

Facility Name & ID Number Lexington of LaGrange

0038083 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF			<u>23,179</u>	<u>23,179</u>	8
9	SNF/PED					9
10	ICF	<u>7,717</u>	<u>4,593</u>		<u>12,310</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,717</u>	<u>4,593</u>	<u>23,179</u>	<u>35,489</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.39%

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 7/31/92

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 110 and days of care provided 22,528

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 1/1/10 Ending: 12/31/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	341,773	13,596	12,387	367,756		367,756		367,756		1
2	Food Purchase		174,511		174,511		174,511	(12,061)	162,450		2
3	Housekeeping	270,066	23,181		293,247		293,247	206	293,453		3
4	Laundry	63,362	12,107		75,469		75,469		75,469		4
5	Heat and Other Utilities			197,760	197,760		197,760	5,305	203,065		5
6	Maintenance	38,593		107,895	146,488		146,488	28,736	175,224		6
7	Other (specify):* Alloc. Mgmt Co. Bene							3,583	3,583		7
8	TOTAL General Services	713,794	223,395	318,042	1,255,231		1,255,231	25,769	1,281,000		8
	B. Health Care and Programs										
9	Medical Director			94,750	94,750		94,750		94,750		9
10	Nursing and Medical Records	3,145,720	375,735	56,306	3,577,761		3,577,761	32,575	3,610,336		10
10a	Therapy			1,724,705	1,724,705		1,724,705		1,724,705		10a
11	Activities	155,759	20,348	16,677	192,784		192,784		192,784		11
12	Social Services	332,584		48,447	381,031		381,031		381,031		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. Mgmt Co. Bene							4,465	4,465		15
16	TOTAL Health Care and Programs	3,634,063	396,083	1,940,885	5,971,031		5,971,031	37,040	6,008,071		16
	C. General Administration										
17	Administrative	106,137		904,931	1,011,068		1,011,068	(890,477)	120,591		17
18	Directors Fees										18
19	Professional Services			133,041	133,041		133,041	3,580	136,621		19
20	Dues, Fees, Subscriptions & Promotions			18,569	18,569		18,569	4,548	23,117		20
21	Clerical & General Office Expenses	334,663	34,538	28,145	397,346		397,346	157,216	554,562		21
22	Employee Benefits & Payroll Taxes			676,409	676,409		676,409	12,061	688,470		22
23	Inservice Training & Education			12,870	12,870		12,870	567	13,437		23
24	Travel and Seminar			6,951	6,951		6,951	(1,958)	4,993		24
25	Other Admin. Staff Transportation			1,656	1,656		1,656	10,758	12,414		25
26	Insurance-Prop.Liab.Malpractice			129,993	129,993		129,993	2,196	132,189		26
27	Other (specify):* Alloc. Mgmt Co. Bene							39,277	39,277		27
28	TOTAL General Administration	440,800	34,538	1,912,565	2,387,903		2,387,903	(662,232)	1,725,671		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,788,657	654,016	4,171,492	9,614,165		9,614,165	(599,423)	9,014,742		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of LaGrange #0038083 Report Period Beginning: 1/1/10 Ending: 12/31/10

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			125,773	125,773		125,773	322,244	448,017			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,214	1,214		1,214	370,345	371,559			32
33	Real Estate Taxes							250,458	250,458			33
34	Rent-Facility & Grounds			967,376	967,376		967,376	(965,215)	2,161			34
35	Rent-Equipment & Vehicles			90,194	90,194		90,194	1,732	91,926			35
36	Other (specify):*											36
37	TOTAL Ownership			1,184,557	1,184,557		1,184,557	(20,436)	1,164,121			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		790,429		790,429		790,429		790,429			39
40	Barber and Beauty Shops			27,442	27,442		27,442		27,442			40
41	Coffee and Gift Shops			3,237	3,237		3,237		3,237			41
42	Provider Participation Fee			53,407	53,407		53,407		53,407			42
43	Other (specify):* Non-Allowable Cos			110,380	110,380		110,380	(110,380)				43
44	TOTAL Special Cost Centers		790,429	194,466	984,895		984,895	(110,380)	874,515			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,788,657	1,444,445	5,550,515	11,783,617		11,783,617	(730,239)	11,053,378			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	(4,620)	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	(338)	30		9
10	Interest and Other Investment Income	(657)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,455)	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	(2,440)	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	(934)	43		24
25	Fund Raising, Advertising and Promotional	(41,389)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,292)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(388,010)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (450,135)		\$	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)	(280,104)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (280,104)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (730,239)		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 LaGrange

ID# 0038083

Report Period Beginning: 1/1/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (176)	21	1
2	Labs-Part A	(8,585)	43	2
3	X-Rays-Part A	(38,731)	43	3
4	Diagnostics Managed Care	(1,940)	43	4
5	Trust Fees	(75)	43	5
6	Collections	(7,727)	19	6
7	Out of Period legal	(440)	19	7
8	Marketing Salary	(111,776)	21	8
9	Education & Seminar marketing	(2,971)	24	9
10	Unrealized loss on FMV swap	(215,589)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(388,010)		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 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Fees	\$	Sambell of LaGrange Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	297,887	297,887	2
3	V	32 Interest Expense		Sambell of LaGrange Limited Partnership	**	360,802	360,802	3
4	V	32 Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	1,339	1,339	4
5	V	33 Property Taxes		Sambell of LaGrange Limited Partnership	**	247,376	247,376	5
6	V	34 Rental Expense	967,376	Sambell of LaGrange Limited Partnership	**		(967,376)	6
7	V	43 Trust Fees		Sambell of LaGrange Limited Partnership	**	75	75	7
8	V	43 Personal Item Replacement		Sambell of LaGrange Limited Partnership	**	6	6	8
9	V	43 Unrealized loss on FMV swap		Sambell of LaGrange Limited Partnership	**	215,589	215,589	9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of La Grange, Inc. owns 100%				12
13	V			of Sambell of LaGrange Limited Partnership.				13
14	Total		\$ 967,376			\$ 1,123,274	\$ * 155,898	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.	**	\$ 206	\$	206	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,715		4,715	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	134		134	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	456		456	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	24,116		24,116	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,405		4,405	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	215		215	21	
22	V	6 Security service		Royal Management Corp.	**				22	
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	3,583		3,583	23	
24	V	10 Medical consultant		Royal Management Corp.	**	2,522		2,522	24	
25	V	10 Management allocation - salaries		Royal Management Corp.	**	30,053		30,053	25	
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	4,465		4,465	26	
27	V	17 Management allocation - salaries		Royal Management Corp.	**	14,454		14,454	27	
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	7,989		7,989	28	
29	V	19 Professional fees		Royal Management Corp.	**	3,558		3,558	29	
30	V	20 Dues & subscriptions		Royal Management Corp.	**	360		360	30	
31	V	23 Inservice Training		Royal Management Corp.	**	567		567	31	
32	V	20 Advertising - help wanted		Royal Management Corp.	**	4,188		4,188	32	
33	V	21 Management allocation - salaries		Royal Management Corp.	**	249,916		249,916	33	
34	V	21 Bank charges		Royal Management Corp.	**	4,949		4,949	34	
35	V	21 Office supplies & printing		Royal Management Corp.	**	6,514		6,514	35	
36	V	21 Postage		Royal Management Corp.	**	2,340		2,340	36	
37	V								37	
38	V	**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 369,705	\$ *	369,705	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.	**	\$ 5,449	\$ 5,449
16	V	24 Travel & seminar		Royal Management Corp.	**	1,013	1,013
17	V	25 Auto expense		Royal Management Corp.	**	10,758	10,758
18	V	26 Insurance general		Royal Management Corp.	**	2,196	2,196
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	39,277	39,277
20	V	30 Depreciation		Royal Management Corp.	**	24,695	24,695
21	V	32 Interest		Royal Management Corp.	**	8,842	8,842
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	19	19
23	V	33 Property taxes		Royal Management Corp.	**	3,082	3,082
24	V	34 Rent expense		Royal Management Corp.	**	2,161	2,161
25	V	35 Equipment rental		Royal Management Corp.	**	642	642
26	V	17 Management fees	904,931	Royal Management Corp.	**		(904,931)
27	V	35 Auto Lease		Royal Management Corp.	**	1,090	1,090
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 904,931			\$ 99,224	\$ * (805,707)

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

Lexington Health Care Center of LaGrange, Inc.
 Provider # 0038083
 FYE 1/1/10 - 12/31/10

Schedule B

VII. Related Parties
 Owners

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

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

Other Business Related Entities

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

See Accountants' Compilation Report

Facility Name & ID Number

Lexington of LaGrange

0038083

Report Period Beginning:

1/1/10

Ending:

12/31/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	James Samatas	Owner/officer	Administrative	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 5,219	L17, C7	1	
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,498	L17, C7	2	
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,738	L17, C7	3	
4											4	
5	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,355	L21,C7	5	
6											6	
7											7	
8											8	
9					Certain Individuals work in excess of 40 hours per week.							9
10											10	
11											11	
12											12	
13								TOTAL	\$ 15,810		13	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

1/1/10

Ending: 12/31/10

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 Available	718,010	10	\$ 3,682	\$ 40,150	\$ 206	1	
2	5	Utilities - gas & electric	Bed Days Available	718,010	10	84,318	40,150	4,715	2	
3	5	Utilities - water & sewer	Bed Days Available	718,010	10	2,399	40,150	134	3	
4	5	Utilities - maintenance office	Bed Days Available	718,010	10	8,161	40,150	456	4	
5	6	Management allocation - salaries	Bed Days Available	718,010	10	431,278	431,278	40,150	24,116	5
6	6	Repairs & maintenance	Bed Days Available	718,010	10	78,772	40,150	4,405	6	
7	6	Scavenger & exterminating	Bed Days Available	718,010	10	3,848	40,150	215	7	
8	6	Security service	Bed Days Available	718,010	10		40,150	0	8	
9	7	Management allocation - employees	Bed Days Available	718,010	10	64,074	40,150	3,583	9	
10	10	Medical consultant	Bed Days Available	718,010	10	45,100	40,150	2,522	10	
11	10	Management allocation - salaries	Bed Days Available	718,010	10	537,439	537,439	40,150	30,053	11
12	15	Management allocation - employees	Bed Days Available	718,010	10	79,846	40,150	4,465	12	
13	17	Management allocation - salaries	Bed Days Available	718,010	10	258,489	258,489	40,150	14,454	13
14	19	Computer consultant & supplies	Bed Days Available	718,010	10	142,872	40,150	7,989	14	
15	19	Professional fees	Bed Days Available	718,010	10	63,628	40,150	3,558	15	
16	20	Dues & subscriptions	Bed Days Available	718,010	10	6,440	40,150	360	16	
17	23	Inservice Training	Bed Days Available	718,010	10	10,139	40,150	567	17	
18	20	Advertising - help wanted	Bed Days Available	718,010	10	74,892	40,150	4,188	18	
19	21	Management allocation - salaries	Bed Days Available	718,010	10	4,469,291	4,469,291	40,150	249,916	19
20	21	Bank charges	Bed Days Available	718,010	10	88,508	40,150	4,949	20	
21	21	Office supplies & printing	Bed Days Available	718,010	10	116,497	40,150	6,514	21	
22	21	Postage	Bed Days Available	718,010	10	41,854	40,150	2,340	22	
23	21	Telephone	Bed Days Available	718,010	10	97,454	40,150	5,449	23	
24	24	Travel and Seminar	Bed Days Available	718,010	10	18,117	40,150	1,013	24	
25	TOTALS					\$ 6,727,098	\$ 5,696,497	\$ 376,167	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

1/1/10

Ending: 12/31/10

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	25	Auto expense	Bed Days	718,010	10	\$ 192,388	\$ 40,150	\$ 10,758	1
2	26	Insurance general	Bed Days	718,010	10	39,272	40,150	2,196	2
3	27	Management allocation - employees	Bed Days	718,010	10	702,398	40,150	39,277	3
4	30	Depreciation	Bed Days	718,010	10	441,627	40,150	24,695	4
5	32	Interest	Bed Days	718,010	10	158,122	40,150	8,842	5
6	32	Amortization of mortgage costs	Bed Days	718,010	10	346	40,150	19	6
7	33	Property taxes	Bed Days	718,010	10	55,117	40,150	3,082	7
8	34	Rent expense	Bed Days	718,010	10	38,647	40,150	2,161	8
9	35	Equipment rental	Bed Days	718,010	10	11,478	40,150	642	9
10	35	Auto Lease	Bed Days	718,010	10	19,500	40,150	1,090	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	\$	\$ 92,762	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of LaGrange

0038083

Report Period Beginning:

1/1/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Lexington Financial	X		Mortgage	Varies	4/30/07	\$ 5,991,000	\$ 5,641,416	5/1/17	0.0625	\$ 360,802	1							
2	Sevices II, LLC											2							
3												3							
4												4							
5							Interest on financing insurance premium				1,214	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						\$ 6,591,000	\$ 5,641,416			\$ 362,016	9							
B. Non-Facility Related*																			
10										Amortization of Loan Cost	1,358	10							
11										Interest Income offset	(657)	11							
12												12							
13										Allocated from Mgmt. Co.	8,842	13							
14	TOTAL Non-Facility Related						\$	\$			\$ 9,543	14							
15	TOTALS (line 9+line14)						\$ 6,591,000	\$ 5,641,416			\$ 371,559	15							

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.		\$	225,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	\$	241,653	2
3. Under or (over) accrual (line 2 minus line 1).		\$	16,053	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	Allocated from Mgmt. Co.	\$	249,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	7,648	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 25,925 For 2006 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(25,925)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	250,458	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	217,905	8
	2006	222,226	9
	2007	226,830	10
	2008	219,332	11
	2009	241,653	12

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

[See attached accrual worksheet](#)

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

1/1/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>40,000</u>	<u>1991</u>	<u>\$ 500,000</u>	<u>1</u>
2	<u>Allocated from Management Co.</u>			<u>10,491</u>	<u>2</u>
3	TOTALS	40,000		\$ 510,491	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

1/1/10

Ending:

12/31/10

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1992	1992	\$ 2,661,448	\$	35	\$ 76,041	\$ 76,041	\$ 1,406,764	4
5	10		1995	1995	79,363		10			79,363	5
6	1		2005	2005	2,321,014		21	110,524	110,524	607,884	6
7											7
8											8
	Improvement Type**										
9		Land Improvements	1992		1,152		20	58	58	1,066	9
10		Building Improvements	1992		2,714		31			2,714	10
11		Building Improvements	1993		2,901		35	83	83	1,492	11
12		Leasehold Improvements	1994		6,402		10			6,402	12
13		Leasehold Improvements - Corner Guards	1996		2,195		10			2,122	13
14		Wiring	1998		3,378		10			3,378	14
15		Resurface & Restripe Parking Lot	1998		3,753		10			3,753	15
16		Lobby Tile	1998		19,488		10			19,488	16
17		Resurface & Restripe Parking Lot	2000		1,997	100	10	100		1,998	17
18		Automatic Door	2000		1,300	65	10	65		1,300	18
19		Kitchen Rehab	2001		1,441	144	10	144		1,369	19
20		Infrared curtains for elevator	2001		3,000	300	10	300		2,850	20
21		Dining room, resident rooms, and corridors renovation	2002		150,083	7,505	20	7,505		60,661	21
22		Elevator upgrade	2002		5,398	540	10	540		4,679	22
23		Air conditioner compressor	2003		9,218	922	10	922		6,837	23
24		Sidewalk and fencing	2005		46,701	2,335	20	2,335		12,064	24
25		HVAC	2005		8,141	407	20	407		2,069	25
26		Wiring	2005		4,506	225	20	225		1,182	26
27		Lobby, lounge and reception renovations	2005		24,362	1,218	20	1,218		6,496	27
28		1st floor new dining room, floors, ceilings, wallcoverings, doors	2005		326,862		20	16,343	16,343	81,715	28
29		Wallcoverings	2005		10,822		5	903	903	10,822	29
30		Medical records room rehab	2006		19,739	987	20	987		3,948	30
31		Activity/PT Room Rehab	2006		1,158	58	20	58		232	31
32		Land scape enhancement	2006		8,726	582	15	582		2,522	32
33		Roof	2006		29,700	1,980	15	1,980		8,580	33
34		HVAC	2006		3,254	163	20	163		706	34
35		Plumbing and sprinkler system	2006		20,725	1,036	20	1,036		5,181	35
36		Laundry Combustion Air	2006		16,814	841	20	841		3,994	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

1/1/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Lobby/Lounge/Reception rehab	2006	\$ 14,033	\$ 1,403	10	\$ 1,403	\$	\$ 6,314	37
38	Cubicle curtains/drapery	2006	6,955	1,391	5	1,391		6,778	38
39	Cabinets/counters for 2nd FI library	2006	2,665	267	10	267		1,134	39
40	TCU rehab	2006	2,402	120	20	120		490	40
41	First floor remodel	2006	212,084		20	10,604	10,604	42,416	41
42	Kitchen rehab	2006	8,165	408	20	408		1,837	42
43	Bath fixtures-2nd floor	2006	2,076	208	10	208		1,005	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		705	44
45	Landscaping	2007	3,862	257	15	257		921	45
46	HVAC	2007	58,326	2,916	20	2,916		9,963	46
47	Common Areas Remodel	2007	2,059	206	10	206		738	47
48	First Floor Remodel	2007	6,517		20	326	326	1,221	48
49	Garage	2007	16,487	824	20	824		2,541	49
50	Land Improvements	2008	3,745	250	15	250		521	50
51	Parking lot-paving	2008	8,720	436	20	436		1,054	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		280	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	16,260	16,260	46,070	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		4,147	55
56	Irrigation System	2009	16,740	1,116	15	1,116		1,395	56
57	Landscaping	2009	10,321	688	15	688		860	57
58	Parking lot repairs	2009	3,500	175	20	175		277	58
59	HVAC Chiller	2009	2,594	130	20	130		184	59
60	Patio Pergola	2009	6,760	338	20	338		620	60
61	Stamped Concrete	2009	16,658	833	20	833		1,111	61
62	Fence	2009	4,084	204	20	204		221	62
63	Patio Wall	2009	8,212	411	20	411		514	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		442	64
65									65
66	Brick Panel Replacement	2010	16,578	402	27	402		402	66
67	Office changes	2010	17,565		27				67
68	Landscaping Enhancements	2010	15,258	509	15	509		509	68
69	Drain tile,sewer concrete	2010	3,221	46	15	46		46	69
70	TOTAL (lines 4 thru 69)		\$ 6,882,020	\$ 37,355		\$ 268,496	\$ 231,141	\$ 2,488,348	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		\$ 6,882,020	\$ 37,355		\$ 268,496	\$ 231,141	\$ 2,488,348	1
2	Retaining wall	2010	15,736		15				2
3	Canopy Installation	2010	4,466	27	27	27		27	3
4	Dining Room HVAC	2010	4,169	76	27	76		76	4
5	Remodel Pantry	2010	2,911	35	27	35		35	5
6	Paint Rooms	2010	4,245		27				6
7	Remodel Library/Lounge-art,painting,flooring	2010	6,477		27				7
8	2nd floor doors	2010	3,046	83	27	83		83	8
9									9
10	Reconcile book depreciation			25			(25)		10
11									11
12									12
13									13
14									14
15	Building - management company	2002	145,176		40	4,477	4,477	38,505	15
16	HVAC, electrical, security system - management company	2003	1,275		30	239	239	654	16
17	Key card system - management company	2004	200		20	10	10	64	17
18	VAV TX controls - management company	2005	61		20	3	3	18	18
19	Interior Signs-management company	2006	44		5	3	3	12	19
20	Building - management company	2008	4,821		5	382	382	823	20
21	Building - management company	2009	362		15	25	25	30	21
22	Building - management company	2010	437		15	36	36	35	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)		\$ 7,075,446	\$ 37,601		\$ 273,892	\$ 236,291	\$ 2,528,710	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	\$ 850,298	\$ 78,226	\$ 144,661	\$ 66,435	5	\$ 536,413	71
72	Current Year Purchases	94,924	9,946	9,946		5	9,946	72
73	Fully Depreciated Assets	38,663					38,663	73
74	Allocated from Mgmt. Co.	154,336		16,337	16,337	5	121,341	74
75	TOTALS	\$ 1,138,221	\$ 88,172	\$ 170,944	\$ 82,772		\$ 706,363	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.			22,737		3,181	3,181	5	16,005	79
80	TOTALS			\$ 22,737	\$	\$ 3,181	\$ 3,181		\$ 16,005	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,746,895	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,773	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 448,017	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 322,244	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,251,078	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP-Payroll office	\$ 1,871	92
93	CIP-Payroll office	652	93
94			94
95		\$ 2,523	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: _____

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.				2,161			6
7	TOTAL				\$ 2,161			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: \$ 90,836 Description: Copier-\$10,075; Mailing Machine-\$60; Med Equip.-\$42,762; Oxygen-\$37,297; Mgmt. Co.-\$642

(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	Allocated from Mgmt. Co.		\$ _____	\$ 1,090	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 1,090	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	\$	12,212	\$ 707,501	\$	12,212	\$ 707,501	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,734	132,418		2,734	132,418	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,507	884,786		7,507	884,786	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				790,429		790,429	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			\$	22,453	\$ 1,724,705	\$ 790,429	22,453	\$ 2,515,134	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange# 0038083Report Period Beginning: 1/1/10Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(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	\$ 15,537	\$ 51,625	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>331,214</u>)	1,528,150	1,528,150	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,159	70,159	6
7	Other Prepaid Expenses	1,158	1,158	7
8	Accounts Receivable (owners or related parties)	5,668	132,402	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,620,672	\$ 1,783,494	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,627	6,627	12
13	Land		510,491	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	929,245	4,413,998	15
16	Equipment, at Historical Cost	586,692	1,160,958	16
17	Accumulated Depreciation (book methods)	(609,286)	(3,251,078)	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	2,523	2,523	22
23	Other(specify): <u>Mortgage cost net</u>		28,891	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 915,801	\$ 5,533,858	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,536,473	\$ 7,317,352	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 18,308	\$ 18,308	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,081	299,081	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,154	7,154	31
32	Accrued Real Estate Taxes(Sch.IX-B)		249,600	32
33	Accrued Interest Payable		32,736	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	292,979	966,850	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 617,522	\$ 1,573,729	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,641,416	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,641,416	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 617,522	\$ 7,215,145	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,918,951	\$ 102,207	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,536,473	\$ 7,317,352	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of LaGrange
FYE 12/31/10
Provider # 0038083
Schedule 17A

XV. Balance Sheet

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Interest Rate Swap Liability		885,680
Accrued Expenses	65,177	65,177
Accrued Royl/Vesta Mgmt	15,451	15,451
Accrued Rent	211,809	
Due to Patient Trust Fund	11,409	11,409
Deffered Income	66,071	66,071
Due to Royal Operating	31,344	31,344
Due to Republic Construction of Illinois, Inc	6,261	6,261
Due to Lombard	758	758
Advance bi-weekly part A payments	(73,505)	(73,505)
Uncollectible part A Co. Pvts	(41,796)	(41,796)
	<u>292,979</u>	<u>966,850</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,501,642	1
2	Restatements (describe):		2
3	Post closing adjustments	(87,119)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,414,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,395,428	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	(891,000)	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)	\$ 504,428	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,918,951	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange# 0038083Report Period Beginning: 1/1/10Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,397,724	1
2	Discounts and Allowances for all Levels	(5,386,075)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,011,649	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,680,080	6
7	Oxygen	30,934	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,711,014	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,888	12
13	Barber and Beauty Care	23,103	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	895,398	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	157,072	19
20	Radiology and X-Ray		20
21	Other Medical Services	375,974	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,455,435	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	771	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 771	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Income</u>	176	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 176	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,179,045	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,255,231	31
32	Health Care	5,971,031	32
33	General Administration	2,387,903	33
B. Capital Expense			
34	Ownership	1,184,557	34
C. Ancillary Expense			
35	Special Cost Centers	931,488	35
36	Provider Participation Fee	53,407	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,783,617	40
41	Income before Income Taxes (line 30 minus line 40)**	1,395,428	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,395,428	43

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

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

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

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

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	1,567	1,740	\$ 90,085	\$ 51.77	1
2	Assistant Director of Nursing	11,371	12,226	422,587	34.56	2
3	Registered Nurses	35,816	39,441	1,170,425	29.68	3
4	Licensed Practical Nurses	19,054	22,130	519,652	23.48	4
5	CNAs & Orderlies	65,461	70,996	786,615	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,143	9,029	120,484	13.34	8
9	Activity Director					9
10	Activity Assistants	11,913	13,017	155,759	11.97	10
11	Social Service Workers	15,914	17,159	332,584	19.38	11
12	Dietician	917	978	17,675	18.07	12
13	Food Service Supervisor	1,954	2,145	54,267	25.30	13
14	Head Cook	1,867	2,131	34,107	16.01	14
15	Cook Helpers/Assistants	13,360	14,338	145,603	10.16	15
16	Dishwashers	10,259	10,850	90,121	8.31	16
17	Maintenance Workers	1,949	2,215	38,593	17.42	17
18	Housekeepers	26,769	29,164	270,066	9.26	18
19	Laundry	6,469	7,124	63,362	8.89	19
20	Administrator	1,477	1,637	106,137	64.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,825	15,161	222,887	14.70	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	1,951	2,164	35,872	16.58	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,904	3,416	111,776	32.72	33
34	TOTAL (lines 1 - 33)	252,940	277,061	\$ 4,788,657 *	\$ 17.28	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	193	\$ 12,387	1(3)	35
36	Medical Director	Monthly	94,750	9(3)	36
37	Medical Records Consultant	20	1,037	10(3)	37
38	Nurse Consultant	Monthly	4,187	10(3)	38
39	Pharmacist Consultant	Monthly	6,540	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	99	4,843	11(3)	44
45	Social Service Consultant	88	4,464	12(3)	45
46	Other(specify) <u>Psychosocial</u>	48	2,304	12(3)	46
47	<u>Pulmonary</u>	Monthly	44,542	10(3)	47
48	<u>Medical Consultant</u>	Monthly	2,522	10(7)	48
49	TOTAL (lines 35 - 48)	448	\$ 177,576		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Christopher Correll	Administrator	0%	\$ 24,723	Workers' Compensation Insurance	\$ 75,205	IDPH License Fee	\$	
Diane Androvich	Administrator	0%	81,414	Unemployment Compensation Insurance	67,545	Advertising: Employee Recruitment	9,565	
				FICA Taxes	351,447	Health Care Worker Background Check		
				Employee Health Insurance	147,482	(Indicate # of checks performed <u>83</u>)	994	
				Employee Meals	12,061	Patient Background Checks	554 6,652	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	493	
				401K	12,233	Miscellaneous Dues & Subscriptions	865	
				Other Employee Benefits	21,539	Allocated from Mgmt. Co.	4,548	
				Unifrom Expense	958			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 106,137					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
Management Fees-Royal Operating			\$ 508,643					
Management Fees-Vesta Mgmt.			396,288					
(Eliminated on page 3,C7,L17)								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 904,931					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Action Computer Service	Computer Consulting	\$ 597	N/A			Out-of-State Travel	\$	
BSKLIVE Inc.	Computer Consulting	4,219						
Bridgepoint Technologies	Computer Consulting	1,247				In-State Travel		
C.D.W. Government	Computer Consulting	256						
Cimco Communications	Computer Consulting	1,149				Seminar Expense	3,980	
Efax Corporate	Computer Consulting	2,201				Allocated from Mgmt. Co.	1,013	
E-Health Data Solutions	Computer Consulting	2,400						
Elton Data Solutions	Computer Consulting	1,265				Entertainment Expense	()	
Information Control	Computer Consulting	867				(agree to Sch. V, line 24, col. 8)		
Krakau Business	Computer Consulting	322				TOTAL	\$ 4,993	
Lanac Technology	Computer Consulting	2,845						
See Sch 21 C		115,673						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 133,041					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

C. Professional Fees

Schedule 21C

Vendor/Payee	Type	Amount
Lintech LLC	Computer Consulting	5,941
Microsoft Licensing	Computer Consulting	5,231
National Datacare	Computer Consulting	874
Red Sky Technologies	Computer Consulting	273
RSM McGladrey	Computer Consulting	8,486
SilverChair Learning Systems	Computer Consulting	4,200
SPM Marketing & Communicat	Computer Consulting	877
Telemedicine Solutions	Computer Consulting	4,750
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	1,360
Warehouse Direct	Computer Consulting	108
TouchPoint Care	Computer Consulting	400
Shaker Recruitment Advertisi	Computer Consulting	30
Bank of America	Banking	27
Grabowski Law Center	Collections	7,727
Cassiday Schade & Gloor LLI	Legal	25,029
McGladrey & Pullen	Accounting	26,165
Medcor	Healthcare	250
Much Shelist	Legal	10,219
Pension Administrators	Pension Administration	579
Personnel Planners	U/C Consulting	2,290
RSM McGladrey	Accounting	5,290
Serpico, Petrosino & Dipiero,	Legal	2,520
Will County Clerk	Accounting	10
		<u>115,673</u>
Total Schedule V, line 19, column 3		133,041
Less collection fees		(7,727)
Out of period legal		(440)
Allocated from Sambell of LaGrange James Samatas		200
Samvest of Lombard II Legal		146
Accounting		54
		<u>200</u>
Allocated from Mgmt Co. Serpico, Petrosino, Dipiero	Legal	61
Duane Morris	Legal	123
McGladrey & Pullen	Accounting	497
RSM McGladrey	Accounting	406
Illinois Secretary of State	Filing Fees	26
LaSalle Network	Recruiting/Finance	614
Gilson Labus & Silverman	KEP	394
KMZ Rosenmann	KEP	64
Pension Administration, Inc.	401(k) Administration	113
Aijilon Professional Staffing	Accounting	501
Personnel Planners, Inc.	U/C Consulting	13
Quattrochi and Parker	Social Service Consulting	13
Gene Whitehorn	Medicaid Reimb Specialist	532
Computer service	Computer Service	7,990
		<u>11,347</u>
Total Schedule V, line 19 column 8		<u>136,621</u>

See Accountant's Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

0038083

Report Period Beginning: 1/1/10

Ending: 12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,808 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. \$ 53,407
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. \$ 12,061 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N?A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT