

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	166	Skilled (SNF)	166	60,590	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			13,898	13,898		8
9	SNF/PED						9
10	ICF	32,675	6,829		39,504		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	32,675	6,829	13,898	53,402		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.14%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/01/89

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 166 and days of care provided 8,657

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: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	355,977	28,156	18,292	402,425		402,425		402,425		1
2	Food Purchase		258,783		258,783		258,783	(13,149)	245,634		2
3	Housekeeping	295,212	29,039		324,251		324,251	311	324,562		3
4	Laundry	61,754	18,066		79,820		79,820		79,820		4
5	Heat and Other Utilities			208,437	208,437		208,437	8,006	216,443		5
6	Maintenance	34,199		147,968	182,167		182,167	50,080	232,247		6
7	Other (specify):* Mgmt Co.-Allocated B							5,407	5,407		7
8	TOTAL General Services	747,142	334,044	374,697	1,455,883		1,455,883	50,655	1,506,538		8
	B. Health Care and Programs										
9	Medical Director			7,875	7,875		7,875		7,875		9
10	Nursing and Medical Records	3,198,454	267,025	39,516	3,504,995		3,504,995	49,158	3,554,153		10
10a	Therapy			1,034,304	1,034,304		1,034,304		1,034,304		10a
11	Activities	214,847	21,382	7,827	244,056		244,056		244,056		11
12	Social Services	197,905		47,437	245,342		245,342		245,342		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co.-Allocated B							6,738	6,738		15
16	TOTAL Health Care and Programs	3,611,206	288,407	1,136,959	5,036,572		5,036,572	55,896	5,092,468		16
	C. General Administration										
17	Administrative	124,710		1,052,082	1,176,792		1,176,792	(1,030,269)	146,523		17
18	Directors Fees										18
19	Professional Services			102,642	102,642		102,642	14,202	116,844		19
20	Dues, Fees, Subscriptions & Promotions			61,064	61,064		61,064	6,863	67,927		20
21	Clerical & General Office Expenses	301,961	35,586	30,218	367,765		367,765	343,892	711,657		21
22	Employee Benefits & Payroll Taxes			680,592	680,592		680,592	13,149	693,741		22
23	Inservice Training & Education			11,621	11,621		11,621	856	12,477		23
24	Travel and Seminar			8,828	8,828		8,828	(1,701)	7,127		24
25	Other Admin. Staff Transportation			1,792	1,792		1,792	16,235	18,027		25
26	Insurance-Prop.Liab.Malpractice			212,066	212,066		212,066	3,314	215,380		26
27	Other (specify):* Mgmt Co.-Allocated B							59,273	59,273		27
28	TOTAL General Administration	426,671	35,586	2,160,905	2,623,162		2,623,162	(574,186)	2,048,976		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,785,019	658,037	3,672,561	9,115,617		9,115,617	(467,635)	8,647,982		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington Health Care Center-Bloomington #0035188 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			165,514	165,514		165,514	295,798	461,312			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,953	14,953		14,953	306,723	321,676			32
33	Real Estate Taxes							131,917	131,917			33
34	Rent-Facility & Grounds			1,207,266	1,207,266		1,207,266	(1,204,005)	3,261			34
35	Rent-Equipment & Vehicles			43,281	43,281		43,281	2,615	45,896			35
36	Other (specify):*											36
37	TOTAL Ownership			1,431,014	1,431,014		1,431,014	(466,952)	964,062			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		328,038		328,038		328,038		328,038			39
40	Barber and Beauty Shops			19,718	19,718		19,718		19,718			40
41	Coffee and Gift Shops			3,036	3,036		3,036		3,036			41
42	Provider Participation Fee			90,885	90,885		90,885		90,885			42
43	Other (specify):* Non-Allowable Cos			88,473	88,473		88,473	(88,473)				43
44	TOTAL Special Cost Centers		328,038	202,112	530,150		530,150	(88,473)	441,677			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,785,019	986,075	5,305,687	11,076,781		11,076,781	(1,023,060)	10,053,721			45

*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

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	(5,369)	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	2,173	30		9
10	Interest and Other Investment Income	(61,432)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,307)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,000)	43		18
19	Entertainment				19
20	Contributions	(2,875)	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	(20,983)	43		24
25	Fund Raising, Advertising and Promotional	(30,184)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,014)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(349,601)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (474,592)		\$	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)	(548,468)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (548,468)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,023,060)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center-Bloomington

ID# 0035188

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Radiology	\$ (12,108)	43	1
2	Laboratory	(10,633)	43	2
3	Personal Item Replacement	(492)	43	3
4	Trust Fees	(50)	43	4
5	Collection Fees	(2,796)	19	5
6	Nonallowable Marketing Salaries	(62,310)	21	6
7	Out of period legal	(627)	19	7
8	Reclass LHI to Repairs and Maintenance	6,714	6	8
9	Education and training marketing	(3,230)	24	9
10	Unrealized loss on FMV swap	(264,069)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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40				40
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(349,601)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule B		See Attached Schedule B		See Attached Schedule B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Fees	\$	Sambell of Bloomingtondale Limited Partnership	**	\$ 200	\$ 200	1
2	V							2
3	V	30 Depreciation Expense		Sambell of Bloomingtondale Limited Partnership	**	256,358	256,358	3
4	V	32 Interest		Sambell of Bloomingtondale Limited Partnership	**	352,612	352,612	4
5	V	32 Amortization of Mortgage Cost		Sambell of Bloomingtondale Limited Partnership	**	2,171	2,171	5
6	V	33 Property Tax		Sambell of Bloomingtondale Limited Partnership	**	127,266	127,266	6
7	V	34 Rent	1,207,266	Sambell of Bloomingtondale Limited Partnership	**		(1,207,266)	7
8	V	43 Trust Fees		Sambell of Bloomingtondale Limited Partnership	**	50	50	8
9	V	43 State Replacement Tax		Sambell of Bloomingtondale Limited Partnership	**	492	492	9
10	V	43 Unrealized loos on FMV of Swap		Sambell of Bloomingtondale Limited Partnership	**	264,069	264,069	10
11	V							11
12	V			** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc. own 100% of Sambell of Bloomingtondale Limited Partnership				12
13	V							13
14	Total		\$ 1,207,266			\$ 1,003,218	\$ * (204,048)	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.	**	\$ 311	\$	311	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,115		7,115	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	202		202	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	689		689	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	36,394		36,394	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	6,647		6,647	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	325		325	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,407		5,407	22	
23	V	10 Medical consultant		Royal Management Corp.	**	3,806		3,806	23	
24	V	10 Management allocation - salaries		Royal Management Corp.	**	45,352		45,352	24	
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	6,738		6,738	25	
26	V	17 Management allocation - salaries		Royal Management Corp.	**	21,813		21,813	26	
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	12,056		12,056	27	
28	V	19 Professional fees		Royal Management Corp.	**	5,369		5,369	28	
29	V	20 Dues & subscriptions		Royal Management Corp.	**	543		543	29	
30	V	20 Advertising - help wanted		Royal Management Corp.	**	6,320		6,320	30	
31	V	21 Management allocation - salaries		Royal Management Corp.	**	377,146		377,146	31	
32	V	21 Bank charges		Royal Management Corp.	**	7,469		7,469	32	
33	V	21 Office supplies & printing		Royal Management Corp.	**	9,831		9,831	33	
34	V	21 Postage		Royal Management Corp.	**	3,532		3,532	34	
35	V								35	
36	V								36	
37	V	**Certaub owners of Lexington Health Care Center of Bloomingtondale, Inc. own 100% of Sambell Bloomingtondale Partnership								37
38	V								38	
39	Total		\$			\$ 557,065	\$ *	557,065	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.	**	\$ 8,224	\$ 8,224	
16	V	24 Travel & seminar		Royal Management Corp.	**	1,529	1,529	
17	V	25 Auto expense		Royal Management Corp.	**	16,235	16,235	
18	V	26 Insurance general		Royal Management Corp.	**	3,314	3,314	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	59,273	59,273	
20	V	30 Depreciation		Royal Management Corp.	**	37,267	37,267	
21	V	32 Interest		Royal Management Corp.	**	13,343	13,343	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	29	29	
23	V	33 Property taxes		Royal Management Corp.	**	4,651	4,651	
24	V	34 Rent expense		Royal Management Corp.	**	3,261	3,261	
25	V	35 Equipment rental		Royal Management Corp.	**	969	969	
26	V	17 Management fees	1,052,082	Royal Management Corp.	**		(1,052,082)	
27	V	35 Auto Lease		Royal Management Corp.	**	1,646	1,646	
28	V	23 Inservice Training		Royal Management Corp.	**	856	856	
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V	**Certaub owners of Lexington Health Care Center of Bloomingtondale, Inc. own 100% of Sambell Bloomingtondale Partnership						
37	V							
38	V							
39	Total		\$ 1,052,082			\$ 150,597	\$ * (901,485)	

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

Lexington Health Care Center of Bloomingdale, Inc.

Provider # 0035188

1/1/10-12/31/10

Schedule B

VII. Related Parties

Owners

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

VII. Related Parties

Related Nursing Homes

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

Other Business Related Entities

Eastgate Manor	Algonquin	Supportive Living Facility
Vesta Management Group LLC	Lombard	Management Company
Sambell of Bloomingdale LP	Bloomingtondale	Real Estate Property
Royal Management Corporation	Lombard	Management Company
Lexington Financial Services II, LLC	Lombard	Finance Company
Lexington Square Life Care of Lombard, LLC	Lombard	Independent and Assisted Living
Samvest of Lombard II, LP	Lombard	Hotel

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	See Sch 7B	See Sch 7B	Salary	\$ 7,875	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,788	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,149	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,045	L21, C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,857		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

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	718,010	10	\$ 3,682	\$ 60,590	\$ 311	1	
2	5	Utilities - gas & electric	Bed Days	718,010	10	84,318	60,590	7,115	2	
3	5	Utilities - water & sewer	Bed Days	718,010	10	2,399	60,590	202	3	
4	5	Utilities - maintenance office	Bed Days	718,010	10	8,161	60,590	689	4	
5	6	Management allocation - salaries	Bed Days	718,010	10	431,278	431,278	60,590	36,394	5
6	6	Repairs & maintenance	Bed Days	718,010	10	78,772	60,590	6,647	6	
7	6	Scavenger & exterminating	Bed Days	718,010	10	3,848	60,590	325	7	
8	7	Management allocation - employees	Bed Days	718,010	10	64,074	60,590	5,407	8	
9	10	Medical consultant	Bed Days	718,010	10	45,100	60,590	3,806	9	
10	10	Management allocation - salaries	Bed Days	718,010	10	537,439	537,439	60,590	45,352	10
11	15	Management allocation - employees	Bed Days	718,010	10	79,846	60,590	6,738	11	
12	17	Management allocation - salaries	Bed Days	718,010	10	258,489	258,489	60,590	21,813	12
13	19	Computer consultant & supplies	Bed Days	718,010	10	142,872	60,590	12,056	13	
14	19	Professional fees	Bed Days	718,010	10	63,628	60,590	5,369	14	
15	20	Dues & subscriptions	Bed Days	718,010	10	6,440	60,590	543	15	
16	20	Advertising - help wanted	Bed Days	718,010	10	74,892	60,590	6,320	16	
17	21	Management allocation - salaries	Bed Days	718,010	10	4,469,291	4,469,291	60,590	377,146	17
18	21	Bank charges	Bed Days	718,010	10	88,508	60,590	7,469	18	
19	21	Office supplies & printing	Bed Days	718,010	10	116,497	60,590	9,831	19	
20	21	Postage	Bed Days	718,010	10	41,854	60,590	3,532	20	
21	21	Telephone	Bed Days	718,010	10	97,454	60,590	8,224	21	
22	24	Travel and Seminar	Bed Days	718,010	10	18,117	60,590	1,529	22	
23									23	
24									24	
25	TOTALS					\$ 6,716,959	\$ 5,696,497	\$ 566,818	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	718,010	10	\$ 192,388	\$ 60,590	\$ 16,235	1
2	26	Insurance general	Bed Days	718,010	10	39,272	60,590	3,314	2
3	27	Management allocation - employees	Bed Days	718,010	10	702,398	60,590	59,273	3
4	30	Depreciation	Bed Days	718,010	10	441,627	60,590	37,267	4
5	32	Interest	Bed Days	718,010	10	158,122	60,590	13,343	5
6	32	Amortization of mortgage costs	Bed Days	718,010	10	346	60,590	29	6
7	33	Property taxes	Bed Days	718,010	10	55,117	60,590	4,651	7
8	34	Rent expense	Bed Days	718,010	10	38,647	60,590	3,261	8
9	35	Equipment rental	Bed Days	718,010	10	11,478	60,590	969	9
10	35	Auto Lease	Bed Days	718,010	10	19,500	60,590	1,646	10
11	23	Inservice Training	Bed Days	718,010	10	10,139	60,590	856	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					\$ 1,669,034	\$	\$ 140,844	25

SEE ACCOUNTANTS' COMPILATION REPORT

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					\$		\$		\$	1								
2	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,375,000	6,045,885	1/1/2033	Variable	352,612	2							
3												3							
4												4							
5							Interest on financing insurance premium				2,018	5							
Working Capital																			
6	LaSalle Bank N.A.		X	Working Capital	Varies	4/6/02	1,300,000		6/30/11	Prime/Libor	3,300	6							
7	Shareholder	X		Capital Improvements	Varies	6/29/10	783,500	783,500	12/1/13	Prime +1%	9,635	7							
8												8							
9	TOTAL Facility Related						\$ 8,458,500	\$ 6,829,385			\$ 367,565	9							
B. Non-Facility Related*																			
10										Amortization of mortgage costs	2,200	10							
11										Interest Income offset	(51,797)	11							
12										Management company allocation	13,343	12							
13										Non-allowable shareholder interest	(9,635)	13							
14	TOTAL Non-Facility Related						\$	\$			\$ (45,889)	14							
15	TOTALS (line 9+line14)						\$ 8,458,500	\$ 6,829,385			\$ 321,676	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	136,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	\$	129,666	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,134)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	134,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	Allocated from Mgmt. Co.		4,651	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	131,917	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	131,254	8
	2006	129,132	9
	2007	126,167	10
	2008	128,400	11
	2009	129,666	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

[See attached real estate accrual sheet](#)

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Bloomingtondale COUNTY Dupage
 FACILITY IDPH LICENSE NUMBER 0035188
 CONTACT PERSON REGARDING THIS REPORT Karen Gillis
 TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>02-15-401-003</u>	<u>Land & Building</u>	\$ <u>129,666.46</u>	\$ <u>129,666.46</u>
2.	<u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>227,778.00</u>	\$ <u>4,651.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>357,444.46</u></u>	\$ <u><u>134,317.46</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>16,555</u>	<u>2</u>
3	TOTALS	43,000		\$ 419,103	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82		1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 1,845,826	4
5	9		1992	1992	178,974		35	5,114	5,114	97,160	5
6	75		1994	1994	2,022,894		35	57,797	57,797	953,649	6
7											7
8											8
	Improvement Type**										
9		Capitalized repairs	1989		9,080		10			9,080	9
10		Building Improvements	1990		3,674		10			3,674	10
11		Building Improvements	1991		2,586		10			2,586	11
12		Building Improvements	1992		3,154		10			2,997	12
13		Building Improvements	1993		1,582		10			1,503	13
14		Building Improvements	1994		15,734		10			15,734	14
15		Land Improvements	1994		1,381		10			1,381	15
16		Land Improvements	1995		1,074		15	30	30	1,068	16
17		Building Improvements	1995		1,288		35	37	37	588	17
18		Building Improvements	1995		9,433	270	35	270		4,185	18
19		Building Improvements	1995		43,839	1,252	35	1,252		19,407	19
20		Concrete flooring, fire doors, tile, sprinkler heads, and basement renovation	1996		8,706		15			3,606	21
22		Land improvements	1996		7,858		15	524	524	7,597	22
23											23
24		Resident room heaters	1997		3,563	102	35	102		1,426	24
25		Automatic doors	1997		12,950	370	35	370		4,841	25
26		Basement renovation	1997		59,358		10			59,358	26
27		Land Improvement - outdoor flagpoles	1997		1,574	105	15	105		1,416	27
28		1st Floor Remodel (Nurses Station/Lounge)	1998		76,487		10			76,487	28
29		Wiring for MDS	1998		4,506		10			4,506	29
30		Flag Pole	1998		787		10			787	30
31		Resurface/Stripe Parking Lot	1998		9,777		10			9,777	31
32		Kitchen tile/paint	1999		718		10			718	32
33		1st Floor Remodel	1999		3,296		10			3,296	33
34		Roof repairs	2000		5,748	383	15	383		4,023	34
35		Sump pump	2000		2,534	127	10	127		2,534	35
36		Sump pump basin repair	2000		6,307	315	10	315		6,307	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic door closers	2000	\$ 1,300	\$ 87	15	\$ 87		\$ 911	37
38	Infrared curtains for elevator doors	2001	3,000	300	10	300		2,850	38
39	Ejector pump	2002	3,050		5			3,050	39
40	Lift station pump	2002	3,359		5			3,359	40
41	New asphalt parking lot	2003	16,450	1,645	10	1,645		11,789	41
42	Roof repairs	2003	2,900	290	10	290		2,054	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		1,485	43
44	Kitchen remodel	2003	7,188	359	20	359		2,665	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		23,806	45
46	Floor tile	2003	16,305	815	20	815		6,522	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		26,837	47
48	Rehab-floor tile	2003	8,117	406	20	406		2,875	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		15,123	49
50	Foundation repair	2003	4,800	240	20	240		1,780	50
51	Parking lot	2004	24,550	2,455	10	2,455		15,753	51
52	Kitchen walk-in cooler floor	2004	7,161	716	10	716		4,535	52
53	Old Towne rehab	2004	13,967	698	20	698		4,364	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		63,552	54
55	Create first floor therapy room	2004	185	9	20	9		36	55
56	Transitional unit	2005	213	11	20	11		43	56
57	Landscaping	2005	8,814	441	20	441		2,278	57
58	Roof repairs	2005	3,250	163	20	163		841	58
59	HVAC upgrade	2005	7,048	352	20	352		1,879	59
60	Kitchen repair	2005	1,631	82	20	82		449	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		4,975	61
62	Window treatments	2005	3,606	479	5	479		3,606	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		2,149	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		10,536	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		9,296	65
66	Basement renovation	2005	14,176	709	20	709		3,544	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,126,921	\$ 37,987		\$ 186,681	\$ 148,694	\$ 3,378,459	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,126,921	\$ 37,987		\$ 186,681	\$ 148,694	\$ 3,378,459	1
2	Landscaping Enhancement	2006	7,084	472	15	472		2,046	2
3	Install Kitchen Sink	2006	2,915	146	20	146		693	3
4	Common area rehab	2006	2,382	119	20	119		556	4
5	Paint Building Exterior	2006	19,500	3,900	5	3,900		17,225	5
6	Patio	2006	53,305	3,554	15	3,554		14,511	6
7	Retaining Wall	2007	2,950	197	15	197		722	7
8	Roof Repair	2007	17,050	853	20	853		3,198	8
9	Air Conditioning units	2007	4,338	217	20	217		850	9
10	Paver walk and stairway	2007	10,500	525	20	525		1,925	10
11	Fire exit stairways	2007	9,379	469	20	469		1,485	11
12	Landscaping	2008	35,147	2,343	15	2,343		4,881	12
13	Parking Lot - Seal & Striping	2008	6,460	323	20	323		808	13
14	Roof	2008	15,300	765	20	765		2,040	14
15	HVAC - Spot Coolers	2008	5,589	140	40	140		280	15
16	Electrical - Storage Room	2008	4,768	238	20	238		575	16
17	Electrical - Fire Alarm Panel	2008	118,395	5,920	20	5,920		12,333	17
18	1st floor remodel-Carpentry,Flooring,Electrical,Parking fixtures	2008	557,202		27	20,262	20,262	54,032	18
19	Lawn Irrigation	2009	14,435	962	15	962		1,283	19
20	Landscaping	2009	12,950	863	15	863		1,007	20
21	Roof	2009	49,330	2,467	20	2,467		2,878	21
22	Front Entrance	2009	19,392	485	40	485		566	22
23	HVAC-Window unit	2009	41,315	4,131	10	4,131		7,230	23
24	HVAC Quick connectors	2009	7,058	706	10	706		1,235	24
25	Lift pump	2009	14,783	1,478	10	1,478		1,724	25
26	Fire alarm panel	2009	93,279	4,664	20	4,664		5,053	26
27	Pantry Cabinets	2009	3,523	352	10	352		411	27
28	Therapy Room counter tops-carpentry	2009	2,500	250	10	250		438	28
29	Patio Pergola	2009	7,930	397	20	397		529	29
30	Patio Stamped Concrete	2009	13,901	927	15	927		1,313	30
31	Lobby 1st floor remodel-Carpentry,doors frames,electrical	2009	52,018		27	1,892	1,892	1,892	31
32	painting,wallpaper								32
33	OT Remodel-carpentry,electrical	2010	791,224		27	10,371	10,371	10,371	33
34	TOTAL (lines 1 thru 33)		\$ 8,122,823	\$ 75,850		\$ 257,069	\$ 181,219	\$ 3,532,549	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 Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,122,823	\$ 75,850		\$ 257,069	\$ 181,219	\$ 3,532,549	1
2									2
3	Lawn irrigation system	2010	5,503	183	15	183		183	3
4	Roof work	2010	15,268	278	27	278		278	4
5	HVAC Chiller	2010	84,004	511	27	511		511	5
6	Pantry-shelves	2010	23,805	362	27	362		362	6
7	Wanderguard	2010	3,747	34	27	34		34	7
8	Concrete work	2010	7,080	43	27	43		43	8
9	Automatic Doors	2010	4,903	245	10	245		245	9
10	Physician office update	2010	4,677	14	27	14		14	10
11	Library/Lounge-art, painting	2010	13,763	126	27	126		126	11
12	Pergola and patio wall	2010	21,186	2,318	27	2,318		2,318	12
13	Office changes	2010	5,744	35	27	35		35	13
14									14
15	Reconcile to book depreciation			428					15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	Building - management company	2002	229,085		40	6,757	6,757	60,761	25
26	HVAC, electrical, security system - management company	2003	2,012		30	361	361	1,031	26
27	Key card system - management company	2004	316		20	16	16	100	27
28	VAV TX controls - management company	2005	96		20	5	5	28	28
29	Interior Signs - management company	2006	70		5	5	5	19	29
30	Building improvements - management company	2008	7,608		5	577	577	1,300	30
31	Building improvements - management company	2009	572		15	38	38	48	31
32	Building improvements - management company	2010	690		15	55	55	55	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,552,952	\$ 80,427		\$ 269,032	\$ 189,033	\$ 3,600,040	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 978,071	\$ 75,015	\$ 150,170	\$ 75,155	5	\$ 585,235	71
72	Current Year Purchases	202,939	10,072	12,655	2,583	5	12,655	72
73	Fully Depreciated Assets	87,863				5	87,863	73
74	Allocated from Mgmt Co.	243,538		24,655	24,655	5	191,472	74
75	TOTALS	\$ 1,512,411	\$ 85,087	\$ 187,480	\$ 102,393		\$ 877,225	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.			35,878		4,800	4,800	5	25,256	79
80	TOTALS			\$ 35,878	\$	\$ 4,800	\$ 4,800		\$ 25,256	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,520,344	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 165,514	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 461,312	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 295,798	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,502,521	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	Floor and Room	13,572	93
94	FFE Remodel	1,728	94
95		\$ 15,300	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	Allocated from Management Company			3,261			6
7	TOTAL			\$ 3,261			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: \$ 44,250 Description: Copier-\$8,509, Mailing System-\$60, Medical Equip.-\$15,731, Oxygen Equip.-\$18,981, Mgmt. Co.-\$969

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Management Company			1,646	20
21	TOTAL		\$	\$ 1,646	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. _____/2011 \$ _____

13. _____/2012 \$ _____

14. _____/2013 \$ _____

* 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	\$	5,168	\$ 318,898	\$	5,168	\$ 318,898	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,406	166,385		2,406	166,385	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		10,222	549,021		10,222	549,021	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				328,038		328,038	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	17,796	\$ 1,034,304	\$ 328,038	17,796	\$ 1,362,342	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	\$ 1,307,087	\$ 1,336,074	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>189,638</u>)	881,291	881,291	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,599	18,599	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	51,788	1,786,237	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,258,765	\$ 4,022,201	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,261	64,261	12
13	Land		419,103	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	1,707,484	3,370,221	15
16	Equipment, at Historical Cost	710,978	1,548,289	16
17	Accumulated Depreciation (book methods)	(970,169)	(4,502,521)	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)	15,300	15,300	22
23	Other(specify): <u>Mort Cost / Accum Amort Mort C</u>		48,599	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,527,854	\$ 6,145,983	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,786,619	\$ 10,168,184	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 470,017	\$ 470,017	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		783,500	29
30	Accrued Salaries Payable	433,965	433,965	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,258	4,258	31
32	Accrued Real Estate Taxes(Sch.IX-B)		134,400	32
33	Accrued Interest Payable		29,248	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	906,573	1,627,637	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,814,813	\$ 3,483,025	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,045,885	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,045,885	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,814,813	\$ 9,528,910	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,971,806	\$ 639,274	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,786,619	\$ 10,168,184	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/10-12/31/10

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to Royal Excess Earnings	-	22,559
Due to Royal	-	10,392
Due to Lex Fin SVCS		51,067
Due From LHCC Elmhurst		1,558
Due to/from Rehab Care Therapy	25,075	25,075
Due from Lombard Square	2,145	2,145
Accrued Roysl/Vesta Mgmt. Fees	3,648	3,648
Due to patient trust fund	22,640	22,640
Due to Royal Operations	33,089	33,089
Due to Republic Construction of Illinois, Inc.	13,559	13,559
Accrued Expenses	18,795	18,795
Due to Bloomingdale	313,000	313,000
Accrued Rent	271,370	-
Deferred Income	234,980	234,980
Interest Rate Swap	-	906,858
Due to LaGrange	5,668	5,668
Advance Bi-weekly part A payments	(20,846)	(20,846)
Uncollectible part A Co. Pvts	(16,550)	(16,550)
	<u>906,573</u>	<u>1,627,637</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,343,380	1
2	Restatements (describe):		2
3	Post closing adjustment	(47,005)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,296,375	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	675,431	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)	\$ 675,431	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)	\$ 1,971,806	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington# 0035188Report Period Beginning: 01/01/2010Ending: 12/31/2010**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	\$ 14,864,817	1
2	Discounts and Allowances for all Levels	(6,023,138)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,841,679	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,330,570	6
7	Oxygen	9,979	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,340,549	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	3,129	12
13	Barber and Beauty Care	21,081	13
14	Non-Patient Meals	222	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	318,228	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	64,708	19
20	Radiology and X-Ray		20
21	Other Medical Services	161,025	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 568,393	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,081	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,081	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	(490)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (490)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,752,212	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,455,883	31
32	Health Care	5,036,572	32
33	General Administration	2,623,162	33
B. Capital Expense			
34	Ownership	1,431,014	34
C. Ancillary Expense			
35	Special Cost Centers	439,265	35
36	Provider Participation Fee	90,885	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,076,781	40
41	Income before Income Taxes (line 30 minus line 40)**	675,431	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 675,431	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.
Entity is 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 Health Care Center-Bloomington**

0035188

Report Period Beginning: **01/01/2010**

Ending:

12/31/2010

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	2,120	2,256	\$ 113,943	\$ 50.51	1
2	Assistant Director of Nursing	7,880	8,643	287,574	33.27	2
3	Registered Nurses	28,610	31,840	978,309	30.73	3
4	Licensed Practical Nurses	18,933	21,127	489,729	23.18	4
5	CNAs & Orderlies	96,366	103,495	1,184,793	11.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,509	9,448	127,835	13.53	8
9	Activity Director					9
10	Activity Assistants	14,747	16,309	214,847	13.17	10
11	Social Service Workers	8,767	9,729	197,905	20.34	11
12	Dietician	880	900	15,560	17.29	12
13	Food Service Supervisor	1,992	2,160	43,396	20.09	13
14	Head Cook	2,072	2,160	31,977	14.80	14
15	Cook Helpers/Assistants	10,444	11,214	109,337	9.75	15
16	Dishwashers	16,403	17,432	155,707	8.93	16
17	Maintenance Workers	1,952	2,157	34,199	15.85	17
18	Housekeepers	30,086	32,620	295,212	9.05	18
19	Laundry	6,412	6,918	61,754	8.93	19
20	Administrator	1,803	1,980	124,710	62.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,918	15,535	239,651	15.43	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	901	1,018	16,271	15.98	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,627	1,914	62,310	32.55	33
34	TOTAL (lines 1 - 33)	274,422	298,855	\$ 4,785,019 *	\$ 16.01	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	914	\$ 18,292	1(3)	35
36	Medical Director	Monthly	7,875	9(3)	36
37	Medical Records Consultant	Monthly	1,221	10(3)	37
38	Nurse Consultant	Monthly	6,365	10(3)	38
39	Pharmacist Consultant	Monthly	9,140	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	12	4,699	11(3)	44
45	Social Service Consultant	11	4,464	12(3)	45
46	Other(specify) <u>Psychosocial</u>	5	1,920	12(3)	46
47	<u>Pulmonary Consultant</u>	Monthly	22,790	10(3)	47
48	<u>Medical Consultant</u>	Monthly	3,806	10(7)	48
49	TOTAL (lines 35 - 48)	942	\$ 80,572		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Lawrence Putz</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 124,710</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 75,116</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>28,434</u>	<u>Advertising: Employee Recruitment</u>	<u>37,850</u>	
				<u>FICA Taxes</u>	<u>349,107</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>177,936</u>	<u>(Indicate # of checks performed <u>27</u>)</u>	<u>326</u>	
				<u>Employee Meals</u>	<u>13,149</u>	<u>Patient Background Checks <u>93</u></u>	<u>1,110</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>21,484</u>	
				<u>401(k) Contributions</u>	<u>21,699</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>199</u>	
				<u>Other Employee Benefits</u>	<u>24,328</u>	<u>AANC</u>	<u>95</u>	
				<u>Uniform Allowance</u>	<u>3,972</u>			
						<u>Management Company Allocation</u>	<u>6,863</u>	
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 124,710			TOTAL (agree to Sch. V,	\$ 67,927	
(List each licensed administrator separately.)				TOTAL (agree to Schedule V,	\$ 693,741	line 20, col. 8)		
				line 22, col.8)				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-Royal Operating</u>			<u>\$ 704,631</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
<u>Management Fees-Vesta Mgmt.</u>			<u>347,451</u>					
<u>Management Fees (Eliminated in Column 7)</u>							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,052,082					
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	<u>5,598</u>
C. Professional Services							<u>Management Company Allocation</u>	<u>1,529</u>
Vendor/Payee	Type		Amount				<u>Entertainment Expense</u>	<u>()</u>
<u>Action Computer Service</u>	<u>Computer Consulting</u>		<u>\$ 565</u>				TOTAL	\$ 7,127
<u>BridgePoint Technologies LLC</u>	<u>Computer Consulting</u>		<u>1,247</u>					
<u>BSKLIVE Inc.</u>	<u>Computer Consulting</u>		<u>4,219</u>					
<u>CDW Government Inc.</u>	<u>Computer Consulting</u>		<u>180</u>					
<u>C.D.W. Direct</u>	<u>Computer Consulting</u>		<u>130</u>					
<u>Cimco</u>	<u>Computer Consulting</u>		<u>829</u>					
<u>E-Fax Corporate</u>	<u>Computer Consulting</u>		<u>2,261</u>					
<u>E-Health Data Solutions</u>	<u>Computer Consulting</u>		<u>2,400</u>					
<u>Elton Designs Inc.</u>	<u>Computer Consulting</u>		<u>1,265</u>					
<u>Enterprise Agreement 2010</u>	<u>Computer Consulting</u>		<u>4,369</u>					
<u>Information Control</u>	<u>Computer Consulting</u>		<u>867</u>					
<u>See attached Schedule 21C</u>			<u>84,310</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 102,642	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Bloomingdale, Inc.**Provider # 0035188****1/1/10 - 12/31/10****Schedule 21C**

XIX. Support Schedules

C. Professional Services

Vendor/Payee

Krakau Business	Computer Consulting	322
Lanac/GP	Computer Consulting	2,846
Lintech LLC	Computer Consulting	5,968
Micro Center	Computer Consulting	19
National Datacare	Computer Consulting	1,721
Red Sky Technologies	Computer Consulting	273
RSM McGladrey	Computer Consulting	8,486
Silverchair Learning Systems	Computer Consulting	4,200
SPM Marketing & Communication:	Computer Consulting	877
Telemedicine Solutions	Computer Consulting	4,750
TouchPoint Care	Computer Consulting	500
Vision Share	Computer Consulting	1,039
Xclutel Communications	Computer Consulting	287
XO Communications	Computer Consulting	1,210
Warehouse Direct	Computer Consulting	108
TouchPoint Care	Computer Consulting	400
Shaker Recruitment Advertising	Recruiting	30
Grabowski Law Center	Collections	2,796
Cassiday Schade LLP	Legal	1,891
CLIA Laboratory Program	Accounting	150
James Samatas, Atty at law	Legal	200
McGladrey & Pullen, LLP	Accounting	23,385
Medcor	Healthcare	250
Much Shelist	Legal	7,148
Pension Administrators	Pension Administration	1,145
Personnel Planners	U/C Consulting	1,550
RSM McGladrey	Accounting	12,659
Secretary of State	Filing Fees	100
		<u>84,310</u>

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

102,642

Allocated from Management Co.

Serpico, Petrosino, Dipiero	Legal	93
Duane Morris	Legal	186
McGladrey & Pullen LLP	Accounting	751
RSM McGladrey	Accounting	613
Illinois Secretary of State	Filing Fees	39
LaSalle Network	Recruiting/Finance	926
Gilson Labus & Silverman	KEP	595
KMZ Rosenmann	KEP	96
Pension Administrators, Inc.	401(k) Administration	170
Ajilon Professional Staffing	Accounting	756
Personnel Planners, Inc.	U/C Consulting	19
Quattrochi and Parker	Social Service Consulting	19
Gene Whitehorn	Medicaid Reimb Specialist	803
Computer Services	Computer Consultant	12,056

Allocated from Samvest of Lombard II

Accounting
Legal82
221

Allocated from Sambell

Secretary of State

Filing Fees

200

Nonallowable legal fees

(627)

Nonallowable collection fees

(2,796)

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

116,844

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- 1 Are nursing employees (RN,LPN,NA) represented by a union? No
- 2 Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- 3 Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- 4 Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- 5 Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- 6 Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,738 Line 10(2)
- 7 Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- 8 Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- 9 Are you presently operating under a sublease agreement? YES X NO
- 10 Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- 11 Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 90,885
This amount is to be recorded on line 42 of Schedule V.
- 12 Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- 13 Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- 14 Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- 15 Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,149 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- 16 Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- 17 Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- 18 Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- 19 If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT