

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc.

0042739 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	203	Skilled (SNF)	203	74,095	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	203	TOTALS	203	74,095	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	Private Pay	4 Other	Total	
8	SNF			16,467	16,467	8
9	SNF/PED					9
10	ICF	34,448	15,271		49,719	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,448	15,271	16,467	66,186	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.33%

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 6/4/91

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 203 and days of care provided 11,964

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Lexington Health Care Center of Chicago Ric # 0042739 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	395,197	35,769	23,865	454,831		454,831		454,831		1
2	Food Purchase		369,254		369,254		369,254	(20,405)	348,849		2
3	Housekeeping	417,786	40,410		458,196		458,196	370	458,566		3
4	Laundry	96,911	26,956		123,867		123,867		123,867		4
5	Heat and Other Utilities			254,883	254,883		254,883	10,148	265,031		5
6	Maintenance	44,430		228,771	273,201		273,201	74,898	348,099		6
7	Other (specify):* Alloc. From Mgmt. C							9,152	9,152		7
8	TOTAL General Services	954,324	472,389	507,519	1,934,232		1,934,232	74,163	2,008,395		8
	B. Health Care and Programs										
9	Medical Director			80,625	80,625		80,625		80,625		9
10	Nursing and Medical Records	5,201,916	464,009	177,354	5,843,279		5,843,279	62,751	5,906,030		10
10a	Therapy			1,862,847	1,862,847		1,862,847		1,862,847		10a
11	Activities	253,391	31,411	11,451	296,253		296,253		296,253		11
12	Social Services	257,680		6,528	264,208		264,208		264,208		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. From Mgmt. C							8,679	8,679		15
16	TOTAL Health Care and Programs	5,712,987	495,420	2,138,805	8,347,212		8,347,212	71,430	8,418,642		16
	C. General Administration										
17	Administrative	135,308		1,672,712	1,808,020		1,808,020	(1,645,520)	162,500		17
18	Directors Fees										18
19	Professional Services			282,327	282,327		282,327	1,384	283,711		19
20	Dues, Fees, Subscriptions & Promotions			50,039	50,039		50,039	5,740	55,779		20
21	Clerical & General Office Expenses	331,995	45,125	52,098	429,218		429,218	604,121	1,033,339		21
22	Employee Benefits & Payroll Taxes			1,193,524	1,193,524		1,193,524	20,405	1,213,929		22
23	Inservice Training & Education			16,641	16,641		16,641	1,618	18,259		23
24	Travel and Seminar			1,603	1,603		1,603	1,184	2,787		24
25	Other Admin. Staff Transportation			494	494		494	19,632	20,126		25
26	Insurance-Prop.Liab.Malpractice			426,893	426,893		426,893	6,785	433,678		26
27	Other (specify):* Alloc. From Mgmt. C							87,210	87,210		27
28	TOTAL General Administration	467,303	45,125	3,696,331	4,208,759		4,208,759	(897,441)	3,311,318		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,134,614	1,012,934	6,342,655	14,490,203		14,490,203	(751,848)	13,738,355		29

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

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

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc. #0042739 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			203,177	203,177		203,177	363,544	566,721			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,259	6,259		6,259	420,680	426,939			32
33	Real Estate Taxes							460,971	460,971			33
34	Rent-Facility & Grounds			1,774,861	1,774,861		1,774,861	(1,770,746)	4,115			34
35	Rent-Equipment & Vehicles			76,812	76,812		76,812	3,320	80,132			35
36	Other (specify):*											36
37	TOTAL Ownership			2,061,109	2,061,109		2,061,109	(522,231)	1,538,878			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		983,882	8,081	991,963		991,963		991,963			39
40	Barber and Beauty Shops			21,274	21,274		21,274		21,274			40
41	Coffee and Gift Shops			6,711	6,711		6,711		6,711			41
42	Provider Participation Fee			274,966	274,966		274,966		274,966			42
43	Other (specify):* Non-Allow Costs	124,817		147,135	271,952		271,952	(271,952)				43
44	TOTAL Special Cost Centers	124,817	983,882	458,167	1,566,866		1,566,866	(271,952)	1,294,914			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,259,431	1,996,816	8,861,931	18,118,178		18,118,178	(1,546,031)	16,572,147			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,333)	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	822	30		9
10	Interest and Other Investment Income	(2,362)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,439)	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	(2,627)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	38,572	43		24
25	Fund Raising, Advertising and Promotional	(42,253)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,449)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(519,272)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (546,341)		\$	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)	(999,690)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (999,690)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,546,031)		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

Lexington Health Care Center of Chicago Ridge, Inc.

ID# 0042739

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Trust Fees	\$ (135)	43	1
2	Labs - Part A	(48,675)	43	2
3	X-Rays - Part A	(25,547)	43	3
4	Diagnostics Managed Care	(20,524)	43	4
5	Misc Income	(425)	21	5
6	Collection Fees	(2,185)	19	6
7	Out of period legal	(20,355)	19	7
8	Reclass LHI under 2500	6,681	6	8
9	Valet Service	(26,870)	43	9
10	Marketing Salary	(124,817)	21	10
11	Travel and Seminar marketing	(1,603)	24	11
12	Dues & subscriptions marketing	(1,626)	20	12
13	Unrealized loss on FMV swap	(253,191)	43	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	(519,272)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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 Chicago Ridge Limited Partnership	**	\$ 200	\$ 200	1
2	V	21 Office Supplies		Sambell of Chicago Ridge Limited Partnership	**	40	40	2
3	V	30 Depreciation		Sambell of Chicago Ridge Limited Partnership	**	315,270	315,270	3
4	V	32 Interest expense		Sambell of Chicago Ridge Limited Partnership	**	405,611	405,611	4
5	V	32 Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	1,288	1,288	5
6	V	33 Real estate tax		Sambell of Chicago Ridge Limited Partnership	**	454,861	454,861	6
7	V	34 Rental expense	1,774,861	Sambell of Chicago Ridge Limited Partnership	**		(1,774,861)	7
8	V	43 Trust fees		Sambell of Chicago Ridge Limited Partnership	**	135	135	8
9	V	43 State Replacement Taxes		Sambell of Chicago Ridge Limited Partnership	**	10	10	9
10	V	43 Unrealized loss on FMV swap				253,191	253,191	10
11	V			** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%				11
12	V			of Sambell of Chicago Ridge Limited Partnership				12
13	V							13
14	Total		\$ 1,774,861			\$ 1,430,606	\$ * (344,255)	14

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

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc.# 0042739Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.	**	\$ 370	\$	370	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	8,831		8,831	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	201		201	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,116		1,116	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	62,190		62,190	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,689		5,689	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	338		338	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	9,152		9,152	22	
23	V	10 Medical consultant		Royal Management Corp.	**	3,779		3,779	23	
24	V	10 Management allocation - salaries		Royal Management Corp.	**	58,972		58,972	24	
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	8,679		8,679	25	
26	V	17 Management allocation - salaries		Royal Management Corp.	**	27,192		27,192	26	
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	17,230		17,230	27	
28	V	19 Professional fees		Royal Management Corp.	**	6,494		6,494	28	
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,333		1,333	29	
30	V	20 Advertising - help wanted		Royal Management Corp.	**	6,033		6,033	30	
31	V	21 Management allocation - salaries		Royal Management Corp.	**	565,402		565,402	31	
32	V	21 Bank charges		Royal Management Corp.	**	10,816		10,816	32	
33	V	21 Office supplies & printing		Royal Management Corp.	**	12,522		12,522	33	
34	V	21 Postage		Royal Management Corp.	**	4,051		4,051	34	
35	V	21 Telephone		Royal Management Corp.	**	11,715		11,715	35	
36	V	23 Inservice Training		Royal Management Corp.	**	1,618		1,618	36	
37	V	24 Travel & seminar		Royal Management Corp.	**	2,787		2,787	37	
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 826,510	\$ *	826,510	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	25 Auto expense	\$	Royal Management Corp.	**	\$ 19,632	\$	19,632	15	
16	V	26 Insurance general		Royal Management Corp.	**	6,785		6,785	16	
17	V	27 Management allocation - employee benefits		Royal Management Corp.	**	87,210		87,210	17	
18	V	30 Depreciation		Royal Management Corp.	**	47,452		47,452	18	
19	V	32 Interest		Royal Management Corp.	**	16,107		16,107	19	
20	V	32 Amortization of mortgage costs		Royal Management Corp.	**	36		36	20	
21	V	33 Property taxes		Royal Management Corp.	**	6,110		6,110	21	
22	V	34 Rent expense		Royal Management Corp.	**	4,115		4,115	22	
23	V	35 Equipment rental		Royal Management Corp.	**	1,188		1,188	23	
24	V	17 Management fees	1,672,712	Royal Management Corp.	**	0		(1,672,712)	24	
25	V	35 Auto Lease		Royal Management Corp.	**	2,132		2,132	25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.								38
39	Total		\$ 1,672,712			\$ 190,767	\$ *	(1,481,945)	39	

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

Facility Name & ID Number Lexington Health Care Center of Chicago Ri # 0042739 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	\$ 9,973	L17, C7	1	
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,413	L17, C7	2	
3	Cynthia Thiem	Owner/Officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,806	L17, C7	3	
4											4	
5	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,793	L21,C7	5	
6											6	
7											7	
8					Certain individuals work in excess of 40 hours per week							8
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 31,985		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

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc. # 0042739 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	722,420	10	\$ 3,612	\$ 74,095	\$ 370	1	
2	5	Utilities - gas & electric	Bed Days	722,420	10	86,099	74,095	8,831	2	
3	5	Utilities - water & sewer	Bed Days	722,420	10	1,961	74,095	201	3	
4	5	Utilities - maintenance office	Bed Days	722,420	10	10,885	74,095	1,116	4	
5	6	Management allocation - salaries	Bed Days	722,420	10	606,344	606,344	74,095	62,190	5
6	6	Repairs & maintenance	Bed Days	722,420	10	55,471	74,095	5,689	6	
7	6	Scavenger & exterminating	Bed Days	722,420	10	3,293	74,095	338	7	
8	7	Management allocation - employees	Bed Days	722,420	10	89,234	74,095	9,152	8	
9	10	Medical consultant	Bed Days	722,420	10	36,843	74,095	3,779	9	
10	10	Management allocation - salaries	Bed Days	722,420	10	574,970	574,970	74,095	58,972	10
11	15	Management allocation - employees	Bed Days	722,420	10	84,616	74,095	8,679	11	
12	17	Management allocation - salaries	Bed Days	722,420	10	265,116	265,116	74,095	27,192	12
13	19	Computer consultant & supplies	Bed Days	722,420	10	167,987	74,095	17,230	13	
14	19	Professional fees	Bed Days	722,420	10	63,319	74,095	6,494	14	
15	20	Dues & subscriptions	Bed Days	722,420	10	13,000	74,095	1,333	15	
16	20	Advertising - help wanted	Bed Days	722,420	10	58,818	74,095	6,033	16	
17	21	Management allocation - salaries	Bed Days	722,420	10	5,512,623	5,512,623	74,095	565,402	17
18	21	Bank charges	Bed Days	722,420	10	105,454	74,095	10,816	18	
19	21	Office supplies & printing	Bed Days	722,420	10	122,091	74,095	12,522	19	
20	21	Postage	Bed Days	722,420	10	39,500	74,095	4,051	20	
21	21	Telephone	Bed Days	722,420	10	114,221	74,095	11,715	21	
22	23	Inservice Training	Bed Days	722,420	10	15,778	74,095	1,618	22	
23	24	Travel and Seminar	Bed Days	722,420	10	27,173	74,095	2,787	23	
24	25	Auto expense	Bed Days	722,420	10	191,407	74,095	19,632	24	
25	TOTALS					\$ 8,249,815	\$ 6,959,053	\$ 846,142	25	

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc. # 0042739 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	26	Insurance general	Bed Days	722,420	10	\$ 66,156	\$ 74,095	\$ 6,785	1
2	27	Management allocation - employees	Bed Days	722,420	10	850,290	74,095	87,210	2
3	30	Depreciation	Bed Days	722,420	10	462,650	74,095	47,452	3
4	32	Interest	Bed Days	722,420	10	157,045	74,095	16,107	4
5	32	Amortization of mortgage costs	Bed Days	722,420	10	354	74,095	36	5
6	33	Property taxes	Bed Days	722,420	10	59,576	74,095	6,110	6
7	34	Rent expense	Bed Days	722,420	10	40,122	74,095	4,115	7
8	35	Equipment rental	Bed Days	722,420	10	11,581	74,095	1,188	8
9	35	Auto Lease	Bed Days	722,420	10	20,791	74,095	2,132	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,668,565	\$	\$ 171,135	25

Facility Name & ID Number

Lexington Health Care Center of Chicago Rid

0042739

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lexington Financial	X		Mortgage	Varies	4/30/07	\$ 6,908,000	\$ 6,340,680	5/1/17	0.0625	\$ 405,611	1								
2	Services II, L.L.C.											2								
3												3								
4												4								
5							Interest on Financing insurance premium				1,206	5								
Working Capital																				
6	JP Morgan Chase		X	Line of Credit	Varies	4/30/07	1,400,000	940,000	6/30/12	Libor +1	5,053	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 8,308,000	\$ 7,280,680			\$ 411,870	9								
B. Non-Facility Related*																				
10										Amortization of loan cost	1,288	10								
11										Interest Income offset	(2,362)	11								
12										Allocate from Home Office	16,143	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 15,069	14								
15	TOTALS (line 9+line14)						\$ 8,308,000	\$ 7,280,680			\$ 426,939	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.)

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Chicago Ridge, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042739

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 2010 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 2010.

	(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>24-18-200-030-0000</u>	<u>Land & Building</u>	\$ <u>476,169.75</u>	\$ <u>476,169.75</u>
2.	<u>24-07-311-012-0000</u>	<u>Land & Building</u>	\$ <u>12,397.15</u>	\$ <u>12,397.15</u>
3.	<u>Royal Management Corp(Samvest of Lombard II)</u>		\$ _____	\$ _____
4.	<u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>229,415.60</u>	\$ <u>6,110.00</u>
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>717,982.50</u></u>	\$ <u><u>494,676.90</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>31,000</u>	<u>1989</u>	<u>\$ 505,000</u>	<u>1</u>
2	<u>Allocation from Management company</u>			<u>22,035</u>	<u>2</u>
3	TOTALS	31,000		\$ 527,035	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	203		1991	1991	\$ 5,143,342	\$	35	\$ 146,951	\$ 146,951	\$ 3,024,776	4
5			1995	1995	97,352	2,781	35	2,781		45,893	5
6											6
7											7
8											8
	Improvement Type**										
9		Leasehold Improvements	1993		2,694	77	35	77		1,425	9
10		Leasehold Improvements	1994		6,581	188	35	188		3,291	10
11		Dishwasher hood	1996		2,480		10			2,480	11
12		Lobby repairs	1996		8,698		10			8,698	12
13		Basement rehab	1997		24,477		10			24,477	13
14		Wiring	1998		3,429		10			3,429	14
15		Handrails	1998		895	60	15	60		807	15
16		Resurface & restripe parking lot	1998		4,450		10			4,451	16
17		Fire wall	1998		2,169	62	35	62		837	17
18		Foyer floor tile	1999		32,379		10			32,379	18
19		Wallpapering / painting / decorating	1999		8,833		10			8,832	19
20		Rebuild garage area	1999		1,762	50	35	50		611	20
21		Roof repairs	2000		6,240		10			6,240	21
22		Electrical wiring	2000		3,986	114	35	114		1,310	22
23		Electrical wiring	2000		2,536	72	35	72		832	23
24		Kitchen rehab	2000		6,623	221	35	221		2,540	24
25		Automatic doors	2000		1,300	65	10	65		1,300	25
26		Elevator eye sensors	2000		4,500	300	15	300		3,450	26
27		Resurface & restripe parking lot	2001		3,319	332	10	332		3,319	27
28		Door releases	2001		5,200	520	10	520		5,200	28
29		Carpeting	2001		10,022	1,002	10	1,002		10,022	29
30		Roof repairs	2002		25,600	1,280	20	1,280		12,587	30
31		Elevator upgrade	2002		9,865	986	10	986		9,452	31
32		Painting/decorating/carpet/wallpaper	2003		38,165	1,908	20	1,908		17,173	32
33		Rehab/new office	2003		26,733	1,337	20	1,337		12,031	33
34		Facility rehab - construction costs, painting & decorating	2003		257,174	12,859	20	12,859		109,300	34
35		Facility rehab - electrical	2003		12,840	642	20	642		5,457	35
36		Facility rehab - carpeting	2003		7,800	780	10	780		6,630	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

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc.

0042739

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Facility rehab - floor tile	2003	\$ 3,548	\$ 177	20	\$ 177		\$ 1,506	37
38									38
39	Kickplates/Door protectors	2004	4,095	410	10	410		3,142	39
40	Kitchen Fire Protection Upgrade	2004	1,427	143	10	143		1,095	40
41	Parking Lot - Paving and Sealcoating	2005	4,375	219	20	219		1,386	41
42	Kitchen Rehab	2005	19,228	961	20	961		5,927	42
43	Lobby/Lounge Reception Area	2005	36,503	1,825	20	1,825		12,015	43
44	Sidewalk - Raise and Support	2005	1,330	67	20	67		418	44
45	Lower Level Therapy Rehab	2005	52,525	2,626	20	2,626		16,632	45
46	Transitional Unit	2005	1,020	51	20	51		310	46
47	Basement Renovation	2005	3,754	188	20	188		1,159	47
48	Landscaping Enhancement	2006	6,463	431	15	431		2,263	48
49	Lhi-Hvac	2006	4,333	217	20	217		1,103	49
50	Rehab Common Areas	2006	7,661	383	20	383		2,107	50
51	Modular Units attached to wall	2006	10,316	516	20	516		2,752	51
52	Cubical Curtains	2006	1,578	316	5	316		1,578	52
53	Landscaping	2007	5,000	333	15	333		1,471	53
54	Parking lot	2007	35,969		20	1,819	1,819	7,276	54
55	HVAC	2007	4,580	229	20	229		1,069	55
56	Emergency A/C	2007	30,293	1,515	20	1,515		6,565	56
57	Portable A/C	2007	3,768	188	20	188		831	57
58	Employee Lunch Room	2007	3,671	184	20	184		767	58
59	Painting	2007	16,150	808	20	808		3,501	59
60	1st floor remodel-carpentry, flooring, plumbing, electrical fixtures	2007	641,616		40	16,225	16,225	64,900	60
61	painting,								61
62	Create first floor therapy	2007	185	9	20	9		45	62
63	Landscaping	2008	19,600	1,307	15	1,307		4,465	63
64	Parking Lot-paving,sealcoating and repairs	2008	44,050	2,203	20	2,203		7,160	64
65	HVAC Sport Coolers	2008	3,790	95	40	95		285	65
66	Plumbing & Sprinkler Shower room	2008	9,668	483	20	483		1,449	66
67	Common areas-doors and locks	2008	3,162	158	20	158		606	67
68	Basement Renovation	2008	7,569	189	40	189		725	68
69	2nd Floor Remodel-Carpentry, Flooring, Electrical, painting	2008	578,270		27	21,028	21,028	64,836	69
70	TOTAL (lines 4 thru 69)		\$ 7,326,941	\$ 41,867		\$ 227,890	\$ 186,023	\$ 3,588,573	70

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

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc.# 0042739

Report Period Beginning:

01/01/2011 Ending: 12/31/2011**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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		\$ 7,326,941	\$ 41,867		\$ 227,890	\$ 186,023	\$ 3,588,573	1
2	Land improvements	2009	15,180	1,012	15	1,012		2,277	2
3	Landscaping	2009	3,693	246	15	246		595	3
4	Chiller	2009	178,462	8,923	20	8,923		23,051	4
5	Quick connectors/spot cooler	2009	10,244	512	20	512		1,357	5
6	Plumbing & Sprinkler	2009	6,172	154	40	154		347	6
7	Chiller Fence	2009	5,350	268	20	268		536	7
8	Land improvements-patio pergola	2009	7,930	397	20	397		926	8
9	Land improvements patio fence	2009	14,308	715	20	715		1,490	9
10	3rd floor remodel-Carpentry, flooring, electrical, painting, sprinkler system	2009	670,689		27	24,389	24,389	50,810	10
11									11
12	Landscaping Enhancements	2010	4,560	304	15	304		355	12
13	Office carpentry, flooring, electrical, painting, plumbing, signs	2010	82,988	10,435	27	10,435		10,435	13
14	Tree removal	2010	12,094	806	15	806		1,075	14
15	Seal Crack Filing and Striping	2010	3,000	200	15	200		267	15
16	Parking lot signage, posts and lamps	2010	30,501	1,113	27	1,113		1,113	16
17	HVAC Quick connects	2010	4,043	147	27	147		160	17
18	Pantries-Tile, shelves	2010	2,855	104	27	104		130	18
19	Director of Nursing office painting	2010	8,090	295	27	295		295	19
20	1st floor rehab-cabinets, library lounge-art, flooring	2010	4,725	172	27	172		213	20
21	2nd floor rehab-painting, flooring	2010	61,521	2,244	27	2,244		2,244	21
22									22
23	Payroll Office Remodel	2011	5,439	132	27	132		132	23
24	Payroll Office Remodel	2011	10,336	157	27	157		157	24
25	Holding Tank	2011	16,400	248	27	248		248	25
26	Bulk Pipe - Removal of vent lines	2011	4,380	27	27	27		27	26
27	Remodel Laundry Room	2011	7,222	66	27	66		66	27
28	2nd Floor Doors	2011	23,290	282	27	282		282	28
29	2nd Floor Remodeling	2011	17,949		27	653	653	653	29
30	Exterior Painting	2011	3,000		27	36	36	36	30
31	Fire Dampers	2011	20,441		27	62	62	62	31
32	Boiler	2011	9,800		27	238	238	238	32
33	Parking Lot - seal and stripe	2011	4,300			39	39	39	33
34	TOTAL (lines 1 thru 33)		\$ 8,575,903	\$ 70,826		\$ 282,266	\$ 211,440	\$ 3,688,189	34

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

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc.

0042739

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,575,903	\$ 70,826		\$ 282,266	\$ 211,440	\$ 3,688,189	1
2									2
3									3
4									4
5									5
6	Land improvements - management company	2002	304,917		40	8,392	8,392	89,944	6
7	HVAC, electrical, security system - management company	2003	2,678		30	481	481	1,559	7
8	Key card system - management company	2004	421		20	19	19	156	8
9	VAV TX controls - management company	2005	128		20	6	6	44	9
10	Interior Signs- management company	2006	93		5	6	6	32	10
11	Building - management company	2008	14,775		5	717	717	3,054	11
12	Building - management company	2009	2,758		15	47	47	366	12
13	Building - management company	2010	2,688		15	103	103	278	13
14	Building - management company	2011	1,898		15	39	39	42	14
15	Reconcile to book depreciation			(823)			823		15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,906,259	\$ 70,003		\$ 292,076	\$ 222,073	\$ 3,783,664	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,346,284	\$ 119,257	\$ 223,086	\$ 103,829	5	\$ 776,967	71
72	Current Year Purchases	191,060	13,917	13,917		5	13,917	72
73	Fully Depreciated Assets	103,134					103,134	73
74	Allocated from Mgmt. Co.	355,211		32,924	32,924	5	276,938	74
75	TOTALS	\$ 1,995,689	\$ 133,174	\$ 269,927	\$ 136,753		\$ 1,170,956	75

D. Vehicle Costs. (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	Alloc. From Mgmt Co.			49,970		4,718	4,718	5	38,716	79
80	TOTALS			\$ 49,970	\$	\$ 4,718	\$ 4,718		\$ 38,716	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,478,953	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 203,177	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 566,721	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 363,544	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,993,336	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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.				4,115			6
7	TOTAL				\$ 4,115			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: \$ 78,000 Description: Copier-\$13,154;Med Equip-\$30,707;Oxygen-\$32,951;Alloc. Mgmt Co.-\$1,188

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Mgmt Co.			2,132	20
21	TOTAL		\$	\$ 2,132	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.	<u>/2012</u>	\$ _____
13.	<u>/2013</u>	\$ _____
14.	<u>/2014</u>	\$ _____

* 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.

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	\$	15,873	\$ 427,341	\$	15,873	\$ 427,341	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,023	132,184		5,023	132,184	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		13,788	1,303,323		13,788	1,303,323	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				983,882		983,882	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			\$	34,684	\$ 1,862,847	\$ 983,882	34,684	\$ 2,846,729	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.

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc.# 0042739Report Period Beginning: 01/01/2011Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	\$ 421,013	\$ 468,886	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>681,552</u>)	4,173,414	4,173,414	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(9,696)	(9,696)	6
7	Other Prepaid Expenses	(39,940)	40,870	7
8	Accounts Receivable (owners or related parties)	35,488	35,488	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,580,279	\$ 4,708,962	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		527,035	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	1,457,208	3,762,917	15
16	Equipment, at Historical Cost	962,864	2,045,659	16
17	Accumulated Depreciation (book methods)	(939,812)	(4,993,336)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage cost net</u>		26,503	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,480,260	\$ 6,512,120	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,060,539	\$ 11,221,082	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 856,706	\$ 856,706	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	940,000	940,000	29
30	Accrued Salaries Payable	361,896	361,896	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,027	18,027	31
32	Accrued Real Estate Taxes(Sch.IX-B)		504,000	32
33	Accrued Interest Payable		35,369	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	1,148,745	1,758,746	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,325,374	\$ 4,474,744	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,340,680	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,340,680	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,325,374	\$ 10,815,424	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,735,165	\$ 405,658	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,060,539	\$ 11,221,082	48

*(See instructions.)

Lexington Health Care Center of Chicago Ridge, Inc.
 Provider # 0036996
 1/1/11-12/31/11

Schedule 17A
 XV. Balance Sheet

C. Current Liabilities
 36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
LHCC ACCRUED RENT	-	-
LHCC Interest Rate Swap Liability	-	-
LHCC SAMBEL RENT RECEIVABLE	-	(551,435)
LHCC DUE FROM REMODELING	109,451	-
LHCC DUE TO/FROM REPUBLIC CONSTRUCTION	4,527	4,527
LHCC ACCRUED EXPENSES	58,559	58,559
LHCC ACCRUED RESIDENT TAX	163,823	163,823
LHCC ACCRUED RENT	551,435	551,435
LHCC ACCRUED INSURANCE	143,261	143,261
LHCC DUE TO PATIENT TRUST FUND	22,064	22,064
LHCC ADVANCE - BIWEEKLY PART A PAYM	(84,614)	(84,614)
LHCC UNCOLLECTIBLE PART A CO PVTS	(34,732)	(34,732)
LHCC DEFERRED INCOME	177,721	177,721
LHCC DUE TO - ROYAL OPERATIONS	46,358	46,358
LHCC Due to Chicago Ridge	-	-
LHCC Due to LHCC Elmhurst	(9,691)	(9,691)
LHCC Due to Orland Park	583	583
LHCC SAMBEL INTEREST RATE SWAP LIABILITY	-	1,270,887
	<u>1,148,745</u>	<u>1,758,746</u>
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,803,898	1
2	Restatements (describe):		2
3	Post closing adjustment	(135,862)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,668,036	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	680,894	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	(613,765)	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)	\$ 67,129	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)	\$ 2,735,165	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, In # 0042739 Report Period Beginning: 01/01/2011Ending: 12/31/2011

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	\$ 20,505,028	1
2	Discounts and Allowances for all Levels	(5,756,524)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,748,504	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,176,444	6
7	Oxygen	831	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,177,275	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	4,169	12
13	Barber and Beauty Care	19,644	13
14	Non-Patient Meals	51	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	451,582	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	192,608	19
20	Radiology and X-Ray		20
21	Other Medical Services	202,017	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 870,071	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,797	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,797	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	425	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 425	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,799,072	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,934,232	31
32	Health Care	8,347,212	32
33	General Administration	4,208,759	33
B. Capital Expense			
34	Ownership	2,061,109	34
C. Ancillary Expense			
35	Special Cost Centers	1,291,900	35
36	Provider Participation Fee	274,966	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,118,178	40
41	Income before Income Taxes (line 30 minus line 40)**	680,894	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 680,894	43

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

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

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

Facility Name & ID Number **Lexington Health Care Center of Chicago Ridge, Inc.**

0042739

Report Period Beginning: **01/01/2011**

Ending:

12/31/2011

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	1,492	1,702	\$ 112,076	\$ 65.85	1
2	Assistant Director of Nursing	46,631	54,363	1,265,403	23.28	2
3	Registered Nurses	20,737	24,535	780,937	31.83	3
4	Licensed Practical Nurses	48,206	54,925	1,387,155	25.26	4
5	CNAs & Orderlies	118,616	134,114	1,511,212	11.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,773	5,568	69,155	12.42	8
9	Activity Director					9
10	Activity Assistants	16,275	19,531	253,391	12.97	10
11	Social Service Workers	14,532	16,054	257,680	16.05	11
12	Dietician					12
13	Food Service Supervisor	1,861	2,132	44,608	20.92	13
14	Head Cook	1,824	2,094	34,797	16.62	14
15	Cook Helpers/Assistants	11,336	12,937	133,770	10.34	15
16	Dishwashers	19,187	21,209	182,022	8.58	16
17	Maintenance Workers	2,152	2,407	44,430	18.46	17
18	Housekeepers	37,326	43,248	417,786	9.66	18
19	Laundry	8,781	10,012	96,911	9.68	19
20	Administrator	1,413	1,884	135,308	71.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,571	16,194	331,995	20.50	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	4,026	4,772	75,978	15.92	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	4,359	5,128	124,817	24.34	33
34	TOTAL (lines 1 - 33)	375,098	432,809	\$ 7,259,431 *	\$ 16.77	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	\$ 23,865	1(3)	35
36	Medical Director	Monthly	80,625	9(3)	36
37	Medical Records Consultant	23	1,334	10(3)	37
38	Nurse Consultant	Monthly	75,413	10(3)	38
39	Pharmacist Consultant	Monthly	12,217	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	96	4,673	11(3)	44
45	Social Service Consultant	96	4,853	12(3)	45
46	Other(specify) <u>Psychosocial</u>	32	1,536	12(3)	46
47	<u>Medical Consultant</u>	Monthly	3,779	10(7)	47
48	<u>Pulmonary Exchange</u>	Monthly	88,390	10(3)	48
49	TOTAL (lines 35 - 48)	247	\$ 296,685		49

C. CONTRACT NURSES

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

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	
Nancy McDonald	Administrator	0%	\$ 135,308	Workers' Compensation Insurance	\$ 145,771	IDPH License Fee	\$	
				Unemployment Compensation Insurance	176,521	Advertising: Employee Recruitment	19,525	
				FICA Taxes	549,308	Health Care Worker Background Check		
				Employee Health Insurance	251,579	(Indicate # of checks performed <u>278.8</u>)	3,346	
				Employee Meals	20,405	Patient Background Checks	10,039	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	13,529	
				401K	25,604	Miscellaneous Dues & Subscriptions	3,600	
				Other Employee Benefits	44,741	Less: marketing	(1,626)	
						Alloc. From Mgmt. Co.	7,366	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 135,308			Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Management Fees-Royal Operating			\$ 1,051,453	\$ 1,213,929			\$ 55,779	
Management Fees-Vesta Mgmt.			555,655					
Management Fees-Capital			65,604					
Management Fees (Eliminated in Column 7)								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,672,712					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Grabowski Law Center	Collections		\$ 5,352	N/A			Out-of-State Travel	\$
Cassiday Schade	Legal		118,560					
McGladrey & Pullen	Accounting		34,693				In-State Travel	
Personnel Planners	U/C Consulting		2,800					
IL Secretary of State	Accounting		100				Seminar Expense	
Serpico, Petrosino & Dipiero	Legal		3,843				Alloc. From Mgmt. Co.	2,787
Much Shelist	Legal		6,375					
North Heron Ins	Insurance		26,676				Entertainment Expense	()
Pension Administrators	Pension Administration		788				(agree to Sch. V, line 24, col. 8)	
RealMed	WC Consulting		151				TOTAL	\$ 2,787
Ability Network	Computer Consulting		768					
See Schedule 21C			82,223					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 282,328	\$				

* Attach copy of IMRF notifications

**See instructions.

C. Professional Fees

Schedule 2

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Action Computer Service	Computer Consulting	861
ADI	Computer Consulting	681
Avtech	Computer Consulting	482
BSKLIVE INC. (Staffknex)	Computer Consulting	1,061
Brook Electric	Computer Consulting	156
Efax Corporate	Computer Consulting	2,105
E-Health Data Solutions	Computer Consulting	2,400
Elton Designs Inc	Computer Consulting	2,175
Facility Wizard Software	Computer Consulting	2,363
Information Control	Computer Consulting	1,697
Kronos	Computer Consulting	1,400
Lanac Technology	Computer Consulting	403
Lintech L LC	Computer Consulting	4,646
Microsoft Licensing	Computer Consulting	9,396
MNJ Technologies Direct	Computer Consulting	6,535
MY Innerview	Computer Consulting	1,848
National Datacare	Computer Consulting	1,948
Paragon Clinical	Computer Consulting	1,100
Question Pro	Computer Consulting	67
On Shift	Computer Consulting	3,968
Right Now Technologies	Computer Consulting	8,927
Royal Mgmt Maint Labor	Computer Consulting	572
SilverChair Learning Systems	Computer Consulting	8,610
Softchoice	Computer Consulting	3,165
Survey Analytics LLC	Computer Consulting	300
System Design	Computer Consulting	44
Telemedicine Solutions	Computer Consulting	5,400
Tympani	Computer Consulting	8,780
Vision Share, Inc.	Computer Consulting	85
XO Communications	Computer Consulting	1,050
		<u>82,223</u>
Schedule V, line 19 column 7		282,328
To disallow collection fees		(2,185)
Out of period legal		(20,355)
Legal allocated from Real Estate Secretary of State		200
<u>Samvest of Lombard</u>		
Legal		230
Accounting		250
Total		<u>480</u>
<u>Allocated from Mgmt Co.</u>		
Katten, Muchin, Rosenman	Legal	429
Much Shelist	Legal	388
Laner Muchin	Legal	16
Seyfarth Shaw LLP	Legal	294
McGladrey & Pullen LLP	Accounting	1,462
Illinois Secretary of State	Filing Fees	40
LaSalle Network	Recruiting/Finance	1,798
Gilson Labus & Silverman	KEP	199
Pension Administrators, Inc.	401K Administration	277
Susan Parker	Social Service Consulting	30
M Werner Consulting	Financial Consultant	4
Christine Toolan	Social Service Consulting	7
Gene Whitehorn	Medicaid Reimb Specialist	1,069
Computer Services	Computer Consulting	17,230
		<u>23,243</u>
Schedule V, line 19, column 8		<u>283,711</u>

Facility Name & ID Number Lexington Health Care Center of Chicago Ridge, Inc.# 0042739Report Period Beginning: 01/01/2011 Ending: 12/31/2011**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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 62,105 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. \$ 274,966
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. \$ 20,405 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. \$ 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.