

Facility Name & ID Number Lexington of LaGrange

0038083 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	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</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>110</u>	TOTALS	<u>110</u>	<u>40,150</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 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			<u>22,826</u>	<u>22,826</u>		8
9	SNF/PED						9
10	ICF	<u>7,167</u>	<u>5,132</u>		<u>12,299</u>		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	<u>7,167</u>	<u>5,132</u>	<u>22,826</u>	<u>35,125</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.48%

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 7/31/92

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 110 and days of care provided 21,799

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 LaGrange # 0038083 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	341,441	14,591	12,251	368,283		368,283		368,283		1
2	Food Purchase		181,015		181,015		181,015	(13,271)	167,744		2
3	Housekeeping	268,459	25,572		294,031		294,031	273	294,304		3
4	Laundry	59,443	11,811		71,254		71,254		71,254		4
5	Heat and Other Utilities			199,990	199,990		199,990	4,524	204,514		5
6	Maintenance	39,208		112,126	151,334		151,334	27,967	179,301		6
7	Other (specify):* <u>Alloc. Mgmt Co. Bene</u>							3,071	3,071		7
8	TOTAL General Services	708,551	232,989	324,367	1,265,907		1,265,907	22,564	1,288,471		8
	B. Health Care and Programs										
9	Medical Director			47,000	47,000		47,000		47,000		9
10	Nursing and Medical Records	3,097,451	318,363	39,673	3,455,487		3,455,487	25,000	3,480,487		10
10a	Therapy			1,750,063	1,750,063		1,750,063		1,750,063		10a
11	Activities	208,930	22,146	10,849	241,925		241,925		241,925		11
12	Social Services	242,695		12,804	255,499		255,499		255,499		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Alloc. Mgmt Co. Bene</u>							3,018	3,018		15
16	TOTAL Health Care and Programs	3,549,076	340,509	1,860,389	5,749,974		5,749,974	28,018	5,777,992		16
	C. General Administration										
17	Administrative	95,596		878,684	974,280		974,280	(854,498)	119,782		17
18	Directors Fees										18
19	Professional Services			74,034	74,034		74,034	10,482	84,516		19
20	Dues, Fees, Subscriptions & Promotions			41,485	41,485		41,485	392	41,877		20
21	Clerical & General Office Expenses	399,531	39,960	22,784	462,275		462,275	101,389	563,664		21
22	Employee Benefits & Payroll Taxes			628,630	628,630		628,630	13,271	641,901		22
23	Inservice Training & Education			5,427	5,427		5,427	11	5,438		23
24	Travel and Seminar			6,298	6,298		6,298	601	6,899		24
25	Other Admin. Staff Transportation			1,618	1,618		1,618	9,856	11,474		25
26	Insurance-Prop.Liab.Malpractice			103,997	103,997		103,997	3,475	107,472		26
27	Other (specify):* <u>Alloc. Mgmt Co. Bene</u>							34,611	34,611		27
28	TOTAL General Administration	495,127	39,960	1,762,957	2,298,044		2,298,044	(680,410)	1,617,634		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,752,754	613,458	3,947,713	9,313,925		9,313,925	(629,828)	8,684,097		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Lexington of LaGrange

#0038083

Report Period Beginning:

01/01/2009

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			111,158	111,158		111,158	334,595	445,753			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,797	3,797		3,797	369,225	373,022			32
33	Real Estate Taxes							155,679	155,679			33
34	Rent-Facility & Grounds			920,800	920,800		920,800	(918,641)	2,159			34
35	Rent-Equipment & Vehicles			96,290	96,290		96,290	2,119	98,409			35
36	Other (specify):*											36
37	TOTAL Ownership			1,132,045	1,132,045		1,132,045	(57,023)	1,075,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		732,821	9,804	742,625		742,625		742,625			39
40	Barber and Beauty Shops			27,746	27,746		27,746		27,746			40
41	Coffee and Gift Shops			7,714	7,714		7,714		7,714			41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* Non-allowable cost			101,967	101,967		101,967	(101,967)				43
44	TOTAL Special Cost Centers		732,821	212,384	945,205		945,205	(101,967)	843,238			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,752,754	1,346,279	5,292,142	11,391,175		11,391,175	(788,818)	10,602,357			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	(5,023)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,756)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,875)	43		19
20	Contributions	(6,365)	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	(6,417)	43		24
25	Fund Raising, Advertising and Promotional	(25,957)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,786)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(214,627)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (282,806)		\$	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)	(506,012)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (506,012)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (788,818)		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 LaGrangeID# 0038083Report Period Beginning: 01/01/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (12,233)	43	1
2	X-Rays-Part a	(30,943)	43	2
3	Diagnostics Managed Care	(1,368)	43	3
4	Marketing Salary	(163,585)	21	4
5	Trust Fees	(75)	43	5
6	Collections	(4,202)	19	6
7	Out of period	(2,221)	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
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(214,627)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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 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: 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 LaGrange Limited Partnership	**	\$ 200	\$	200	1
2	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	304,005		304,005	2
3	V	32 Interest Expense		Sambell of LaGrange Limited Partnership	**	370,098		370,098	3
4	V	32 Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	1,338		1,338	4
5	V	33 Property Taxes		Sambell of LaGrange Limited Partnership	**	152,800		152,800	5
6	V	34 Rental Expense	920,800	Sambell of LaGrange Limited Partnership	**			(920,800)	6
7	V	43 Trust Fees		Sambell of LaGrange Limited Partnership	**	75		75	7
8	V								8
9	V								9
10	V								10
11	V			**The owners of Lexington Health Care Center of LaGrange, Inc. owns 100% of Sambell of LaGrange Limited Partnership.					11
12	V								12
13	V								13
14	Total		\$ 920,800			\$ 828,516	\$ *	(92,284)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 273	\$	273	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,894		3,894	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	106		106	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	524		524	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	23,804		23,804	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	3,958		3,958	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	205		205	21	
22	V	6 Security service		Royal Management Corp.	**				22	
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	3,071		3,071	23	
24	V	10 Medical consultant		Royal Management Corp.	**	1,602		1,602	24	
25	V	10 Management allocation - salaries		Royal Management Corp.	**	23,398		23,398	25	
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,018		3,018	26	
27	V	17 Management allocation - salaries		Royal Management Corp.	**	24,186		24,186	27	
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	11,068		11,068	28	
29	V	19 Professional fees		Royal Management Corp.	**	5,637		5,637	29	
30	V	20 Dues & subscriptions		Royal Management Corp.	**	219		219	30	
31	V	23 Inservice Training		Royal Management Corp.	**	11		11	31	
32	V	20 Advertising - help wanted		Royal Management Corp.	**	173		173	32	
33	V	21 Management allocation - salaries		Royal Management Corp.	**	244,112		244,112	33	
34	V	21 Bank charges		Royal Management Corp.	**	4,905		4,905	34	
35	V	21 Office supplies & printing		Royal Management Corp.	**	6,923		6,923	35	
36	V	21 Postage		Royal Management Corp.	**	2,263		2,263	36	
37	V								37	
38	V	**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 363,350	\$ *	363,350	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.	**	\$ 6,771	\$ 6,771	
16	V	24 Travel & seminar		Royal Management Corp.	**	601	601	
17	V	25 Auto expense		Royal Management Corp.	**	9,856	9,856	
18	V	26 Insurance general		Royal Management Corp.	**	3,475	3,475	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	34,611	34,611	
20	V	30 Depreciation		Royal Management Corp.	**	30,590	30,590	
21	V	32 Interest		Royal Management Corp.	**	8,527	8,527	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	18	18	
23	V	33 Property taxes		Royal Management Corp.	**	2,879	2,879	
24	V	34 Rent expense		Royal Management Corp.	**	2,159	2,159	
25	V	35 Equipment rental		Royal Management Corp.	**	498	498	
26	V	17 Management fees	878,684	Royal Management Corp.	**		(878,684)	
27	V	35 Auto Lease		Royal Management Corp.	**	1,621	1,621	
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V	** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						
39	Total		\$ 878,684			\$ 101,606	\$ * (777,078)	

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

Lexington Health Care Center of LaGrange, Inc.
 Provider # 0038083
 FYE 1/1/09 - 12/31/09

Schedule B

VII. Related Parties
 Owners

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

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

Other Business Related Entities

<u>Eastgate Manor</u>	Algonquin	Supportive Living Facility
Vesta Management Group LLC	Lombard	Management Company
Sambell of LaGrange Ltd. Ptsp.	LaGrange	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 LaGrange

#

0038083

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	1.78	4.46	Salary	\$ 5,883	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	1.95	3.90	Salary	9,510	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	1.78	4.46	Salary	4,473	L17, C7	3
4											4
5	Jason Samatas	Officer	Admin/SNF ops	0.00	See Schedule 7A	2.79	5.57	Salary	4,320	L17,C7	5
6											6
7											7
8											8
9					Certain Individuals work in excess of 40 hours per week.						9
10											10
11											11
12											12
13								TOTAL	\$ 24,186		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2009

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	720658	10	\$ 4,909	\$	40,150	\$ 273	1
2	5	Utilities - gas & electric	720658	10	69,894		40,150	3,894	2
3	5	Utilities - water & sewer	720658	10	1,894		40,150	106	3
4	5	Utilities - maintenance office	720658	10	9,406		40,150	524	4
5	6	Management allocation - salaries	720658	10	427,259	427,259	40,150	23,804	5
6	6	Repairs & maintenance	720658	10	71,047		40,150	3,958	6
7	6	Scavenger & exterminating	720658	10	3,681		40,150	205	7
8	6	Security service	720658	10			40,150	0	8
9	7	Management allocation - employee	720658	10	55,118		40,150	3,071	9
10	10	Medical consultant	720658	10	28,762		40,150	1,602	10
11	10	Management allocation - salaries	720658	10	419,975	419,975	40,150	23,398	11
12	15	Management allocation - employee	720658	10	54,178		40,150	3,018	12
13	17	Management allocation - salaries	720658	10	434,122	434,122	40,150	24,186	13
14	19	Computer consultant & supplies	720658	10	198,663		40,150	11,068	14
15	19	Professional fees	720658	10	101,182		40,150	5,637	15
16	20	Dues & subscriptions	720658	10	3,923		40,150	219	16
17	23	Inservice Training	720658	10	193		40,150	11	17
18	20	Advertising - help wanted	720658	10	3,108		40,150	173	18
19	21	Management allocation - salaries	720658	10	4,381,596	4,381,596	40,150	244,112	19
20	21	Bank charges	720658	10	88,048		40,150	4,905	20
21	21	Office supplies & printing	720658	10	124,253		40,150	6,923	21
22	21	Postage	720658	10	40,624		40,150	2,263	22
23	21	Telephone	720658	10	121,527		40,150	6,771	23
24	24	Travel and Seminar	720658	10	10,782		40,150	601	24
25	TOTALS				\$ 6,654,144	\$ 5,662,952		\$ 370,722	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

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	\$ 40,150	\$ 9,856	1
2	26	Insurance general	Bed Days	720,658	10	62,379	40,150	3,475	2
3	27	Management allocation - employees	Bed Days	720,658	10	621,243	40,150	34,611	3
4	30	Depreciation	Bed Days	720,658	10	549,069	40,150	30,590	4
5	32	Interest	Bed Days	720,658	10	153,050	40,150	8,527	5
6	32	Amortization of mortgage costs	Bed Days	720,658	10	321	40,150	18	6
7	33	Property taxes	Bed Days	720,658	10	51,670	40,150	2,879	7
8	34	Rent expense	Bed Days	720,658	10	38,747	40,150	2,159	8
9	35	Equipment rental	Bed Days	720,658	10	8,933	40,150	498	9
10	35	Auto Lease	Bed Days	720,658	10	29,103	40,150	1,621	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	\$	\$ 94,234	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of LaGrange

0038083

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	X		Mortgage	Varies	4/30/07	\$ 6,022,000	\$ 5,758,426	5/1/17	0.0625	\$ 370,098	1							
2	Services II, LLC											2							
3												3							
4												4							
5							Interest on financing insurance premium				309	5							
Working Capital																			
6	JP Morgan Chase		X	Line of Credit	Various	4/30/07	600,000		5/1/10	Libor +1	3,488	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 6,622,000	\$ 5,758,426			\$ 373,895	9							
B. Non-Facility Related*																			
10										Amortization of loan costs	1,356	10							
11										Interest income offset	(10,756)	11							
12												12							
13										Allocated from management company	8,527	13							
14	TOTAL Non-Facility Related						\$	\$			\$ (873)	14							
15	TOTALS (line 9+line14)						\$ 6,622,000	\$ 5,758,426			\$ 373,022	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 LaGrange

0038083

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>40,000</u>	<u>1991</u>	<u>\$ 500,000</u>	<u>1</u>
2	<u>Allocated from Management Co.</u>			<u>9,735</u>	<u>2</u>
3	TOTALS	40,000		\$ 509,735	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

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	99		1992	1992	\$ 2,661,448	\$	35	\$ 76,041	\$ 76,041	\$ 1,330,723	4
5	10		1995	1995	79,363		10			79,363	5
6	1		2005	2005	2,321,014		21	110,524	110,524	497,360	6
7											7
8											8
	Improvement Type**										
9		Land Improvements	1992		1,152		20	58	58	1,009	9
10		Building Improvements	1992		2,714		31			2,714	10
11		Building Improvements	1993		2,901		35	83	83	1,409	11
12		Leasehold Improvements	1994		6,402		10			6,402	12
13		Leasehold Improvements - Corner Guards	1996		2,195		10			2,122	13
14		Wiring	1998		3,378		10			3,378	14
15		Resurface & Restripe Parking Lot	1998		3,753		10			3,753	15
16		Lobby Tile	1998		19,488		10			19,488	16
17		Resurface & Restripe Parking Lot	2000		1,997	200	10	200		1,898	17
18		Automatic Door	2000		1,300	130	10	130		1,235	18
19		Kitchen Rehab	2001		1,441	144	10	144		1,225	19
20		Infrared curtains for elevator	2001		3,000	300	10	300		2,550	20
21		Dining room, resident rooms, and corridors renovation	2002		150,083	7,505	20	7,505		53,156	21
22		Elevator upgrade	2002		5,398	540	10	540		4,139	22
23		Air conditioner compressor	2003		9,218	922	10	922		5,915	23
24		Sidewalk and fencing	2005		46,701	2,335	20	2,335		9,729	24
25		HVAC	2005		8,141	407	20	407		1,662	25
26		Wiring	2005		4,506	225	20	225		957	26
27		Lobby, lounge and reception renovations	2005		24,362	1,218	20	1,218		5,278	27
28		1st floor new dining room, floors, ceilings, wallcoverings, doors	2005		326,862		20	16,343	16,343	65,372	28
29		Wallcoverings	2005		10,822		5	2,164	2,164	9,919	29
30		Medical records room rehab	2006		19,739	987	20	987		2,961	30
31		Activity/PT Room Rehab	2006		1,158	58	20	58		174	31
32		Land scape enhancement	2006		8,726	582	15	582		1,940	32
33		Roof	2006		29,700	1,980	15	1,980		6,600	33
34		HVAC	2006		3,254	163	20	163		543	34
35		Plumbing and sprinkler system	2006		20,725	1,036	20	1,036		4,145	35
36		Laundry Combustion Air	2006		16,814	841	20	841		3,153	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

01/01/2009 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	Lobby/Lounge/Reception rehab	2006	\$ 14,033	\$ 1,403	10	\$ 1,403	\$	\$ 4,911	37
38	Cubicle curtains/drapery	2006	6,955	1,391	5	1,391		5,387	38
39	Cabinets/counters for 2nd FI library	2006	2,665	267	10	267		867	39
40	TCU rehab	2006	2,402	120	20	120		370	40
41	First floor remodel	2006	212,084		20	10,604	10,604	31,812	41
42	Kitchen rehab	2006	8,165	408	20	408		1,429	42
43	Bath fixtures-2nd floor	2006	2,076	208	10	208		797	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		529	44
45	Landscaping	2007	3,862	257	15	257		664	45
46	HVAC	2007	58,326	2,916	20	2,916		7,047	46
47	Common Areas Remodel	2007	2,059	206	10	206		532	47
48	First Floor Remodel	2007	6,517		20	326	326	896	48
49	Garage	2007	16,487	824	20	824		1,717	49
50	Land Improvements	2008	3,745	250	15	250		271	50
51	Parking lot-paving	2008	8,720	436	20	436		618	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		140	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	16,260	16,260	29,810	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	319	40	319		319	55
56	Irrigation System	2009	16,740	279	15	279		279	56
57	Landscaping	2009	10,321	172	15	172		172	57
58	Parking lot repairs	2009	3,500	102	20	102		102	58
59	HVAC Chiller	2009	2,594	54	20	54		54	59
60	Patio Pergola	2009	6,760	282	20	282		282	60
61	Stamped Concrete	2009	16,658	278	20	278		278	61
62	Fence	2009	4,084	17	20	17		17	62
63	Patio Wall	2009	8,212	103	20	103		103	63
64	HVAC Quick Connectors	2009	5,300	177	20	177		177	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,829,398	\$ 30,358		\$ 262,760	\$ 232,402	\$ 2,219,851	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		\$ 6,829,398	\$ 30,358		\$ 262,760	\$ 232,402	\$ 2,219,851	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Building - management company	2002	134,712		40	4,139	4,139	31,723	8
9	HVAC, electrical, security system - management company	2003	1,183		30	85	85	524	9
10	Key card system - management company	2004	186		20	10	10	50	10
11	VAV TX controls - management company	2005	57		20	3	3	14	11
12	Interior Signs-management company	2006	41		5	3	3	9	12
13	Building - management company	2008	4,474		5	354	354	422	13
14	Building - management company	2009	337		15	6	6	6	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,970,388	\$ 30,358		\$ 267,360	\$ 237,002	\$ 2,252,599	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 LaGrange

0038083

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	\$ 811,985	\$ 74,934	\$ 146,536	\$ 71,602	5	\$ 427,486	71
72	Current Year Purchases	79,904	5,866	5,866			5,866	72
73	Fully Depreciated Assets	178,159					178,159	73
74	Allocated from Mgmt Co.	148,133		22,838	22,838		107,745	74
75	TOTALS	\$ 1,218,181	\$ 80,800	\$ 175,240	\$ 94,440		\$ 719,256	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from Mgmt Co.			21,870		3,153	3,153		13,797	79
80	TOTALS			\$ 21,870	\$	\$ 3,153	\$ 3,153		\$ 13,797	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,720,174	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 111,158	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 445,753	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 334,595	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,985,652	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					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 10,488	92
93			93
94			94
95		\$ 10,488	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.			2,159			6
7	TOTAL			\$ 2,159			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: \$ 96,788 Description: Copier-\$4,121;Fax Machine-\$3,871;Med Equip-\$52,483;\$Oxygen-\$35,815;Alloc. Mgmt. Co.-\$498

(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	Allocated from Mgmt Co.			1,621	19
20					20
21	TOTAL		\$	\$ 1,621	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	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	\$	11,411	\$ 713,312	\$	11,411	\$ 713,312	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,887	128,613		1,887	128,613	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		16,251	908,138		16,251	908,138	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				732,821		732,821	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Dentist</u>	39(3)				2,025			2,025	12
13	Other (specify): <u>Ambulance</u>	39(3)				7,779			7,779	13
14	TOTAL			\$	29,549	\$ 1,759,867	\$ 732,821	29,549	\$ 2,492,688	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange# 0038083Report 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	\$ 7,663	\$ 31,073	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>359,990</u>)	1,461,654	1,461,654	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,985	82,985	6
7	Other Prepaid Expenses	60,166	60,166	7
8	Accounts Receivable (owners or related parties)		125,346	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,612,468	\$ 1,761,224	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,406	6,406	12
13	Land		509,735	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	835,573	4,308,940	15
16	Equipment, at Historical Cost	528,693	1,240,051	16
17	Accumulated Depreciation (book methods)	(520,438)	(2,985,652)	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 (spe CIP	10,488	10,488	22
23	Other(specify): <u>Mortgage cost net</u>		30,229	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 860,722	\$ 5,781,645	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,473,190	\$ 7,542,869	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 260,820	\$ 260,820	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	261,362	261,362	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,008	3,008	31
32	Accrued Real Estate Taxes(Sch.IX-B)		225,600	32
33	Accrued Interest Payable		32,120	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	446,358	941,093	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 971,548	\$ 1,724,003	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,758,426	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,758,426	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 971,548	\$ 7,482,429	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,501,642	\$ 60,440	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,473,190	\$ 7,542,869	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of LaGrange
FYE 12/31/09
Provider # 0038083
Schedule 17A

XV. Balance Sheet

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Interest Rate Swap Liability		670,091
Accrued Expenses	50,847	50,847
Accrued Royl Gen mgmt	38,191	38,191
Accrued Rent	175,356	
Due to Patient Trust Fund	4,105	4,105
Deffered Income	159,257	159,257
Due to Royal Operating	17,435	17,435
Due to Bloomingdale	409	409
Due to Lombard	758	758
	<u>446,358</u>	<u>941,093</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,167,528	1
2	Restatements (describe):		2
3	Post closing adjustments	(93,869)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,073,659	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,642,983	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,215,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 427,983	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)	\$ 1,501,642	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange# 0038083Report 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	\$ 11,727,110	1
2	Discounts and Allowances for all Levels	(4,628,862)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,098,248	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,498,000	6
7	Oxygen	29,155	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,527,155	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	8,705	12
13	Barber and Beauty Care	26,843	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	840,057	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	159,316	19
20	Radiology and X-Ray		20
21	Other Medical Services	363,088	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,398,009	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,379	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,379	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Recovery of write off</u>	367	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 367	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,034,158	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,265,907	31
32	Health Care	5,749,974	32
33	General Administration	2,298,044	33
B. Capital Expense			
34	Ownership	1,132,045	34
C. Ancillary Expense			
35	Special Cost Centers	880,052	35
36	Provider Participation Fee	65,153	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,391,175	40
41	Income before Income Taxes (line 30 minus line 40)**	1,642,983	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,642,983	43

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

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

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

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

Facility Name & ID Number **Lexington of LaGrange**

0038083

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,681	1,943	\$ 104,442	\$ 53.75	1
2	Assistant Director of Nursing	9,534	10,164	345,413	33.98	2
3	Registered Nurses	36,914	39,500	1,188,376	30.09	3
4	Licensed Practical Nurses	18,933	20,257	492,119	24.29	4
5	CNAs & Orderlies	67,268	71,011	802,454	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,683	9,502	130,862	13.77	8
9	Activity Director					9
10	Activity Assistants	16,231	17,704	208,930	11.80	10
11	Social Service Workers	14,082	14,990	242,695	16.19	11
12	Dietician	8,209	8,717	83,530	9.58	12
13	Food Service Supervisor	2,029	2,209	55,882	25.30	13
14	Head Cook	2,086	2,209	36,860	16.69	14
15	Cook Helpers/Assistants	6,541	6,924	70,782	10.22	15
16	Dishwashers	11,062	11,684	94,387	8.08	16
17	Maintenance Workers	1,970	2,248	39,208	17.44	17
18	Housekeepers	27,311	29,597	268,459	9.07	18
19	Laundry	6,269	6,884	59,443	8.63	19
20	Administrator	1,460	1,741	95,596	54.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,694	26,796	399,531	14.91	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	1,813	2,059	33,785	16.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	266,770	286,139	\$ 4,752,754 *	\$ 16.61	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	192	\$ 12,251	1(3)	35
36	Medical Director	Monthly	47,000	9(3)	36
37	Medical Records Consultant	36	1,994	10(3)	37
38	Nurse Consultant	Monthly	23,719	10(3)	38
39	Pharmacist Consultant	Monthly	6,540	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	4,606	11(3)	44
45	Social Service Consultant	97	4,885	12(3)	45
46	Other(specify) <u>Psychosocial</u>	48	2,292	12(3)	46
47	<u>Clinical Consultant</u>	Monthly	6,707	10(3)	47
48	<u>Medical Consultant</u>	Monthly	1,602	10(7)	48
49	TOTAL (lines 35 - 48)	465	\$ 111,596		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 713	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 713		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jeffrey Baker	Administrator	0%	\$ 81,333	Workers' Compensation Insurance	\$ 66,702	IDPH License Fee	\$ 1,990	
Christopher Correll	Administrator	0%	6,625	Unemployment Compensation Insurance	44,254	Advertising: Employee Recruitment	32,497	
Nicholas Papp	Administrator	0%	7,638	FICA Taxes	348,696	Health Care Worker Background Check	0	
				Employee Health Insurance	136,481	(Indicate # of checks performed <u>64</u>)	767	
				Employee Meals	13,271	Patient Background Checks <u>436.2</u>	5,234	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	997	
				<u>401K</u>	<u>9,355</u>	Allocated from Mgmt Co.	392	
				Other Employee Benefits	22,266			
				Uniform Allowance	876			
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 95,596			Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Management Fees-Royal Operating			\$ 487,915	\$ 641,901			\$ 41,877	
Management Fees-Royal General			390,769					
(Eliminated on page 3,C7,L17)								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 878,684					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Grabowski Law Center	Collections		\$ 4,122	N/A			Out-of-State Travel	\$
Aronberg Goldgehn	401K Audit		9					
Cassiday Schade & Gloor LLP	Legal		7,431				In-State Travel	
Chicago Legal Clinic	Legal		894					
Freedman Anselmo Lindberg	Collections		80					
James Samatas	Legal		100				Seminar Expense	6,298
Serpico,Petrosino & Dipiero, LTD	Legal		4,286				Allocated from Mgmt. Co.	601
McGladrey & Pullen	Accounting		22,896					
Much Shelist	Legal		1,798				Entertainment Expense	()
Pension Administrators,Inc.	401 Administration		806				(agree to Sch. V, line 24, col. 8)	
Personnel Planners	U/C Consulting		1,140				TOTAL	\$ 6,899
See Schedule 21C			30,473					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 74,034	\$				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

C. Professional Fees

Schedule 21C

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Reed Smith/Sachnoff & Weaver	Legal	188
RSM McGladrey	Accounting	7,385
Action Computer Service	Computer Consulting	597
B2B Computer	Computer Consulting	46
Lintech LLC	Computer Consulting	4,311
National Datacare	Computer Consulting	791
E-Health Data Solutions	Computer Consulting	2,400
C.D.W. Direct	Computer Consulting	606
Krakau Business	Computer Consulting	319
Healthware Consulting	Computer Consulting	1,415
Information Control	Computer Consulting	1,228
Microsoft2	Computer Consulting	4,389
SilverChair Learning Systems	Computer Consulting	4,200
Lanac Technology	Computer Consulting	1,682
Vision Share, Inc.	Computer Consulting	792
Visual Click Software	Computer Consulting	124
		<u>30,473</u>
Total Schedule V, line 19, column 3		74,034
Less collection fees		(4,202)
Out of period legal		(2,221)
Allocated from Sambell of LaGrange James Samatas		200
Samvest of Lombard II Legal		119
Accounting		51
		<u>170</u>
Allocated from Mgmt Co. James Samatas	Legal	32
Reed Smith	Legal	1,322
Much Shelist	Legal	833
Serpico,Petrosino, Dipiero	Legal	6
McGladrey & Pullen	Accounting	404
RSM McGladrey	Accounting	312
Aronberg,Goldgehn Davis	401K Administration	1
LaSalle Network	Accounting	527
Gilson Labus & Silverman	Accounting	263
KMZ Rosenmann	Legal	964
ING Life Annuity	401K Administration	64
Pension Administration, Inc.	401K Administration	281
Personnel Planners, Inc.	Unemployment Consulting	17
Gene Whitehorn	Medicaid Reimb Specialist	441
Computer service	Computer Service	11,068
		<u>16,535</u>
Total Schedule V, line 19 column 8		<u>84,516</u>

See Accountant's 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
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 LaGrange

0038083

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. \$ 28,800 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 No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,153
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,271 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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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