288)	43		19
20	Contributions	(4,329)	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	(25,943)	43		24
25	Fund Raising, Advertising and Promotional	(20,421)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,351)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(20,970)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (187,739)		\$	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)	(216,990)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (216,990)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (404,729)		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 of ElmhurstID# 0037317Report Period Beginning: 01/01/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (664)	43	1
2	Labs-Part A	(5,483)	43	2
3	X-Rays-Part A	(13,076)	43	3
4	Trust Fees	(50)	43	4
5	Misc. Income	(408)	21	5
6	Collection fees	(1,264)	19	6
7	Out of period legal	(25)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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31				31
32				32
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(20,970)		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 Schedule 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental expense	\$ 998,960	Sambell of Elmhurst II Limited Partnership	**	\$	(998,960)	1
2	V	19 Professional Fees		Sambell of Elmhurst II Limited Partnership	**	200	200	2
3	V							3
4	V	30 Depreciation		Sambell of Elmhurst II Limited Partnership	**	252,070	252,070	4
5	V	32 Interest expense		Sambell of Elmhurst II Limited Partnership	**	843,414	843,414	5
6	V	32 Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	3,405	3,405	6
7	V	33 Property taxes		Sambell of Elmhurst II Limited Partnership	**	62,960	62,960	7
8	V							8
9	V	43 Trust fees		Sambell of Elmhurst II Limited Partnership	**	50	50	9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Sambell of Elmhurst II Limited Partnership				12
13	V							13
14	Total		\$ 998,960			\$ 1,162,099	\$ * 163,139	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.	**	\$ 343	\$	343	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,885		4,885	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	132		132	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	657		657	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	29,863		29,863	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,966		4,966	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	257		257	21
22	V	6 Security service		Royal Management Corp.	**				22
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	3,852		3,852	23
24	V	10 Medical consultant		Royal Management Corp.	**	2,010		2,010	24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	29,354		29,354	25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,787		3,787	26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	30,343		30,343	27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	13,885		13,885	28
29	V	19 Professional fees		Royal Management Corp.	**	7,072		7,072	29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	274		274	30
31	V	23 Inservice Training		Royal Management Corp.	**	13		13	31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	217		217	32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	306,249		306,249	33
34	V	21 Bank charges		Royal Management Corp.	**	6,154		6,154	34
35	V	21 Office supplies & printing		Royal Management Corp.	**	8,685		8,685	35
36	V	21 Postage		Royal Management Corp.	**	2,839		2,839	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.							38
39	Total		\$			\$ 455,837	\$ *	455,837	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.	**	\$ 8,494	\$ 8,494	
16	V	24 Travel & seminar		Royal Management Corp.	**	754	754	
17	V	25 Auto expense		Royal Management Corp.	**	12,364	12,364	
18	V	26 Insurance general		Royal Management Corp.	**	4,360	4,360	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	43,421	43,421	
20	V	30 Depreciation		Royal Management Corp.	**	38,377	38,377	
21	V	32 Interest		Royal Management Corp.	**	10,697	10,697	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	22	22	
23	V	33 Property taxes		Royal Management Corp.	**	3,611	3,611	
24	V	34 Rent expense		Royal Management Corp.	**	2,708	2,708	
25	V	35 Equipment rental		Royal Management Corp.	**	624	624	
26	V	17 Management fees	963,432	Royal Management Corp.	**		(963,432)	
27	V	35 Auto Lease		Royal Management Corp.	**	2,034	2,034	
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.						
38	V							
39	Total		\$ 963,432			\$ 127,466	\$ * (835,966)	

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

Lexington Health Care Center of Elmhurst, Inc.

Provider # 0037317

1/1/09 - 12/31/09

Schedule B

VII. Related Parties

Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	16.66%
John Samatas Discretionary Trust	16.67%
Cynthia Thiem Discretionary Trust	16.67%
David S. Bell Revocable Trust	12.50%
Jeffrey J. Bell Revocable Trust	12.50%
Lawrence W. Bell Revocable Trust	12.50%
David S. Bell 2001 Trust	4.16%
Jeffrey J. Bell 2001 Trust	4.17%
Lawrence W. Bell 2001 Trust	4.17%

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc	Chicago Ridge
Lexington Health Care Center of 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 Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
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 Elmhurst Ltd. Ptsp.	Elmhurst	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 of Elmhurst

#

0037317

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	16.66	See Schedule 7A	2.24	5.59	Salary	\$ 7,380	L 17, C7	1	
2	John Samatas	Owner/Officer	Admin/Plant Ops	16.67	See Schedule 7A	2.45	4.89	Salary	11,931	L 17, C7	2	
3	Cynthia Thiem	Owner/Officer	Administrative	16.67	See Schedule 7A	2.24	5.59	Salary	5,611	L 17, C7	3	
4	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	3.49	6.99	Salary	5,420	L 17, C7	4	
5											5	
6											6	
7					Certain Individuals work in excess of 40 hours per week.							7
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 30,342		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 Elmhurst# 0037317

Report Period Beginning:

01/01/2009Ending: 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	\$ 50,370	\$ 343	1
2	5	Utilities - gas & electric	Bed Days	720,658	10	69,894	50,370	4,885	2
3	5	Utilities - water & sewer	Bed Days	720,658	10	1,894	50,370	132	3
4	5	Utilities - maintenance office	Bed Days	720,658	10	9,406	50,370	657	4
5	6	Management allocation - salaries	Bed Days	720,658	10	427,259	427,259	29,863	5
6	6	Repairs & maintenance	Bed Days	720,658	10	71,047	50,370	4,966	6
7	6	Scavenger & exterminating	Bed Days	720,658	10	3,681	50,370	257	7
8	6	Security service	Bed Days	720,658	10		50,370	0	8
9	7	Management allocation - employee	Bed Days	720,658	10	55,118	50,370	3,852	9
10	10	Medical consultant	Bed Days	720,658	10	28,762	50,370	2,010	10
11	10	Management allocation - salaries	Bed Days	720,658	10	419,975	419,975	29,354	11
12	15	Management allocation - employee	Bed Days	720,658	10	54,178	50,370	3,787	12
13	17	Management allocation - salaries	Bed Days	720,658	10	434,122	434,121	30,343	13
14	19	Computer consultant & supplies	Bed Days	720,658	10	198,663	50,370	13,885	14
15	19	Professional fees	Bed Days	720,658	10	101,182	50,370	7,072	15
16	20	Dues & subscriptions	Bed Days	720,658	10	3,923	50,370	274	16
17	23	Inservice Training	Bed Days	720,658	10	193	50,370	13	17
18	20	Advertising - help wanted	Bed Days	720,658	10	3,108	50,370	217	18
19	21	Management allocation - salaries	Bed Days	720,658	10	4,381,596	4,381,596	306,249	19
20	21	Bank charges	Bed Days	720,658	10	88,048	50,370	6,154	20
21	21	Office supplies & printing	Bed Days	720,658	10	124,253	50,370	8,685	21
22	21	Postage	Bed Days	720,658	10	40,624	50,370	2,839	22
23	21	Telephone	Bed Days	720,658	10	121,527	50,370	8,494	23
24	24	Travel and Seminar	Bed Days	720,658	10	10,782	50,370	754	24
25	TOTALS					\$ 6,654,144	\$ 5,662,951	\$ 465,085	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

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	\$ 50,370	\$ 12,364	1
2	26	Insurance general	Bed Days	720,658	10	62,379	50,370	4,360	2
3	27	Management allocation - employees	Bed Days	720,658	10	621,243	50,370	43,421	3
4	30	Depreciation	Bed Days	720,658	10	549,069	50,370	38,377	4
5	32	Interest	Bed Days	720,658	10	153,050	50,370	10,697	5
6	32	Amortization of mortgage costs	Bed Days	720,658	10	321	50,370	22	6
7	33	Property taxes	Bed Days	720,658	10	51,670	50,370	3,611	7
8	34	Rent expense	Bed Days	720,658	10	38,747	50,370	2,708	8
9	35	Equipment rental	Bed Days	720,658	10	8,933	50,370	624	9
10	35	Auto Lease	Bed Days	720,658	10	29,103	50,370	2,034	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	\$	\$ 118,218	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Elmhurst

0037317

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										
										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 Services	X		Mortgage	Varies	4/30/07	\$ 13,891,000	\$ 13,239,955	5/1/17	0.0625	\$ 843,414	1							
2	II, L.L.C											2							
3												3							
4												4							
5							Interest on financing insurance premium				482	5							
Working Capital																			
6	JP Morgan Chase		X	Line of Credit	Various	4/30/07	600,000		5/1/10	Libor +1	9,234	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 14,491,000	\$ 13,239,955			\$ 853,130	9							
B. Non-Facility Related*																			
10										Interest Income Offset	(84,061)	10							
11										Amortization of Loan Cost	3,427	11							
12										Allocated from Home Office	10,697	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (69,937)	14							
15	TOTALS (line 9+line14)						\$ 14,491,000	\$ 13,239,955			\$ 783,193	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.)

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 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).

Lexington Square Life Care of Elmhurst, Inc.: Retirement Community: 342 units

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: _____ 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>55,000</u>	<u>1991</u>	<u>\$ 1,277,670</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>13,397</u>	<u>2</u>
3	TOTALS	55,000		\$ 1,291,067	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	133		1991	1991	\$ 4,110,586	\$	35	\$ 117,445	\$ 117,445	\$ 2,126,785	4
5	5		1995	1995	73,302	2,095	35	2,095		30,697	5
6			2001	2001							6
7											7
8											8
	Improvement Type**										
9		Building Improvement	1992		693	20	35	20		342	9
10		Land Improvement	1995		7,500	500	15	500		7,167	10
11		Fan Coil Units	1996		4,904	140	35	140		1,891	11
12		Patio	1996		2,322	155	15	155		2,090	12
13		Basement rehab	1997		17,151		10			17,151	13
14		Baseboards	1997		3,129		10			3,129	14
15		Wiring	1998		3,090		10			3,090	15
16		Lobby Tile	1999		19,354	161	10	161		19,353	16
17		Patio	1999		4,196	280	15	280		2,798	17
18		Automatic Door	2000		1,300	130	10	130		1,235	18
19		Wallpaper	2000		6,853	685	10	685		6,510	19
20		Patio	2000		1,242	83	15	83		787	20
21		Storage closet for HVAC	2000		3,745	250	15	250		2,372	21
22		Fire pump system	2001		4,140	414	10	414		3,519	22
23		Door releases	2001		4,420	442	10	442		3,757	23
24		Infrared curtains for elevators	2001		3,000	300	10	300		2,550	24
25		Parking lot	2002		2,532	253	10	253		2,025	25
26		Kitchen tile and plumbing	2002		9,661	966	10	966		7,407	26
27		Elevator upgrade	2002		2,596		5			2,596	27
28		Facility Rehab-Painting/wallpaper/carpeting	2003		175,251	17,525	10	17,525		121,215	28
29		Facility Rehab-Floor tile/room upgrade	2003		38,140	1,907	20	1,907		13,190	29
30		Facility Rehab-Carpeting	2003		7,861	786	10	786		5,371	30
31		Parking lot	2004		2,000	267	5	267		2,000	31
32		Roof	2004		15,000	750	20	750		4,063	32
33		Landscaping	2005		5,396	270	20	270		1,214	33
34		Paint for building	2005		9,000	900	10	900		3,825	34
35		Roof	2005		14,300	715	20	715		2,979	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

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	HVAC upgrade	2005	\$ 3,230	\$ 162	20	\$ 162		\$ 755	37
38	Sprinkler system	2005	1,060	53	20	53		225	38
39	Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		6,785	39
40	Window treatment	2005	1,932	193	10	193		901	40
41	Cubicle curtains	2005	820	164	5	164		711	41
42	Countertop	2005	845	169	5	169		789	42
43	HVAC	2006	3,793	190	20	190		585	43
44	Automatic Door Lock	2006	2,784	139	20	139		417	44
45	Storeroom Door Lock	2006	1,904	95	20	95		301	45
46	Service Door	2006	2,545	127	20	127		381	46
47	Landscaping Enhancement-Patio	2006	2,340	156	15	156		533	47
48	PT Therapy Room	2006	570	14	40	14		42	48
49									49
50									50
51									51
52	Transitional Unit	2007	1,864	93	20	93		256	52
53	Employee Lunch Room	2007	2,827	141	20	141		353	53
54	PT Room Rehab	2007	58,628	2,941	20	2,941		6,667	54
55	Landscaping-brick pavers	2008	43,813	2,921	15	2,921		3,651	55
56	Parking Lot	2008	31,700	1,585	20	1,585		2,510	56
57	Roof Repairs	2008	4,200	280	15	280		467	57
58	HVAC-New Chillers	2008	118,557	5,928	20	5,928		7,904	58
59	Emergency A/C	2008	5,706	285	20	285		380	59
60	Building Addition	2008			27				60
61	Kitchen Upgrade	2008	7,214		27	262	262	306	61
62	2nd Floor Remodel-painting, flooring, electrical	2008	561,274		27	20,410	20,410	23,812	62
63	Foundation Stabilization	2008	66,195		27	2,407	2,407	2,808	63
64	Irrigation System	2009	15,485	344	15	344		344	64
65	Landscaping Enhancements	2009	26,798	744	15	744		744	65
66	Patio Fence	2009	9,319	272	20	272		272	66
67	Chiller	2009	82,310	3,087	20	3,087		3,087	67
68	Plumbing	2009	4,280		20				68
69	2nd floor remodel-MDS office, HR office, Nursing call system	2009	6,853	10	27	10		10	69
70	TOTAL (lines 4 thru 69)		\$ 5,649,111	\$ 51,467		\$ 191,991	\$ 140,524	\$ 2,467,104	70

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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,649,111	\$ 51,467		\$ 191,991	\$ 140,524	\$ 2,467,104	1
2	Patio Pergola	2009	12,814	214	20	214		214	2
3	Tub Room	2009	5,828		27				3
4	2nd Floor remodel-Carpentry,doors,flooring,electrical	2009	455,801		7	12,431	12,431	17,521	4
5	painting,sprinkler system								5
6									6
7									7
8									8
9									9
10									10
11									11
12	Land improvements - management company	2002	21,115		15	1,286	1,286	11,144	12
13	Building - management company	2002	164,270		40	3,907	3,907	32,512	13
14	HVAC, electrical, security system - management company	2003	1,628		30	107	107	721	14
15	Key card system - management company	2004	256		20	12	12	69	15
16	VAV TX controls - management company	2005	78		20	4	4	19	16
17	Interior Signs- management company	2006	57		5	4	4	12	17
18	Building - management company	2008	6,157		5	444	444	581	18
19	Building - management company	2009	463		15	8	8	8	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)		\$ 6,317,578	\$ 51,681		\$ 210,408	\$ 158,727	\$ 2,529,905	34

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 Elmhurst

0037317

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 710,579	\$ 56,471	\$ 125,466	\$ 68,995	5	\$ 283,619	71
72	Current Year Purchases	494,688	11,071	42,890	31,819		21,660	72
73	Fully Depreciated Assets	29,010					29,010	73
74	Alloc. From Mgmt Co.	203,853		28,651	28,651		148,273	74
75	TOTALS	\$ 1,438,130	\$ 67,542	\$ 197,007	\$ 129,465		\$ 482,562	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	Allocated from Mgmt Co.			30,097		3,956	3,956		18,987	77
78										78
79										79
80	TOTALS			\$ 30,097	\$	\$ 3,956	\$ 3,956		\$ 18,987	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)	\$ 9,076,872	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,223	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 411,371	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 292,148	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,031,454	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co.				2,708			6
7	TOTAL				\$ 2,708			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: \$ 37,914 Description: Copier-\$8,161;Med Equip-\$8,636;Oxygen-\$20,493; Mgmt Co. Allocation-624

(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	Allocated from Mgmt Co.			2,034	18
19					19
20					20
21	TOTAL		\$	\$ 2,034	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?</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	\$	5,308	\$ 437,538	\$	5,308	\$ 437,538	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,495	117,970		1,495	117,970	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,153	539,183		9,153	539,183	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				276,961		276,961	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39(3)				804			804	12
13	Other (specify): _____									13
14	TOTAL			\$	15,956	\$ 1,095,495	\$ 276,961	15,956	\$ 1,372,456	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 Elmhurst# 0037317Report 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	\$ 10,357	\$ 292,516	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>465,660</u>)	1,965,270	1,965,270	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,338	29,338	6
7	Other Prepaid Expenses	66,653	66,653	7
8	Accounts Receivable (owners or related parties)	22,105	8,482,186	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,093,723	\$ 10,835,963	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,569	17,569	12
13	Land		1,291,067	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	922,989	2,206,992	15
16	Equipment, at Historical Cost	552,229	1,468,227	16
17	Accumulated Depreciation (book methods)	(536,875)	(3,031,454)	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 Net Cost</u>		76,885	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 955,912	\$ 6,139,872	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,049,635	\$ 16,975,835	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 479,023	\$ 479,023	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	341,367	341,367	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,048	7,048	31
32	Accrued Real Estate Taxes(Sch.IX-B)		64,800	32
33	Accrued Interest Payable		73,545	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	433,392	2,004,705	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,260,830	\$ 2,970,488	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,239,955	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)	\$	\$ 13,239,955	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,260,830	\$ 16,210,443	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,788,805	\$ 765,392	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,049,635	\$ 16,975,835	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
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>
Interest Rate Swap Liability		1,540,815
PA Audit Settlement	123,788	123,788
Due to/from Republic Cont	1,703	1,703
Due from Royal	1,327	1,327
Accrued Expenses	58,469	58,469
Accrued Royl Mgmt Fees	39,894	39,894
Accrued Rent	(30,498)	
Due to Patient Trust Fund	29,283	29,283
Deferered Income	190,730	190,730
Due to Royal Operations	18,696	18,696
	<u>433,392</u>	<u>2,004,705</u>

See Accountants' Compliance Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,496,231	1
2	Restatements (describe):		2
3	Post closing adjustment	(1,198,185)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 298,046	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,490,759	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)	\$ 1,490,759	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)	\$ 1,788,805	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst# 0037317Report 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	\$ 12,601,553	1
2	Discounts and Allowances for all Levels	(3,938,238)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,663,315	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,458,314	6
7	Oxygen	22,036	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,480,350	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	2,082	12
13	Barber and Beauty Care	29,686	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	316,504	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	56,112	19
20	Radiology and X-Ray		20
21	Other Medical Services	114,292	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 518,676	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22,869	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,869	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	1,858	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,858	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,687,068	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,346,768	31
32	Health Care	4,823,845	32
33	General Administration	2,370,895	33
B. Capital Expense			
34	Ownership	1,165,189	34
C. Ancillary Expense			
35	Special Cost Centers	410,224	35
36	Provider Participation Fee	79,388	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,196,309	40
41	Income before Income Taxes (line 30 minus line 40)**	1,490,759	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,490,759	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This is a cash basis tax payer

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

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

Lexington Health Care Center of Elmhurst, Inc.
1/1/09-12/31/09
Provider # 0037317

Schedule XVII. Income Statement

E. Other Revenue (specify) Schedule 19A

Line 28

<u>Description</u>	<u>Amount</u>
Rental Income-Specialized Wheelchair	305
Miscellaneous Income	408
Recovery of Write off	1,145
	<u>1,858</u>

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst

0037317

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	2,045	2,295	\$ 116,196	\$ 50.63	1
2	Assistant Director of Nursing	6,494	7,229	252,376	34.91	2
3	Registered Nurses	33,504	36,625	1,149,452	31.38	3
4	Licensed Practical Nurses	14,196	14,985	356,593	23.80	4
5	CNAs & Orderlies	77,301	81,775	1,006,898	12.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,473	7,925	103,691	13.08	8
9	Activity Director					9
10	Activity Assistants	14,814	15,873	205,789	12.96	10
11	Social Service Workers	11,379	12,221	179,210	14.66	11
12	Dietician	7,302	7,853	74,106	9.44	12
13	Food Service Supervisor	1,699	1,816	35,192	19.38	13
14	Head Cook	2,070	2,227	35,783	16.07	14
15	Cook Helpers/Assistants	8,179	8,702	90,048	10.35	15
16	Dishwashers	12,031	12,667	107,322	8.47	16
17	Maintenance Workers	2,084	2,256	40,410	17.91	17
18	Housekeepers	31,097	33,342	286,637	8.60	18
19	Laundry	4,196	4,511	36,805	8.16	19
20	Administrator	1,550	1,743	86,134	49.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,577	21,825	272,811	12.50	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	1,161	1,178	18,254	15.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	259,152	277,048	\$ 4,453,707 *	\$ 16.08	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	Monthly	\$ 14,811	1(3)	35
36	Medical Director	Monthly	48,375	9(3)	36
37	Medical Records Consultant	4	1,114	10(3)	37
38	Nurse Consultant	Monthly	25,978	10(3)	38
39	Pharmacist Consultant	Monthly	7,930	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	7,006	11(3)	44
45	Social Service Consultant	Monthly	5,135	12(3)	45
46	Other(specify) <u>Psychosocial</u>	26	1,260	12(3)	46
47	<u>Pulmonary</u>	Monthly	11,819	10(3)	47
48	<u>Medical Consultant</u>	Monthly	2,010	10(7)	48
49	TOTAL (lines 35 - 48)	30	\$ 125,438		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	100	\$ 5,354	10(3)	50
51	Licensed Practical Nurses	121	5,192	10(3)	51
52	Certified Nurse Assistants/Aides	304	7,850	10(3)	52
53	TOTAL (lines 50 - 52)	525	\$ 18,396		53

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 21C

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Action Computer Service	Computer Consulting	474
B2B Computer Products	Computer Consulting	46
C.D.W Direct	Computer Consulting	236
E-Health Consulting	Computer Consulting	2,400
Healthware Consulting	Computer Consulting	1,415
Information Control	Computer Consulting	1,185
Krakau Business	Computer Consulting	320
Lanac/GP	Computer Consulting	2,028
Lintech, LLC	Computer Consulting	3,046
Microsoft License	Computer Consulting	4,389
MNJ Technolgies	Computer Consulting	1,823
National Datacare	Computer Consulting	1,366
Silverchair Learning Systems	Computer Consulting	4,200
Vision Share	Computer Consulting	865
Visual Click	Computer Consulting	124
Royal Management	Self Insurance	4,420
		<u>28,337</u>

Schedule V, line 19, column 3 110,001

Collection Fees (1,264)
Out of period legal (25)

Allocated from Sambell of Chicago Ridge
James Samatas 200

Allocated from Samvest of Lombard II

Legal 149
Accounting 63
212

Allocated from Mgmt Co.

McGladrey & Pullen LLP	Accounting	510
RSM McGladrey	Accounting	391
LaSalle Network	Accounting	1
Gilson Labus & Silverman	Accounting	662
KMZ Rosenman	Legal	330
ING Life Annuity	401K Administration	1,209
Pension Administrators	401K Administration	80
Addison Search	Recruitment Consultir	352
Beth Schwarz	Operations consultan	21
Gene Whitehorn	Accounting	553
James Samatas	Legal	40
Reed Smith	Legal	1,659
Much Shelist	Legal	1,045
Serpico, Petrosino, Dipiero	Legal	7
Compute Service	Computer Services	13,885
		<u>20,745</u>

Schedule V, line 19, column 8 129,869

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	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report 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? 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. \$ 43,993 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,388
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. \$ 12,826 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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