

Facility Name & ID Number Lexington of Elmhurst

0037317 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	145	Skilled (SNF)	145	52,925	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	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			11,388	11,388	8
9	SNF/PED					9
10	ICF	23,111	5,559	6,120	34,790	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,111	5,559	17,508	46,178	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.25%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 145 and days of care provided 9,450

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 of Elmhurst # 0037317 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	340,495	23,336	13,018	376,849		376,849		376,849		1
2	Food Purchase		231,695		231,695		231,695	(12,443)	219,252		2
3	Housekeeping	282,676	27,672		310,348		310,348	271	310,619		3
4	Laundry	37,427	15,285		52,712		52,712		52,712		4
5	Heat and Other Utilities			208,517	208,517		208,517	6,994	215,511		5
6	Maintenance	41,223		96,115	137,338		137,338	42,741	180,079		6
7	Other (specify):* Mgmt Co. Alloc. Bene							4,723	4,723		7
8	TOTAL General Services	701,821	297,988	317,650	1,317,459		1,317,459	42,286	1,359,745		8
	B. Health Care and Programs										
9	Medical Director			66,425	66,425		66,425		66,425		9
10	Nursing and Medical Records	3,061,705	211,850	90,783	3,364,338		3,364,338	42,939	3,407,277		10
10a	Therapy			1,146,820	1,146,820		1,146,820		1,146,820		10a
11	Activities	188,257	20,122	8,007	216,386		216,386		216,386		11
12	Social Services	180,786		39,707	220,493		220,493		220,493		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co. Alloc. Bene							5,886	5,886		15
16	TOTAL Health Care and Programs	3,430,748	231,972	1,351,742	5,014,462		5,014,462	48,825	5,063,287		16
	C. General Administration										
17	Administrative	95,705		964,621	1,060,326		1,060,326	(945,568)	114,758		17
18	Directors Fees										18
19	Professional Services			110,973	110,973		110,973	6,478	117,451		19
20	Dues, Fees, Subscriptions & Promotions			39,360	39,360		39,360	5,745	45,105		20
21	Clerical & General Office Expenses	289,827	36,103	30,944	356,874		356,874	252,250	609,124		21
22	Employee Benefits & Payroll Taxes			653,459	653,459		653,459	12,438	665,897		22
23	Inservice Training & Education			13,217	13,217		13,217	747	13,964		23
24	Travel and Seminar			11,658	11,658		11,658	(2,232)	9,426		24
25	Other Admin. Staff Transportation			1,900	1,900		1,900	14,181	16,081		25
26	Insurance-Prop.Liab.Malpractice			177,693	177,693		177,693	2,895	180,588		26
27	Other (specify):* Mgmt Co. Alloc. Bene							51,774	51,774		27
28	TOTAL General Administration	385,532	36,103	2,003,825	2,425,460		2,425,460	(601,292)	1,824,168		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,518,101	566,063	3,673,217	8,757,381		8,757,381	(510,181)	8,247,200		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Lexington of Elmhurst

#0037317

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			140,356	140,356		140,356	313,789	454,145			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,894	1,894		1,894	834,962	836,856			32
33	Real Estate Taxes							71,217	71,217			33
34	Rent-Facility & Grounds			1,003,155	1,003,155		1,003,155	(1,000,306)	2,849			34
35	Rent-Equipment & Vehicles			53,613	53,613		53,613	2,283	55,896			35
36	Other (specify):*											36
37	TOTAL Ownership			1,199,018	1,199,018		1,199,018	221,945	1,420,963			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		299,548		299,548		299,548		299,548			39
40	Barber and Beauty Shops			27,171	27,171		27,171		27,171			40
41	Coffee and Gift Shops			2,325	2,325		2,325		2,325			41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):* Non-Allowable Cos			106,405	106,405		106,405	(106,405)				43
44	TOTAL Special Cost Centers		299,548	215,289	514,837		514,837	(106,405)	408,432			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,518,101	865,611	5,087,524	10,471,236		10,471,236	(394,641)	10,076,595			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	(5)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,986)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,930	30		9
10	Interest and Other Investment Income	(9,691)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,400)	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	(5,493)	43		18
19	Entertainment				19
20	Contributions	(6,225)	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	(21,730)	43		24
25	Fund Raising, Advertising and Promotional	(24,282)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,455)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(631,709)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (720,046)		\$	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)	325,405		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 325,405		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (394,641)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of ElmhurstID# 0037317Report Period Beginning: 01/01/2010Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (1,517)	43	1
2	Labs-Part A	(4,410)	43	2
3	X-Rays-Part A	(19,907)	43	3
4	Trust Fees	(50)	43	4
5	Chamber of commerce dues	(250)	22	5
6	Collection fees	(793)	19	6
7	Out of period legal	(8,150)	19	7
8	Education & Seminar Marketing	(3,567)	24	8
9	Loss on FMV swap	(495,363)	43	9
10	Marketing Salary	(102,563)	21	10
11	Reclass assets to Repairs & Maintenance	4,861	6	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(631,709)		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	34 Rental expense	\$ 1,003,155	Sambell of Elmhurst II Limited Partnership	**	\$	\$ (1,003,155)	1
2	V	19 Professional Fees		Sambell of Elmhurst II Limited Partnership	**	200	200	2
3	V							3
4	V	30 Depreciation		Sambell of Elmhurst II Limited Partnership	**	279,306	279,306	4
5	V	32 Interest expense		Sambell of Elmhurst II Limited Partnership	**	829,567	829,567	5
6	V	32 Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	3,405	3,405	6
7	V	33 Property taxes		Sambell of Elmhurst II Limited Partnership	**	67,154	67,154	7
8	V	43 Unrealized loss on FMV swap		Sambell of Elmhurst II Limited Partnership	**	495,363	495,363	8
9	V	43 Trust fees		Sambell of Elmhurst II Limited Partnership	**	50	50	9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Sambell of Elmhurst II Limited Partnership				12
13	V							13
14	Total		\$ 1,003,155			\$ 1,675,045	\$ * 671,890	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.	**	\$ 271	\$	271	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,215		6,215	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	177		177	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	602		602	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	31,790		31,790	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,806		5,806	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	284		284	21
22	V	6 Security service		Royal Management Corp.	**				22
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	4,723		4,723	23
24	V	10 Medical consultant		Royal Management Corp.	**	3,324		3,324	24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	39,615		39,615	25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	5,886		5,886	26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	19,053		19,053	27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	10,531		10,531	28
29	V	19 Professional fees		Royal Management Corp.	**	4,690		4,690	29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	475		475	30
31	V	23 Inservice Training		Royal Management Corp.	**	747		747	31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	5,520		5,520	32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	329,434		329,434	33
34	V	21 Bank charges		Royal Management Corp.	**	6,524		6,524	34
35	V	21 Office supplies & printing		Royal Management Corp.	**	8,587		8,587	35
36	V	21 Postage		Royal Management Corp.	**	3,085		3,085	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.							38
39	Total		\$			\$ 487,339	\$ *	487,339	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.	**	\$ 7,183	\$ 7,183	
16	V	24 Travel & seminar		Royal Management Corp.	**	1,335	1,335	
17	V	25 Auto expense		Royal Management Corp.	**	14,181	14,181	
18	V	26 Insurance general		Royal Management Corp.	**	2,895	2,895	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	51,774	51,774	
20	V	30 Depreciation		Royal Management Corp.	**	32,553	32,553	
21	V	32 Interest		Royal Management Corp.	**	11,655	11,655	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	26	26	
23	V	33 Property taxes		Royal Management Corp.	**	4,063	4,063	
24	V	34 Rent expense		Royal Management Corp.	**	2,849	2,849	
25	V	35 Equipment rental		Royal Management Corp.	**	846	846	
26	V	17 Management fees	964,621	Royal Management Corp.	**		(964,621)	
27	V	35 Auto Lease		Royal Management Corp.	**	1,437	1,437	
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.						
38	V							
39	Total		\$ 964,621			\$ 130,797	\$ * (833,824)	

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

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/10 - 12/31/10

Schedule B

VII. Related Parties
 Owners

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

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

Other Related Business Entities

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

#

0037317

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	16.66	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 6,879	L 17, C7	1	
2	John Samatas	Owner/Officer	Admin/Plant Ops	16.67	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,929	L 17, C7	2	
3	Cynthia Thiem	Owner/Officer	Administrative	16.67	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,245	L 17, C7	3	
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,786	L 21, C7	4	
5											5	
6											6	
7					Certain Individuals work in excess of 40 hours per week.							7
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 20,839		13	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst# 0037317

Report Period Beginning:

01/01/2010Ending: 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	\$ 52,925	\$ 271	1	
2	5	Utilities - gas & electric	Bed Days	718,010	10	84,318	52,925	6,215	2	
3	5	Utilities - water & sewer	Bed Days	718,010	10	2,399	52,925	177	3	
4	5	Utilities - maintenance office	Bed Days	718,010	10	8,161	52,925	602	4	
5	6	Management allocation - salaries	Bed Days	718,010	10	431,278	431,278	52,925	31,790	5
6	6	Repairs & maintenance	Bed Days	718,010	10	78,772	52,925	5,806	6	
7	6	Scavenger & exterminating	Bed Days	718,010	10	3,848	52,925	284	7	
8	6	Security service	Bed Days	718,010	10		52,925	0	8	
9	7	Management allocation - employees	Bed Days	718,010	10	64,074	52,925	4,723	9	
10	10	Medical consultant	Bed Days	718,010	10	45,100	52,925	3,324	10	
11	10	Management allocation - salaries	Bed Days	718,010	10	537,439	537,439	52,925	39,615	11
12	15	Management allocation - employees	Bed Days	718,010	10	79,846	52,925	5,886	12	
13	17	Management allocation - salaries	Bed Days	718,010	10	258,489	258,489	52,925	19,053	13
14	19	Computer consultant & supplies	Bed Days	718,010	10	142,872	52,925	10,531	14	
15	19	Professional fees	Bed Days	718,010	10	63,628	52,925	4,690	15	
16	20	Dues & subscriptions	Bed Days	718,010	10	6,440	52,925	475	16	
17	23	Inservice Training	Bed Days	718,010	10	10,139	52,925	747	17	
18	20	Advertising - help wanted	Bed Days	718,010	10	74,892	52,925	5,520	18	
19	21	Management allocation - salaries	Bed Days	718,010	10	4,469,291	4,469,291	52,925	329,434	19
20	21	Bank charges	Bed Days	718,010	10	88,508	52,925	6,524	20	
21	21	Office supplies & printing	Bed Days	718,010	10	116,497	52,925	8,587	21	
22	21	Postage	Bed Days	718,010	10	41,854	52,925	3,085	22	
23	21	Telephone	Bed Days	718,010	10	97,454	52,925	7,183	23	
24	24	Travel and Seminar	Bed Days	718,010	10	18,117	52,925	1,335	24	
25	TOTALS					\$ 6,727,098	\$ 5,696,497	\$ 495,857	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317 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 Ave.
 City / State / Zip Code Lombard, IL 60148
 Phone Number (630) 458-4700
 Fax Number (630) 458-4796

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	718,010	10	\$ 192,388	\$ 52,925	\$ 14,181	1
2	26	Insurance general	Bed Days	718,010	10	39,272	52,925	2,895	2
3	27	Management allocation - employees	Bed Days	718,010	10	702,398	52,925	51,774	3
4	30	Depreciation	Bed Days	718,010	10	441,627	52,925	32,553	4
5	32	Interest	Bed Days	718,010	10	158,122	52,925	11,655	5
6	32	Amortization of mortgage costs	Bed Days	718,010	10	346	52,925	26	6
7	33	Property taxes	Bed Days	718,010	10	55,117	52,925	4,063	7
8	34	Rent expense	Bed Days	718,010	10	38,647	52,925	2,849	8
9	35	Equipment rental	Bed Days	718,010	10	11,478	52,925	846	9
10	35	Auto Lease	Bed Days	718,010	10	19,500	52,925	1,437	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,658,895	\$	\$ 122,279	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Elmhurst

0037317

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Lexington Financial Services	X		Mortgage	Varies	4/30/07	\$ 13,891,000	\$ 12,970,923	5/1/17	0.0625	\$ 829,567	1							
2	II, L.L.C											2							
3												3							
4												4							
5							Interest on financing insurance premium				1,894	5							
Working Capital																			
6	JP Morgan Chase		X	Line of Credit	Various	4/30/07	600,000		6/30/11	Libor + 2.25%		6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 14,491,000	\$ 12,970,923			\$ 831,461	9							
B. Non-Facility Related*																			
10										Interest Income Offset	(9,691)	10							
11										Amortization of Loan Cost	3,431	11							
12										Allocated from Home Office	11,655	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 5,395	14							
15	TOTALS (line 9+line14)						\$ 14,491,000	\$ 12,970,923			\$ 836,856	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 of Elmhurst COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0037317

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>06-14-317-008</u>	<u>Land & Building</u>	\$ <u>68,354.76</u>	\$ <u>68,354.76</u>
2.	<u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>227,778.04</u>	\$ <u>4,063.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>296,132.80</u>	\$ <u>72,417.76</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 of Elmhurst

0037317

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>55,000</u>	<u>1991</u>	<u>\$ 1,277,670</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>14,437</u>	<u>2</u>
3	TOTALS	55,000		\$ 1,292,107	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	133		1991	1991	\$ 4,110,586	\$	35	\$ 117,445	\$ 117,445	\$ 2,244,230	4
5	12		1995	1995	73,302	2,095	35	2,095		32,792	5
6			2001	2001							6
7											7
8											8
	Improvement Type**										
9	Building Improvement		1992		693	20	35	20		362	9
10	Land Improvement		1995		7,500	333	15	333		7,500	10
11	Fan Coil Units		1996		4,904	140	35	140		2,031	11
12	Patio		1996		2,322	155	15	155		2,245	12
13	Basement rehab		1997		17,151		10			17,151	13
14	Baseboards		1997		3,129		10			3,129	14
15	Wiring		1998		3,090		10			3,090	15
16	Lobby Tile		1999		19,354		10			19,354	16
17	Patio		1999		4,196	280	15	280		3,078	17
18	Automatic Door		2000		1,300	65	10	65		1,300	18
19	Wallpaper		2000		6,853	343	10	343		6,853	19
20	Patio		2000		1,242	83	15	83		870	20
21	Storage closet for HVAC		2000		3,745	250	15	250		2,622	21
22	Fire pump system		2001		4,140	414	10	414		3,933	22
23	Door releases		2001		4,420	442	10	442		4,199	23
24	Infrared curtains for elevators		2001		3,000	300	10	300		2,850	24
25	Parking lot		2002		2,532	253	10	253		2,278	25
26	Kitchen tile and plumbing		2002		9,661	966	10	966		8,373	26
27	Elevator upgrade		2002		2,596		5			2,596	27
28	Facility Rehab-Painting/wallpaper/carpeting		2003		175,251	17,525	10	17,525		138,740	28
29	Facility Rehab-Floor tile/room upgrade		2003		38,140	1,907	20	1,907		15,097	29
30	Facility Rehab-Carpeting		2003		7,861	786	10	786		6,157	30
31	Parking lot		2004		2,000		5			2,000	31
32	Roof		2004		15,000	750	20	750		4,813	32
33	Landscaping		2005		5,396	270	20	270		1,484	33
34	Paint for building		2005		9,000	900	10	900		4,725	34
35	Roof		2005		14,300	715	20	715		3,694	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 HVAC upgrade	2005	\$ 3,230	\$ 162	20	\$ 162	\$	\$ 917	37
38 Sprinkler system	2005	1,060	53	20	53		278	38
39 Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		8,165	39
40 Window treatment	2005	1,932	193	10	193		1,094	40
41 Cubicle curtains	2005	820	109	5	109		820	41
42 Countertop	2005	845	56	5	56		845	42
43 HVAC	2006	3,793	190	20	190		775	43
44 Automatic Door Lock	2006	2,784	139	20	139		556	44
45 Storeroom Door Lock	2006	1,904	95	20	95		396	45
46 Service Door	2006	2,545	127	20	127		508	46
47 Landscaping Enhancement-Patio	2006	2,340	156	15	156		689	47
48 PT Therapy Room	2006	570	14	40	14		56	48
49								49
50								50
51								51
52 Transitional Unit	2007	1,864	93	20	93		349	52
53 Employee Lunch Room	2007	2,827	141	20	141		494	53
54 PT Room Rehab	2007	58,628	2,941	20	2,941		9,608	54
55 Landscaping-brick pavers	2008	43,813	2,921	15	2,921		6,572	55
56 Parking Lot	2008	31,700	1,585	20	1,585		4,095	56
57 Roof Repairs	2008	4,200	280	15	280		747	57
58 HVAC-New Chillers	2008	118,557	5,928	20	5,928		13,832	58
59 Emergency A/C	2008	5,706	285	20	285		665	59
60 Building Addition	2008			27				60
61 Kitchen Upgrade	2008	7,214		27	262	262	568	61
62 2nd Floor Remodel-painting, flooring, electrical	2008	561,274		27	20,410	20,410	44,222	62
63 Foundation Stabilization	2008	66,195		27	2,407	2,407	5,215	63
64 Irrigation System	2009	15,485	1,032	15	1,032		1,376	64
65 Landscaping Enhancements	2009	26,798	1,787	15	1,787		2,531	65
66 Patio Fence	2009	9,319	466	20	466		738	66
67 Chiller	2009	82,310	4,115	20	4,115		7,202	67
68 Plumbing	2009	4,280	214	20	214		214	68
69 2nd floor remodel-MDS office, HR office, Nursing call system	2009	6,853	250	27	250		260	69
70 TOTAL (lines 4 thru 69)		\$ 5,649,111	\$ 53,704		\$ 194,228	\$ 140,524	\$ 2,661,333	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Elmhurst

0037317

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		\$ 5,649,111	\$ 53,704		\$ 194,228	\$ 140,524	\$ 2,661,333	1
2	Patio Pergola	2009	12,814	641	20	641		855	2
3	Tub Room	2009	5,828	212	27	212		212	3
4	2nd Floor remodel-Carpentry,doors,flooring,electrical	2009	455,801		7	16,575	12,431	29,006	4
5	painting,sprinkler system								5
6	Landscaping	2010	3,314	55	15	55		55	6
7	Physician office remodel-carpentry,tiling	2010	6,450	20	27	20		20	7
8	Front Entrance-door and drain tile	2010	4,418	47	27	47		47	8
9	Nurse pull cord station	2010	3,256		27				9
10	Remodel Pantry-shelves	2010	7,146		27				10
11	Paint rooms	2010	5,539		27				11
12	Cooridor remodel-flag poll,tiling	2010	13,777	64	27	64		64	12
13	Library/Lounge remodel-art,carpentry,electrical	2010	11,870		27				13
14	Steel frame remodel	2010	6,740	123	27	123		123	14
15	2nd Floor remodel-Carpentry,doors,flooring,electrical	2010	17,168	624	27	624		624	15
16	Tub Room	2010	11,731	356	27	356		356	16
17	Pergola	2010	8,180	545	5	545		545	17
18	Stamped concrete	2010	17,260	209	27	209		209	18
19									19
20									20
21	Reconcile to book depreciation			(238)					21
22									22
23									23
24									24
25	Land improvements - management company	2002	199,784		15	5,902	5,902	52,989	25
26	Building - management company	2002			40				26
27	HVAC, electrical, security system - management company	2003	1,755		30	315	315	899	27
28	Key card system - management company	2004	276		20	14	14	88	28
29	VAV TX controls - management company	2005	84		20	4	4	24	29
30	Interior Signs- management company	2006	61		5	4	4	17	30
31	Building - management company	2008	6,634		5	504	504	1,133	31
32	Building - management company	2009	499		15	33	33	42	32
33	Building - management company	2010	601			48	48	49	33
34	TOTAL (lines 1 thru 33)		\$ 6,450,097	\$ 56,362		\$ 220,523	\$ 159,779	\$ 2,748,690	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	\$ 1,176,774	\$ 77,730	\$ 201,265	\$ 123,535	5	\$ 499,285	71
72	Current Year Purchases	66,529	6,264	6,628	364	5	6,628	72
73	Fully Depreciated Assets	37,558					37,558	73
74	Alloc. From Mgmt Co.	212,388		21,536	21,536	5	166,982	74
75	TOTALS	\$ 1,493,249	\$ 83,994	\$ 229,429	\$ 145,435		\$ 710,453	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	Alloc. From Mgmt Co.			31,289		4,193	4,193	5	22,026	77
78										78
79										79
80	TOTALS			\$ 31,289	\$	\$ 4,193	\$ 4,193		\$ 22,026	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,266,742	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,356	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 454,145	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 313,789	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,481,169	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	CIP-Payroll office 1st floor	\$ 40,299	92
93			93
94			94
95		\$ 40,299	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co.				2,849			6
7	TOTAL				\$ 2,849			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: \$ 54,459 Description: Copier-\$10,607;Med Equip-\$18,132;Oxygen-\$24,874; Mgmt Co. Allocation-846

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	Allocated from Mgmt Co.			1,437	18
19					19
20					20
21	TOTAL		\$	\$ 1,437	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	\$	6,578	\$ 469,852	\$	6,578	\$ 469,852	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,698	139,798		2,698	139,798	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,720	537,170		9,720	537,170	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 prescrpts				299,548		299,548	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			\$	18,996	\$ 1,146,820	\$ 299,548	18,996	\$ 1,446,368	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 01/01/2010Ending: 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	\$ 706,244	\$ 803,557	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>306,350</u>)	1,419,449	1,419,449	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,123	11,123	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	26,203	8,511,352	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,163,019	\$ 10,745,481	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	18,177	18,177	12
13	Land		1,292,107	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	1,044,192	2,339,511	15
16	Equipment, at Historical Cost	596,254	1,524,538	16
17	Accumulated Depreciation (book methods)	(659,320)	(3,481,169)	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	40,299	40,299	22
23	Other(specify): <u>Mortgage Net Cost</u>		73,481	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,039,602	\$ 5,917,530	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,202,621	\$ 16,663,011	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 366,585	\$ 366,585	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	354,443	354,443	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,150	5,150	31
32	Accrued Real Estate Taxes(Sch.IX-B)		63,600	32
33	Accrued Interest Payable		75,268	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	212,338	2,277,058	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 938,516	\$ 3,142,104	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,970,923	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)	\$	\$ 12,970,923	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 938,516	\$ 16,113,027	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,264,105	\$ 549,984	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,202,621	\$ 16,663,011	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
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>
Interest Rate Swap Liability	-	2,036,177
Due to Republic Construction of Illinois	2,442	2,442
Due to LHCC Elmhurst	3,253	3,253
Accrued Expenses	31,245	31,245
Accrued Royl Mgmt Fees/Vesta Fees	5,305	5,305
Accrued Rent	(28,543)	-
Due to Patient Trust Fund	25,889	25,889
Deferered Income	181,763	181,763
Due to Royal Operations	31,234	31,234
Advance-Bi-weekly Part A Payments	(27,480)	(27,480)
Uncollectible Part A Co. Pvts.	(12,770)	(12,770)
	<u>212,338</u>	<u>2,277,058</u>

See Accountants' Compliance Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,788,805	1
2	Restatements (describe):		2
3	Post closing adjustment	22,135	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,810,940	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,077,165	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	(624,000)	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)	\$ 453,165	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)	\$ 2,264,105	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 01/01/2010Ending: 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	\$ 13,020,548	1
2	Discounts and Allowances for all Levels	(4,648,212)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,372,336	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,619,501	6
7	Oxygen	42,551	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,662,052	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	663	12
13	Barber and Beauty Care	29,603	13
14	Non-Patient Meals	5	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	299,979	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,205	19
20	Radiology and X-Ray		20
21	Other Medical Services	134,621	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 513,076	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	697	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 697	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Rental Income</u>	240	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 240	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,548,401	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,317,459	31
32	Health Care	5,014,462	32
33	General Administration	2,425,460	33
B. Capital Expense			
34	Ownership	1,199,018	34
C. Ancillary Expense			
35	Special Cost Centers	435,449	35
36	Provider Participation Fee	79,388	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,471,236	40
41	Income before Income Taxes (line 30 minus line 40)**	1,077,165	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,077,165	43

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

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

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

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

Facility Name & ID Number Lexington of Elmhurst

0037317

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	1,615	1,973	\$ 100,304	\$ 50.84	1
2	Assistant Director of Nursing	10,194	11,205	374,108	33.39	2
3	Registered Nurses	26,824	30,010	913,277	30.43	3
4	Licensed Practical Nurses	22,774	25,516	579,508	22.71	4
5	CNAs & Orderlies	76,234	83,114	968,308	11.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,473	9,140	108,835	11.91	8
9	Activity Director					9
10	Activity Assistants	13,087	14,427	188,257	13.05	10
11	Social Service Workers	8,303	8,973	180,786	20.15	11
12	Dietician	880	900	15,690	17.43	12
13	Food Service Supervisor	1,992	2,160	42,038	19.46	13
14	Head Cook	2,024	2,442	36,387	14.90	14
15	Cook Helpers/Assistants	11,894	12,824	126,942	9.90	15
16	Dishwashers	13,149	14,009	119,438	8.53	16
17	Maintenance Workers	2,068	2,278	41,223	18.10	17
18	Housekeepers	29,310	31,419	282,676	9.00	18
19	Laundry	4,135	4,431	37,427	8.45	19
20	Administrator	1,791	1,966	95,705	48.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,193	14,149	187,264	13.24	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	1,047	1,132	17,365	15.34	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,497	2,938	102,563	34.91	33
34	TOTAL (lines 1 - 33)	251,484	275,006	\$ 4,518,101 *	\$ 16.43	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 13,018	1(3)	35
36	Medical Director	Number	66,425	9(3)	36
37	Medical Records Consultant	28	1,565	10(3)	37
38	Nurse Consultant	Monthly	24,838	10(3)	38
39	Pharmacist Consultant	Monthly	7,980	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,699	11(3)	44
45	Social Service Consultant	Monthly	4,464	12(3)	45
46	Other(specify) <u>Psychosocial</u>	Monthly	1,788	12(3)	46
47	<u>Pulmonary</u>	Monthly	56,400	10(3)	47
48	<u>Medical Consultant</u>			10(7)	48
49	TOTAL (lines 35 - 48)	28	\$ 181,177		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	10(3)	50
51	Licensed Practical Nurses			10(3)	51
52	Certified Nurse Assistants/Aides			10(3)	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	
Quinn Corcoran	Administrator	0%	\$ 15,616	Workers' Compensation Insurance	\$ 69,741	IDPH License Fee	\$	
T'Kira Siler	Administrator	0%	67,486	Unemployment Compensation Insurance	62,795	Advertising: Employee Recruitment	33,536	
William Pfeiffer III	Administrator	0%	12,603	FICA Taxes	337,729	Health Care Worker Background Check		
				Employee Health Insurance	143,817	(Indicate # of checks performed <u>213</u>)	2,552	
				Employee Meals	12,438	Patient Background Checks <u>79</u>	944	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,490	
				401K	15,863	Miscellaneous Subscriptions & Dues	838	
				Other Employee Benefits	23,514			
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated from Mgmt Co.	5,995	
(List each licensed administrator separately.)			\$ 95,705			Less: Chamber of commerce dues	(250)	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fees-Royal Operating			\$ 620,638			Yellow page advertising	()	
Management Fees-Vesta Mgmt.			343,983					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 964,621	TOTAL (agree to Schedule V, line 22, col.8)	\$ 665,897	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 45,105	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Action Computer Service	Computer Consulting		\$ 790	N/A			Out-of-State Travel	\$
BSKLIVE Inc.	Computer Consulting		4,219					
Bridgepoint Technologies	Computer Consulting		1,247				In-State Travel	
Cimco Communications	Computer Consulting		1,067					
Efax Corporate	Computer Consulting		2,201					
E-Health Data Solutions	Computer Consulting		2,400					
Elton Desings Inc.	Computer Consulting		1,265					
Facility Wizard Software	Computer Consulting		1,413				Seminar Expense	8,091
Information Control	Computer Consulting		867					
Krakau Business	Computer Consulting		322					
Lanac Technology	Computer Consulting		2,846				Allocated from Mgmt Co.	1,335
See Schedule 21C			92,336				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 110,973				TOTAL	\$ 9,426

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Schedule 21C

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Lintech, LLC	Computer Consulting	5,997
Micro Center A/R	Computer Consulting	16
Microsoft License	Computer Consulting	3,728
MNJ Technolgies	Computer Consulting	641
National Datacare	Computer Consulting	1,370
Red Sky Technologies	Computer Consulting	273
RSM McGladrey	Computer Consulting	8,486
Silverchair Learning Systems	Computer Consulting	4,200
SPM Marketing & Communic	Computer Consulting	877
Telemedicine Solutions	Computer Consulting	1,750
TouchPoint Care	Computer Consulting	500
Vision Share	Computer Consulting	1,039
Xclutel Communications	Computer Consulting	287
XO Communications	Computer Consulting	1,211
MNJ Technolgies	Computer Consulting	585
Warehouse Direct	Computer Consulting	108
TouchPoint Care	Computer Consulting	400
Shaker Recruitment Advertis	Computer Consulting	30
Micro Center A/R	Computer Consulting	32
Grabowski Law Center	Collections	793
Cassidy Schade, LLP	Legal	10,501
McGladrey & Pullen, LLP	Accounting	28,432
Medocr	Healthcare	250
Much Shelist	Legal	6,568
Pension Administrators	Pension Administration	709
Personnel Planners	U/C Consulting	2,440
Polsinelli Shughart	Legal	3,283
RSM McGladrey	Accounting	7,730
Secretary of State	Filing Fees	100
		<u>92,336</u>

Schedule V, line 19, column 3 110,973

Collection Fees (793)
Out of period legal (8,150)

Allocated from Sambell of Elmhurst
Secretary of State 200

Allocated from Samvest of Lombard II

Legal 193
Accounting 71
264

Allocated from Mgmt Co.

McGladrey & Pullen LLP	Accounting	654
RSM McGladrey	Accounting	536
LaSalle Network	Recruiting/Finance	809
Gilson Labus & Silverman	Accounting	520
KMZ Rosenman	Legal	84
Personnel Planners	U/C Consulting	17
Pension Administrators	401K Administration	149
Illinois Secretary of State	Filing Fees	34
Ajilon Professional Staffing	Accounting	661
Quattrochi and Parker	Social Service Consulti	17
Gene Whitehorn	Medicaid Reim Speciali	701
Duane Morris	Legal	163
Serpico, Petrosino, Dipiero	Legal	81
Compute Service	Computer Services	10,531
		<u>14,957</u>

Schedule V, line 19, column 8 117,451

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 of Elmhurst

0037317

Report 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? 5 Years
- 6 Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 43,359 Line 10
- 7 Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- 8 Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- 9 Are you presently operating under a sublease agreement? YES X NO
- 10 Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- 11 Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,388
This amount is to be recorded on line 42 of Schedule V.
- 12 Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- 13 Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- 14 Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- 15 Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 12,438 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5
- 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