

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860 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	<u>224</u>	Skilled (SNF)	<u>224</u>	<u>81,760</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>224</u>	TOTALS	<u>224</u>	<u>81,760</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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>15,566</u>	<u>15,566</u>	8
9	SNF/PED					9
10	ICF	<u>36,730</u>	<u>9,114</u>	<u>8,569</u>	<u>54,413</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>36,730</u>	<u>9,114</u>	<u>24,135</u>	<u>69,979</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.59%

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? None

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

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

I. On what date did you start providing long term care at this location?
Date started 10/9/84

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 224 and days of care provided 13,134

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-Lombard # 0028860 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	413,358	34,583	17,122	465,063		465,063		465,063		1
2	Food Purchase		337,668		337,668		337,668	(16,473)	321,195		2
3	Housekeeping	373,274	36,240		409,514		409,514	419	409,933		3
4	Laundry	99,163	23,763		122,926		122,926		122,926		4
5	Heat and Other Utilities			263,322	263,322		263,322	10,803	274,125		5
6	Maintenance	40,029		133,538	173,567		173,567	58,518	232,085		6
7	Other (specify):* Mgmt Co. - Allocated							7,296	7,296		7
8	TOTAL General Services	925,824	432,254	413,982	1,772,060		1,772,060	60,563	1,832,623		8
	B. Health Care and Programs										
9	Medical Director			78,525	78,525		78,525		78,525		9
10	Nursing and Medical Records	4,234,331	283,979	70,351	4,588,661		4,588,661	66,334	4,654,995		10
10a	Therapy			1,365,846	1,365,846		1,365,846		1,365,846		10a
11	Activities	301,159	22,068	18,633	341,860		341,860		341,860		11
12	Social Services	243,142		37,411	280,553		280,553		280,553		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co. - Allocated							9,092	9,092		15
16	TOTAL Health Care and Programs	4,778,632	306,047	1,570,766	6,655,445		6,655,445	75,426	6,730,871		16
	C. General Administration										
17	Administrative	126,397		1,410,204	1,536,601		1,536,601	(1,380,770)	155,831		17
18	Directors Fees										18
19	Professional Services			112,460	112,460		112,460	15,760	128,220		19
20	Dues, Fees, Subscriptions & Promotions			22,124	22,124		22,124	8,191	30,315		20
21	Clerical & General Office Expenses	393,250	37,662	31,312	462,224		462,224	444,415	906,639		21
22	Employee Benefits & Payroll Taxes			946,292	946,292		946,292	16,473	962,765		22
23	Inservice Training & Education			11,933	11,933		11,933	1,155	13,088		23
24	Travel and Seminar			4,782	4,782		4,782	2,063	6,845		24
25	Other Admin. Staff Transportation			1,740	1,740		1,740	21,907	23,647		25
26	Insurance-Prop.Liab.Malpractice			256,172	256,172		256,172	4,472	260,644		26
27	Other (specify):* Mgmt Co. - Allocated							79,982	79,982		27
28	TOTAL General Administration	519,647	37,662	2,797,019	3,354,328		3,354,328	(786,352)	2,567,976		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,224,103	775,963	4,781,767	11,781,833		11,781,833	(650,363)	11,131,470		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-Lombard #0028860 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			220,389	220,389		220,389	335,593	555,982			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,944	18,944		18,944	(900)	18,044			32
33	Real Estate Taxes							137,444	137,444			33
34	Rent-Facility & Grounds			1,583,168	1,583,168		1,583,168	(1,578,767)	4,401			34
35	Rent-Equipment & Vehicles			65,294	65,294		65,294	3,527	68,821			35
36	Other (specify):*											36
37	TOTAL Ownership			1,887,795	1,887,795		1,887,795	(1,103,103)	784,692			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		479,849	8,447	488,296		488,296		488,296			39
40	Barber and Beauty Shops			29,448	29,448		29,448		29,448			40
41	Coffee and Gift Shops			1,979	1,979		1,979		1,979			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Non-Allowable Cos			121,095	121,095		121,095	(121,095)				43
44	TOTAL Special Cost Centers		479,849	283,609	763,458		763,458	(121,095)	642,363			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,224,103	1,255,812	6,953,171	14,433,086		14,433,086	(1,874,561)	12,558,525			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	(6,577)	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	(73,073)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,149)	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				18
19	Entertainment				19
20	Contributions	(5,375)	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	(3,572)	43		24
25	Fund Raising, Advertising and Promotional	(27,637)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(60,941)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(144,822)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (324,146)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,550,415)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,550,415)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,874,561)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center-Lombard

ID# 0028860

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (1,672)	43	1
2	Labs-Part A	(7,267)	43	2
3	X-Rays-Part A	(22,547)	43	3
4	Marketing Salary	(103,913)	21	4
5	Trust Fees	(450)	43	5
6	Misc Income	202	21	6
7	Collections	(6,467)	19	7
8	Out of period legal	(1,638)	19	8
9	Dues & Subscriptions Marketing	(1,070)	20	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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44				44
45				45
46				46
47				47
48				48
49	Total	(144,822)		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
James Samatas	33.33%	See Attached Schedule B	See Attached Schedule B	See Attached Schedule B		
John Samatas	33.33%					
Cynthia Thiem	33.34%					

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	34 Rental Expense	\$ 1,583,168	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	\$	\$ (1,583,168)	1
2	V	30 Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	285,305	285,305	2
3	V	32 Interest Expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	54,129	54,129	3
4	V							4
5	V	33 Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	131,168	131,168	5
6	V	43 State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	16,642	16,642	6
7	V	43 Trust fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	450	450	7
8	V	19 Professional Fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	351	351	8
9	V							9
10	V							10
11	V			**-The owners of Lexington Health Care Center of Lombard, Inc. own 100% of Lexington Health Care Systems of Lombard Limited Partnership.				11
12	V							12
13	V							13
14	Total		\$ 1,583,168			\$ 488,045	\$ * (1,095,123)	14

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

Lexington Health Care Center of Lombard, Inc.

Provider # 0028660

1/1/10-12/31/10

Schedule 6B

VII. Related Parties

Related Nursing Homes

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

<u>Other Related Business Entities</u>	<u>City</u>	<u>Type of Business</u>
Eastgate Manor	Algonquin	Supportive Living Facility
Vesta Management Group LLC	Lombard	Management Company
Lexington Health Care Systems of Lombard Ltd. Ptsp.	Lombard	Real Estate Property
Royal Management Corporation	Lombard	Management Company
Lexington Financial Services, 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-Lombard

0028860

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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.	**	\$ 419	\$	419	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	9,601		9,601	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	273		273	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	929		929	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	49,110		49,110	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	8,970		8,970	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	438		438	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	7,296		7,296	22
23	V	10 Medical consultant		Royal Management Corp.	**	5,136		5,136	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	61,198		61,198	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	9,092		9,092	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	29,434		29,434	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	16,269		16,269	27
28	V	19 Professional fees		Royal Management Corp.	**	7,245		7,245	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	733		733	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	8,528		8,528	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	508,919		508,919	31
32	V	21 Bank charges		Royal Management Corp.	**	10,078		10,078	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	13,266		13,266	33
34	V	21 Postage		Royal Management Corp.	**	4,766		4,766	34
35	V	21 Telephone		Royal Management Corp.	**	11,097		11,097	35
36	V	23 Inservice Training		Royal Management Corp.	**	1,155		1,155	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 763,952	\$ *	763,952	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	24 Travel & seminar	\$	Royal Management Corp.	**	\$ 2,063	\$ 2,063
16	V	25 Auto expense		Royal Management Corp.	**	21,907	21,907
17	V	26 Insurance general		Royal Management Corp.	**	4,472	4,472
18	V	27 Management allocation - employee benefits		Royal Management Corp.	**	79,982	79,982
19	V	30 Depreciation		Royal Management Corp.	**	50,288	50,288
20	V	32 Interest		Royal Management Corp.	**	18,005	18,005
21	V	32 Amortization of mortgage costs		Royal Management Corp.	**	39	39
22	V	33 Property taxes		Royal Management Corp.	**	6,276	6,276
23	V	34 Rent expense		Royal Management Corp.	**	4,401	4,401
24	V	35 Equipment rental		Royal Management Corp.	**	1,307	1,307
25	V	17 Management fees	1,410,204	Royal Management Corp.	**		(1,410,204)
26	V	35 Auto Lease expense		Royal Management Corp.	**	2,220	2,220
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,410,204			\$ 190,960	\$ * (1,219,244)

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

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 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	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 10,627	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,160	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,647	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,759	L21, C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 32,193		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-Lombard

0028860

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	\$ 81,760	\$ 419	1	
2	5	Utilities - gas & electric	Bed Days	718,010	10	84,318	81,760	9,601	2	
3	5	Utilities - water & sewer	Bed Days	718,010	10	2,399	81,760	273	3	
4	5	Utilities - maintenance office	Bed Days	718,010	10	8,161	81,760	929	4	
5	6	Management allocation - salaries	Bed Days	718,010	10	431,278	431,278	81,760	49,110	5
6	6	Repairs & maintenance	Bed Days	718,010	10	78,772	81,760	8,970	6	
7	6	Scavenger & exterminating	Bed Days	718,010	10	3,848	81,760	438	7	
8	7	Management allocation - employees	Bed Days	718,010	10	64,074	81,760	7,296	8	
9	10	Medical consultant	Bed Days	718,010	10	45,100	81,760	5,136	9	
10	10	Management allocation - salaries	Bed Days	718,010	10	537,439	537,439	81,760	61,198	10
11	15	Management allocation - employees	Bed Days	718,010	10	79,846	81,760	9,092	11	
12	17	Management allocation - salaries	Bed Days	718,010	10	258,489	258,489	81,760	29,434	12
13	19	Computer consultant & supplies	Bed Days	718,010	10	142,872	81,760	16,269	13	
14	19	Professional fees	Bed Days	718,010	10	63,628	81,760	7,245	14	
15	20	Dues & subscriptions	Bed Days	718,010	10	6,440	81,760	733	15	
16	20	Advertising - help wanted	Bed Days	718,010	10	74,892	81,760	8,528	16	
17	21	Management allocation - salaries	Bed Days	718,010	10	4,469,291	4,469,291	81,760	508,919	17
18	21	Bank charges	Bed Days	718,010	10	88,508	81,760	10,078	18	
19	21	Office supplies & printing	Bed Days	718,010	10	116,497	81,760	13,266	19	
20	21	Postage	Bed Days	718,010	10	41,854	81,760	4,766	20	
21	21	Telephone	Bed Days	718,010	10	97,454	81,760	11,097	21	
22	23	Inservice Training	Bed Days	718,010	10	10,139	81,760	1,155	22	
23									23	
24									24	
25	TOTALS					\$ 6,708,981	\$ 5,696,497	\$ 763,952	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860

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

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	24	Travel & seminar	Bed Days	718,010	10	\$ 18,117	\$ 81,760	\$ 2,063	1
2	25	Auto expense	Bed Days	718,010	10	192,388	81,760	21,907	2
3	26	Insurance general	Bed Days	718,010	10	39,272	81,760	4,472	3
4	27	Management allocation - employees	Bed Days	718,010	10	702,398	81,760	79,982	4
5	30	Depreciation	Bed Days	718,010	10	441,627	81,760	50,288	5
6	32	Interest	Bed Days	718,010	10	158,122	81,760	18,005	6
7	32	Amortization of mortgage costs	Bed Days	718,010	10	346	81,760	39	7
8	33	Property taxes	Bed Days	718,010	10	55,117	81,760	6,276	8
9	34	Rent expense	Bed Days	718,010	10	38,647	81,760	4,401	9
10	35	Equipment rental	Bed Days	718,010	10	11,478	81,760	1,307	10
11	35	Auto Lease expense	Bed Days	718,010	10	19,500	81,760	2,220	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					\$ 1,677,012	\$	\$ 190,960	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington Health Care Center-Lombard

0028860

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5						Interest on financing insurance premium			2,727	5										
Working Capital																				
6	Bank of America		X	Line of Credit	Varies	4/6/02	1,200,000		6/30/11	Prime		6								
7	Shareholder Loan	X		Working Capital	Varies	7/16/08	499,000	499,000	Demand	Prime	16,217	7								
8	Shareholder Loan	X		Capital Improvements	Varies	4/30/08	2,230,000	2,230,000	Demand	Prime	54,129	8								
9	TOTAL Facility Related						\$ 3,929,000	\$ 2,729,000			\$ 73,073	9								
B. Non-Facility Related*																				
10								Interest Income Offset			(2,726)	10								
11								Offset of Shareholder Interest			(70,347)	11								
12								Amortization of mortgage cost			39	12								
13								Allocation of Management Costs			18,005	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (55,029)	14								
15	TOTALS (line 9+line14)						\$ 3,929,000	\$ 2,729,000			\$ 18,044	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.)

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Lombard COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0028860

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>06-19-307-002</u>	<u></u>	\$ <u>146,767.56</u>	\$ <u>146,767.56</u>
2.	<u>Royal Management Corp. (Samvest of Lombard II)</u>	<u></u>	\$ <u>227,778.04</u>	\$ <u>6,276.00</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>374,545.60</u></u>	\$ <u><u>153,043.56</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.**

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,770 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square feet

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>30,000</u>	<u>1984</u>	<u>\$ 616,761</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>21,560</u>	<u>2</u>
3	TOTALS	30,000		\$ 638,321	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	215	1984	1984	\$ 3,661,472	\$	35	\$ 104,614	\$ 104,614	\$ 2,743,922	4
5	9	1995	1995	284,156	8,119	35	8,119		125,840	5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvements	1990		96,219		10			96,218	9
10	Leasehold Improvements Additions	1995		71,493		10			71,493	10
11	Building Improvements	1994		20,200		10			20,200	11
12	Building Improvements	1995		14,535	415	35	415		6,436	12
13	Building Improvements - dishwasher hood	1996		2,748		10			2,748	13
14	Building Improvements - outside painting	1996		11,308		10			11,308	14
15	Building Improvements - dining room	1996		3,752		10			3,752	15
16	Leasehold Improvements	1992		16,299	466	35	466		8,617	16
17	Leasehold Improvements	1994		21,836		10			21,836	17
18	Leasehold Improvements - 2nd floor	1996		19,319		10			18,353	18
19	Leasehold Improvements - bathroom rehal	1996		9,216		10			8,909	19
20	Leasehold Improvements - fan coil repairs	1996		6,669	191	35	191		2,733	20
21	Land Improvements	1993		2,985		15			2,985	21
22	Land Improvements	1995		4,596	153	15	153		4,595	22
23	Capitalized Repairs	1986		1,730		10			1,730	23
24	Building Improvements - basement	1996		18,993		10			18,993	24
25	Leasehold Improvements - Corner Guards	1997		520		10			520	25
26	Leasehold Improvements - Corridor flooring	1997		10,380		10			10,380	26
27	BI: Kitchen Rehab	1998		2,494		10			2,494	27
28	Wiring for MDS project	1998		3,365		10			3,365	28
29	Install Fire Sprinklers in Mechanical Rms	1998		4,600	131	35	131		1,642	29
30	Tile for Lobby	1998		20,530		10			20,530	30
31	Walk in Freezers/Coolers	1998		3,183	91	35	91		1,137	31
32	Fire Wall Repairs	1998		12,411	355	35	355		4,434	32
33	Underground storage tank	1998		2,613		10			2,613	33
34	Repave parking lot	1999		7,625	508	15	508		5,845	34
35	Lounge Floor Tile	1999		2,963		10			2,963	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860

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	Rewire Building	1999	\$ 9,083	\$ 260	35	\$ 260	\$	\$ 2,986	37
38	Heat exchanger for water heater	1999	1,660		5			1,660	38
39	Compressor and tank for freezer	1999	2,924		5			2,924	39
40	Plumbing Improvements	2000	2,833	142	10	142		2,833	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		660	41
42	Water heater repairs	2000	3,831		5			3,831	42
43	Automatic door	2000	4,556	130	35	130		1,366	43
44	Install sprinklers	2001	6,082	608	10	608		5,828	44
45	Infrared curtains for elevator	2001	4,500	450	10	450		4,125	45
46	Elevator upgrade	2002	3,006		5			3,006	46
47	Condensor	2002	2,679		5			2,679	47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		11,382	48
49	Plumbing loop repairs	2003	6,125	613	10	613		4,340	49
50	Fire alarm panel/call system	2003	8,495	425	20	425		3,363	50
51	Facility Rehab - Painting	2003	6,872	687	10	687		4,970	51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		10,524	52
53	Nurse call system	2003	49,451	2,473	20	2,473		17,515	53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		2,172	54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		125,792	55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		110,530	56
57	Floor Tile	2003	58,720	2,936	20	2,936		23,488	57
58	Carpeting/cove base	2003	29,518	2,952	10	2,952		23,615	58
59	Water heater	2004	9,209	921	10	921		5,679	59
60	Kitchen sewer and dishroom	2004	31,233	1,562	20	1,562		9,501	60
61	Landscaping	2005	3,255	163	20	163		882	61
62	HVAC	2005	8,028	401	20	401		2,073	62
63	Kitchen sewer, dishroom and ceiling	2005	22,924	1,146	20	1,146		6,399	63
64	Lobby and reception redecorating - painting/wallpaper	2005	37,999	1,900	20	1,900		10,767	64
65	Rehab therapy room - electrical, carpet, tile	2005	66,393	3,320	20	3,320		18,812	65
66	Rehab 1st floor therapy room - electrical, carpet, tile	2005	39,341	1,967	20	1,967		11,146	66
67	Wallpaper, tile, electrical for transitional unit	2005	22,946	1,147	20	1,147		6,596	67
68	Window treatments	2005	8,053	403	20	403		2,249	68
69	Tile, flooring, and wallpaper	2005	57,699	2,885	20	2,885		16,108	69
70	TOTAL (lines 4 thru 69)		\$ 5,504,063	\$ 70,795		\$ 175,409	\$ 104,614	\$ 3,686,392	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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,504,063	\$ 70,795		\$ 175,409	\$ 104,614	\$ 3,686,392	1
2	Countertops	2005	845	56	5	56		845	2
3	Curtains and blinders	2005	4,672	597	5	597		4,672	3
4	Mini scroll	2005	527	79	5	79		527	4
5	Medical Records Storage/Office Room	2006	5,901	148	40	148		616	5
6	Office Remodel	2006	5,537	138	40	138		552	6
7	Piping	2006	4,511	301	15	301		1,304	7
8	HVAC	2006	7,985	200	40	200		800	8
9	Emergency A/C	2006	9,385	235	40	235		940	9
10	Adm Office-HVAC	2006	6,421	161	40	161		710	10
11	Sink installation	2006	2,561	64	40	64		304	11
12	Land Improvements Patio	2006	23,736	1,582	15	1,582		6,856	12
13	Brick Pavers	2007	8,500	567	15	567		2,079	13
14	Landscaping	2007	16,420	821	20	821		2,805	14
15	Parking Lot	2007	13,219	661	20	661		2,258	15
16	Roof	2007	9,800	490	20	490		1,838	16
17	HVAC	2007	8,197	410	20	410		1,435	17
18	LHI-Emergency A/C	2007	11,126	556	20	556		1,761	18
19	LHI-Plumbing & Sprinkler	2007	6,799	680	10	680		2,210	19
20	Automatic Doors in Common Areas	2007	20,874	1,044	20	1,044		3,567	20
21	Tike System & Foundation	2007	4,500	225	20	225		694	21
22	Exterior of Building Painting	2007	16,600	830	20	830		2,698	22
23	Landscaping	2008	21,600	1,440	15	1,440		3,960	23
24	Parking Lot	2008	9,625	481	20	481		1,243	24
25	Roof Repair	2008	11,001	550	20	550		1,283	25
26	HVAC	2008	20,164	1,102	20	1,102		2,749	26
27	Sink and Toilet	2008	4,000	400	10	400		1,067	27
28	Elevator Upgrades	2008	171,955	4,299	40	4,299		9,673	28
29	Metal Doors	2008	3,907	195	20	195		537	29
30	Basement Renovation	2008	25,195	1,260	20	1,260		3,360	30
31	Trash Compactor	2008	11,590	580	20	580		1,450	31
32	Painting Gazebo	2008	4,450	223	20	223		538	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,975,666	\$ 91,170		\$ 195,784	\$ 104,614	\$ 3,751,723	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-Lombard

0028860

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		\$ 5,975,666	\$ 91,170		\$ 195,784	\$ 104,614	\$ 3,751,723	1
2	2nd floor remodel-Electric, flooring,painting	2008	561,165		27	20,406	20,406	42,513	2
3	Kitchen Upgrade-Carpentry, painting, plumbing	2008	18,364		27	668	668	1,392	3
4	1st floor remodel-painting, electrical, flooring,plumbing	2008	547,836		27	19,921	19,921	58,103	4
5	Irrigation System	2009	14,235	949	15	949		1,344	5
6	Landscaping Enhancements	2009	22,005	1,467	15	1,467		2,201	6
7	Roof	2009	139,578	6,979	20	6,979		9,887	7
8	Fan Coil	2009	5,607	280	20	280		491	8
9	Quick Connectors	2009	5,300	265	20	265		442	9
10	Room Convector	2009	4,962	248	20	248		310	10
11	Nurse Call System	2009	35,509	1,291	27	1,291		1,506	11
12	Electrical key pad	2009	5,995	218	27	218		309	12
13	PT Room Countertops	2009	4,050	147	27	147		160	13
14	2nd floor remodel-Electric, flooring,painting	2009	2,935	107	27	107		196	14
15	Patio Pergola	2009	10,849	542	20	542		633	15
16	Landscaping/Retaining wall	2010	4,741	158	15	158		158	16
17	Ejector Pump	2010	6,983	233	15	233		233	17
18	Parking lot repair/signs	2010	8,970	376	15	376		376	18
19	Repair Roof	2010	24,000	100	20	100		100	19
20	Key pad entrance	2010	3,085	231	10	231		231	20
21	Canopy	2010	2,567	150	10	150		150	21
22	Exhaust HVAC	2010	4,003	24	27	24		24	22
23	Drainline	2010	4,130	13	27	13		13	23
24	Pantry update	2010	7,566	115	27	115		115	24
25	Paint over bed lights	2010	6,319	154	27	154		154	25
26	Library/Lounge update	2010	8,441	103	27	103		103	26
27	Second floor doors	2010	3,144	236	10	236		236	27
28	Med Room Update	2010	7,678	117	27	117		117	28
29	Patio Pergola	2010	11,695	585	5	585		585	29
30	Stamped concrete	2010	15,862	704	15	704		705	30
31	Office changes	2010	64,446		27				31
32	3rd floor remodel-carpentry,plumbing,electrical,painting	2010	753,399		27	35,049	35,049	35,049	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,291,085	\$ 106,962		\$ 287,620	\$ 180,658	\$ 3,909,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,291,085	\$ 106,962		\$ 287,620	\$ 180,658	\$ 3,909,559	1
2									2
3									3
4									4
5	Building-management company	2002	298,343		40	9,117	9,117	79,130	5
6	HVAC, electrical, security system-management company	2003	2,620		30	487	487	1,343	6
7	Key card system-management company	2004	412		20	21	21	131	7
8	VAV TX controls-management compnay	2005	125		20	6	6	37	8
9	Building Improvements-management company	2006	91		20	6	6	25	9
10	Building Improvements-management company	2008	9,908		20	779	779	1,693	10
11	Building Improvements-management company	2009	745		20	51	51	63	11
12	Building Improvements-management company	2010	899		20	74	74	73	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,604,228	\$ 106,962		\$ 298,161	\$ 191,199	\$ 3,992,054	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	\$ 632,643	\$ 12,414	\$ 109,121	\$ 96,707	5	\$ 257,981	71
72	Current Year Purchases	869,578	101,013	108,953	7,940	5	476,169	72
73	Fully Depreciated Assets	66,500					66,500	73
74	Allocated from Mgmt. Co.	317,168		33,269	33,269	5	249,360	74
75	TOTALS	\$ 1,885,889	\$ 113,427	\$ 251,343	\$ 137,916		\$ 1,050,010	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.			46,725		6,478	6,478	5	32,892	79
80	TOTALS			\$ 46,725	\$	\$ 6,478	\$ 6,478		\$ 32,892	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)	\$ 11,175,163	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 220,389	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 555,982	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 335,593	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,074,956	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			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	Allocated from Management Company			4,401			6
7	TOTAL			\$ 4,401			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: \$ 66,601 Description: Copier-\$13,788;Postage-\$60;Oxygen-\$34,086;Med Equip-\$17,360;Mgmt. Co.-\$1,307

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Management Company			2,220	20
21	TOTAL		\$	\$ 2,220	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	\$	5,961	\$ 465,125	\$	5,961	\$ 465,125	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,720	181,267		2,720	181,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		16,009	719,454		16,009	719,454	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				479,849		479,849	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Dentist Hearing Aides</u>	39(3)					8,447		8,447	13
14	TOTAL			\$	24,690	\$ 1,365,846	\$ 488,296	24,690	\$ 1,854,142	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-Lombard# 0028860Report Period Beginning: 01/01/2010Ending: 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	\$ 965,337	\$ 1,388,987	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>509,584</u>)	1,703,315	1,703,315	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	120,628	120,628	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	429,486	429,486	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,218,766	\$ 3,642,416	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		638,321	13
14	Buildings, at Historical Cost		3,945,629	14
15	Leasehold Improvements, at Historical Cost	2,546,348	4,658,599	15
16	Equipment, at Historical Cost	861,666	1,932,614	16
17	Accumulated Depreciation (book methods)	(1,351,385)	(5,074,956)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage Cost Net</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,056,629	\$ 6,100,207	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,275,395	\$ 9,742,623	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 523,865	\$ 523,865	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	536,497	536,497	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,427	7,427	31
32	Accrued Real Estate Taxes(Sch.IX-B)		130,800	32
33	Accrued Interest Payable		6,155	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	376,363	592,335	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,444,152	\$ 1,797,079	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	499,000	2,729,000	39
40	Mortgage Payable			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)	\$ 499,000	\$ 2,729,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,943,152	\$ 4,526,079	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,332,243	\$ 5,216,544	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,275,395	\$ 9,742,623	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Lombard, Inc.
1/1/10-12/31/10
Provider # 0028660

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other current liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due from LHCC Streamwood		120,157
Note Payable	-	65,000
Accrued Rent	(30,815)	-
Medicare Payment Voucher	2,289	2,289
401K Withholding	(68)	(68)
Accrued Expenses	57,835	57,835
Accrued Royl/Vesta Mgmt fees	1,260	1,260
Due to patient trust fund	26,223	26,223
Deferred Income	428,318	428,318
Due to Royal Operations	33,380	33,380
Due to Republic Construction of Illinois, Inc	1,307	1,307
Advance biweekly Part A payments	(2,047)	(2,047)
Uncollectible Part A Co. Pvts	(21,162)	(21,162)
Due from LHCC Lombard	(120,157)	(120,157)
	<u>376,363</u>	<u>592,335</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,845,100	1
2	Restatements (describe):		2
3	Post closing adjustment	(174,296)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,670,804	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,155,439	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	(1,494,000)	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)	\$ 661,439	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)	\$ 3,332,243	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard# 0028860Report 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	\$ 18,895,215	1
2	Discounts and Allowances for all Levels	(6,920,066)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,975,149	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,104,422	6
7	Oxygen	2,530	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,106,952	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	1,191	12
13	Barber and Beauty Care	30,897	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	457,152	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	106,135	19
20	Radiology and X-Ray		20
21	Other Medical Services	140,670	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 736,045	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,784	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,784	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(202)	28
28a	Bed Hold Early Discharge	755,797	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 755,595	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,588,525	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,772,060	31
32	Health Care	6,655,445	32
33	General Administration	3,354,328	33
B. Capital Expense			
34	Ownership	1,887,795	34
C. Ancillary Expense			
35	Special Cost Centers	640,818	35
36	Provider Participation Fee	122,640	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,433,086	40
41	Income before Income Taxes (line 30 minus line 40)**	2,155,439	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,155,439	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 entity 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 Health Care Center-Lombard**

0028860

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	2,086	2,145	\$ 126,537	\$ 58.99	1
2	Assistant Director of Nursing	9,757	10,666	353,063	33.10	2
3	Registered Nurses	47,157	52,091	1,608,162	30.87	3
4	Licensed Practical Nurses	18,940	21,541	511,700	23.75	4
5	CNAs & Orderlies	118,525	129,424	1,495,768	11.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,423	8,219	106,439	12.95	8
9	Activity Director					9
10	Activity Assistants	19,793	21,770	301,159	13.83	10
11	Social Service Workers	13,194	13,837	243,142	17.57	11
12	Dietician	1,059	1,128	19,634	17.41	12
13	Food Service Supervisor	1,051	1,135	21,758	19.17	13
14	Head Cook	1,935	2,158	48,702	22.57	14
15	Cook Helpers/Assistants	12,180	13,423	149,727	11.15	15
16	Dishwashers	19,084	20,467	173,537	8.48	16
17	Maintenance Workers	2,060	2,282	40,029	17.54	17
18	Housekeepers	38,280	41,580	373,274	8.98	18
19	Laundry	9,994	10,969	99,163	9.04	19
20	Administrator	1,925	2,006	126,397	63.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,652	16,856	289,338	17.17	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	1,961	2,121	32,662	15.40	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,493	2,933	103,912	35.43	33
34	TOTAL (lines 1 - 33)	344,549	376,751	\$ 6,224,103 *	\$ 16.52	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	958	\$ 17,122	1(3)	35
36	Medical Director	Monthly	78,525	9(3)	36
37	Medical Records Consultant	55	974	10(3)	37
38	Nurse Consultant	Monthly	7,370	10(3)	38
39	Pharmacist Consultant	Monthly	12,060	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	384	4,699	11(3)	44
45	Social Service Consultant	400	4,464	12(3)	45
46	Other(specify) <u>Psychosocial</u>	192	2,304	12(3)	46
47	<u>Pulmonary & Kidney</u>	Monthly	49,947	10(3)	47
48	<u>Medical</u>	Monthly	5,136	10(7)	48
49	TOTAL (lines 35 - 48)	1,989	\$ 182,601		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

C. Professional Fees

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Krakau Business	Computer Consulting	322
Lanac LLC	Computer Consulting	2,846
Microsoft Licensing	Computer Consulting	4,630
MNJ Technologies Direct	Computer Consulting	762
National Datacare	Computer Consulting	1,462
Red Sky Technologies	Computer Consulting	273
RSM McGladrey	Computer Consulting	8,486
SilverChair Learning Systems	Computer Consulting	4,200
SPM Marketing & Communications	Computer Consulting	877
Telemedicine Solutions	Computer Consulting	3,550
TouchPoint Care	Computer Consulting	500
Vision Share, Inc.	Computer Consulting	1,039
Xclutel Communications	Computer Consulting	287
XO Communications	Computer Consulting	1,211
MNJ Technologies Direct	Computer Consulting	585
Warehouse Direct	Computer Consulting	108
TouchPoint Care	Computer Consulting	400
Shaker Recruitment Advertising	Recruiting	30
Grabowski Law Center, LLC	Collections	6,467
Cassiday Shade, LLP	Legal	9,412
McGladrey & Pullen, LLP	Accounting	25,574
Medcor	Healthcare	250
Much Shelist	Legal	5,813
Pension Administrators, Inc.	Pension Administration	1,020
Personnel Planners	U/C Consulting	2,880
RSM McGladrey	Accounting	5,625
Secretary of State	Filing Fees	125
Serpico, Petrosino & Dipiero, LTD	Legal	3,211
Centrad	Regulatory Consultant	229
		<u>92,174</u>
Total Schedule V, line 19, column 3		112,460
Less: Collections		(6,467)
Out of period legal		(1,638)
Lexington Health Care Systems of Lombard Partnerships Secretary of State		351
Allocated from Management Co.		
Serpico, Petrosino, Dipiero	Legal	125
Duane Morris	Legal	251
McGladrey & Pullen LLP	Accounting	1,012
RSM McGladrey, Inc.	Accounting	828
Illinois Secretary of State	Filing Fees	52
LaSalle Network	Recruiting/Finance	1,250
Gilson Labus & Silverman	KEP	803
KMZ ROSENMANN	KEP	130
Pension Administrators, Inc.	401(k) Administration	230
Aijilon Professional Staffing	Accounting	1,021
Personnel Planners, Inc.	Unemployment Consultant	26
Quattrochi and Parker	Social Service Consulting	26
Gene Whitehorn	Medicaid Reim. Specialist	1,083
Computer Services	Computer Consultant	16,269
Allocated from Samvest of Lombard II		
	Accounting	110
	Legal	298
Total Schedule V, line 19, column 8		<u>128,220</u>

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	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

Facility Name & ID Number Lexington Health Care Center-Lombard# 0028860Report Period Beginning: 01/01/2010 Ending: 12/31/2010**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? 6 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 63,900 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 122,640
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. \$ 16,473 Has any meal income been offset against related costs? Yes Indicate the amount. \$ XX
- (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