

		FOR BHF USE					

LL1

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0039768</u></p> <p>Facility Name: <u>Lexington Health Care Center of Lake Zurich, Inc.</u></p> <p>Address: <u>930 South Rand Road</u> <u>Lake Zurich</u> <u>60047</u> <small>Number City Zip Code</small></p> <p>County: <u>Lake</u></p> <p>Telephone Number: <u>(847) 726-1200</u> Fax # <u>(847) 726-1265</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/20/94</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>SEE ACCOUNTANTS' PREPERATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' PREPERATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' PREPERATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>							

Facility Name & ID Number Lexington Health Care Center of Lake Zurich, Inc.

0039768 Report Period Beginning: 1/1/2011 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	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</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>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>17,871</u>	<u>17,871</u>	8
9	SNF/PED					9
10	ICF	<u>45,688</u>	<u>6,648</u>		<u>52,336</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>45,688</u>	<u>6,648</u>	<u>17,871</u>	<u>70,207</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.75%

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 8/20/94

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 203 and days of care provided 11,276

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/11 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 Lake Zurich # 0039768 Report Period Beginning: 1/1/2011 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	369,835	53,966	28,772	452,573		452,573		452,573		1
2	Food Purchase		359,136		359,136		359,136	(17,058)	342,078		2
3	Housekeeping	351,000	36,330		387,330		387,330	370	387,700		3
4	Laundry	107,086	23,907		130,993		130,993		130,993		4
5	Heat and Other Utilities			247,496	247,496		247,496	10,148	257,644		5
6	Maintenance	41,844		167,193	209,037		209,037	74,141	283,178		6
7	Other (specify):* Mgmt Co.-Allocated B							9,152	9,152		7
8	TOTAL General Services	869,765	473,339	443,461	1,786,565		1,786,565	76,753	1,863,318		8
	B. Health Care and Programs										
9	Medical Director			89,500	89,500		89,500		89,500		9
10	Nursing and Medical Records	4,973,742	319,767	100,364	5,393,873		5,393,873	62,751	5,456,624		10
10a	Therapy		4,300	1,100,940	1,105,240		1,105,240		1,105,240		10a
11	Activities	261,659	31,884	8,489	302,032		302,032		302,032		11
12	Social Services	130,168		7,996	138,164		138,164		138,164		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co.-Allocated B							8,679	8,679		15
16	TOTAL Health Care and Programs	5,365,569	355,951	1,307,289	7,028,809		7,028,809	71,430	7,100,239		16
	C. General Administration										
17	Administrative	103,308		1,571,154	1,674,462		1,674,462	(1,543,962)	130,500		17
18	Directors Fees										18
19	Professional Services			155,796	155,796		155,796	16,573	172,369		19
20	Dues, Fees, Subscriptions & Promotions			48,772	48,772		48,772	5,318	54,090		20
21	Clerical & General Office Expenses	224,916	35,240	40,611	300,767		300,767	604,506	905,273		21
22	Employee Benefits & Payroll Taxes			1,014,361	1,014,361		1,014,361	16,728	1,031,089		22
23	Inservice Training & Education			20,359	20,359		20,359	1,618	21,977		23
24	Travel and Seminar			1,694	1,694		1,694	1,093	2,787		24
25	Other Admin. Staff Transportation			4,671	4,671		4,671	19,632	24,303		25
26	Insurance-Prop.Liab.Malpractice			397,247	397,247		397,247	6,785	404,032		26
27	Other (specify):* Mgmt Co.-Allocated B							87,210	87,210		27
28	TOTAL General Administration	328,224	35,240	3,254,665	3,618,129		3,618,129	(784,499)	2,833,630		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,563,558	864,530	5,005,415	12,433,503		12,433,503	(636,316)	11,797,187		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 Lake Zurich, Inc. #0039768 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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			159,404	159,404		159,404	400,324	559,728			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,250	24,250		24,250	447,091	471,341			32
33	Real Estate Taxes							170,275	170,275			33
34	Rent-Facility & Grounds			1,484,165	1,484,165		1,484,165	(1,480,050)	4,115			34
35	Rent-Equipment & Vehicles			89,806	89,806		89,806	3,320	93,126			35
36	Other (specify):*											36
37	TOTAL Ownership			1,757,625	1,757,625		1,757,625	(459,040)	1,298,585			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		610,890	4,306	615,196		615,196		615,196			39
40	Barber and Beauty Shops			27,683	27,683		27,683		27,683			40
41	Coffee and Gift Shops			11,411	11,411		11,411		11,411			41
42	Provider Participation Fee			290,036	290,036		290,036		290,036			42
43	Other (specify):* Non-Allow Costs	123,976		146,549	270,525		270,525	(270,525)				43
44	TOTAL Special Cost Centers	123,976	610,890	479,985	1,214,851		1,214,851	(270,525)	944,326			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,687,534	1,475,420	7,243,025	15,405,979		15,405,979	(1,365,881)	14,040,098			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	(330)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,501)	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	(133)	30		9
10	Interest and Other Investment Income	(17,067)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10,180)	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	(2,403)	43		18
19	Entertainment				19
20	Contributions	(5,000)	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	(42,198)	43		24
25	Fund Raising, Advertising and Promotional	(52,160)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,384)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(435,476)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (571,832)		\$	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)	(794,049)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (794,049)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,365,881)		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 Lake Zurich, Inc.

ID# 0039768

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (275)	43	1
2	Labs Part A	(12,172)	43	2
3	X-Rays-Part A	(15,306)	43	3
4	Marketing Salary	(123,976)	43	4
5	Trust Fees	(60)	43	5
6	Disallow collection	(7,251)	19	6
7				7
8				8
9	Reclass LHI to Repairs & Maintenance	5,924	6	9
10	Travel and Seminar Marketing	(1,694)	24	10
11	Due and subscriptions marketing	(1,558)	20	11
12	Chamber of commerce dues	(490)	20	12
13	Unrealized loss on FMV swap	(278,618)	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	(435,476)		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 page page 6 supplemental		See page page 6 supplemental		See page page 6 supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Fees	\$	Lexington Helath Care Systems of Lake Zurich Ltd Ptsp		\$ 100	\$ 100	1
2	V							2
3	V	30 Depreciation		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp		353,005	353,005	3
4	V	32 Interest Expense		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp		446,600	446,600	4
5	V	32 Amortization of Mortgage Costs		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp		1,415	1,415	5
6	V	33 Property Taxes		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp		164,165	164,165	6
7	V	34 Rental Expense	1,484,165	Lexington Helath Care Systems of Lake Zurich Ltd Ptsp			(1,484,165)	7
8	V	43 Trust Fees		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp		60	60	8
9	V	43 Unrealized loss on FMV swap		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp		278,618	278,618	9
10	V	43 State Replacement		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp		30	30	10
11	V							11
12	V	** The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Lexington Health Care Systems						12
13	V	of Lake Zurich Limited Partnership.						13
14	Total		\$ 1,484,165			\$ 1,243,993	\$ * (240,172)	14

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

Facility Name & ID Number Lexington Health Care Center of Lake Zurich, Inc.# 0039768Report Period Beginning: 1/1/2011Ending: 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								35	
36	V								36	
37	V	**Certain owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management								37
38	V								38	
39	Total		\$			\$ 810,390	\$ *	810,390	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.	**	\$ 11,715	\$ 11,715	
16	V	24 Travel & seminar		Royal Management Corp.	**	2,787	2,787	
17	V	25 Auto expense		Royal Management Corp.	**	19,632	19,632	
18	V	26 Insurance general		Royal Management Corp.	**	6,785	6,785	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	87,210	87,210	
20	V	30 Depreciation		Royal Management Corp.	**	47,452	47,452	
21	V	32 Interest		Royal Management Corp.	**	16,107	16,107	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	36	36	
23	V	33 Property taxes		Royal Management Corp.	**	6,110	6,110	
24	V	34 Rent expense		Royal Management Corp.	**	4,115	4,115	
25	V	35 Equipment rental		Royal Management Corp.	**	1,188	1,188	
26	V	17 Management fees	1,571,154	Royal Management Corp.	**		(1,571,154)	
27	V	35 Auto Lease		Royal Management Corp.	**	2,132	2,132	
28	V	23 Inservice Training		Royal Management Corp.	**	1,618	1,618	
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V	**Certain owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management						
38	V							
39	Total		\$ 1,571,154			\$ 206,887	\$ * (1,364,267)	

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

Facility Name & ID Number Lexington Health Care Center of Lake Zurich # 0039768 Report Period Beginning: 1/1/2011 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	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 9,972	L17, C7	1	
2	John Samatas	Owner/Officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,413	L17, C7	2	
3	Cynthia Thiem	Owner/Officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,806	L17, C7	3	
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,793	L21, C7	4	
5											5	
6											6	
7		Certain individuals work in excess of 40 hours per week.										7
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 31,984		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 Lake Zurich, Inc. # 0039768 Report Period Beginning: 1/1/2011 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	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	24	Travel and Seminar	Bed Days	722,420	10	27,173	74,095	2,787	22	
23									23	
24									24	
25	TOTALS					\$ 8,042,630	\$ 6,693,937	\$ 824,892	25	

Facility Name & ID Number Lexington Health Care Center of Lake Zurich, Inc. # 0039768 Report Period Beginning: 1/1/2011 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 Avenue, Suite 500
 City / State / Zip Code Lombard, IL 60148
 Phone Number (630) 458-4700
 Fax Number (630) 458-476

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	722,420	10	\$ 191,407	\$ 74,095	\$ 19,632	1
2	26	Insurance general	Bed Days	722,420	10	66,156	74,095	6,785	2
3	27	Management allocation - employees	Bed Days	722,420	10	850,290	74,095	87,210	3
4	30	Depreciation	Bed Days	722,420	10	462,650	74,095	47,452	4
5	32	Interest	Bed Days	722,420	10	157,045	74,095	16,107	5
6	32	Amortization of mortgage costs	Bed Days	722,420	10	354	74,095	36	6
7	33	Property taxes	Bed Days	722,420	10	59,576	74,095	6,110	7
8	34	Rent expense	Bed Days	722,420	10	40,122	74,095	4,115	8
9	35	Equipment rental	Bed Days	722,420	10	11,581	74,095	1,188	9
10	35	Auto Lease	Bed Days	722,420	10	20,791	74,095	2,132	10
11	23	Inservice Training	Bed Days	722,420	10	15,778	74,095	1,618	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					\$ 1,875,750	\$	\$ 192,385	25

Facility Name & ID Number

Lexington Health Care Center of Lake Zurich

0039768

Report Period Beginning:

1/1/2011

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		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						\$	\$		\$	1								
2	Services II, LLC	X		Mortgage	Varies	4/30/07	7,606,000	6,981,558	5/1/2017	0.0625	446,600	2							
3											3								
4											4								
5							Interest on financing insurance premium				1,005	5							
	Working Capital																		
6	Shareholders	X		Working Capital	None	Varies	270,033	1,698,172	Demand	Prime +1	16,814	6							
7	JP Morgan Chase N.A.		X	Line of Credit	Varies	4/30/07	1,700,000	1,260,000	6/30/12	Libor +2.25%	6,431	7							
8											8								
9	TOTAL Facility Related						\$ 9,576,033	\$ 9,939,730			\$ 470,850	9							
	B. Non-Facility Related*																		
10								Amortization of loan cost			1,415	10							
11								Interest Income offset			(253)	11							
12								Allocated from Management Co.			16,143	12							
13								Nonallowable shareholder interest			(16,814)	13							
14	TOTAL Non-Facility Related						\$	\$			\$ 491	14							
15	TOTALS (line 9+line14)						\$ 9,576,033	\$ 9,939,730			\$ 471,341	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.)

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 2010 report.			\$	145,200	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.)	2010		\$	152,165	2
3. Under or (over) accrual (line 2 minus line 1).			\$	6,965	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		Allocated from Management Company		6,110	
			\$	157,200	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.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	170,275	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	116,252			8
	2007	137,671			9
	2008	146,400			10
	2009	146,253			11
	2010	152,165			12
See Accrual summary sheet					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2010	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Lake Zurich, Inc. COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0039768

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>14-28-100-020</u>	<u>Nursing Facility</u>	\$ <u>139,043.30</u>	\$ <u>139,043.30</u>
2.	<u>14-29-200-033</u>	<u>Nursing Facility</u>	\$ <u>13,121.24</u>	\$ <u>13,121.24</u>
3.	<u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ <u>229,415.60</u>	\$ <u>6,110.00</u>
4.	<u>05-01-202-021</u>		\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>381,580.14</u></u>	\$ <u><u>158,274.54</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: 78,901 B. General Construction Type: Exterior Brick 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).

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>250,344</u>	<u>1990</u>	<u>\$ 495,000</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>19,969</u>	<u>2</u>
3	TOTALS	250,344		\$ 514,969	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		1994	1994	\$ 6,418,908	\$	40	\$ 160,473	\$ 160,473	\$ 2,781,527	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements		1994		10,701		10			10,701	9
10	Land Improvements		1994		13,330		10			13,330	10
11	Leasehold Improvements		1994		4,737		15			4,737	11
12	Leasehold Improvements		1995		4,005	133	15	133		4,138	12
13	Land Improvements		1995		3,221		10			3,221	13
14	Building Improvements		1995		3,019		40	75	75	1,282	14
15	Building Improvements		1995		64,500	1,654	39	1,654		27,635	15
16	Patio		1996		1,168	38	15	38		1,130	16
17	Compressor		1996		5,145		10			5,145	17
18	Road sidewalk		1997		18,094		20	905	905	13,120	18
19	Foundation/Sprinkler		1997		2,068	59	35	59		856	19
20	Flagpoles		1997		1,573	105	15	105		1,521	20
21	Basement rehab		1998		12,867		10			12,867	21
22	MDS Telnet wiring		1998		3,365		10			3,365	22
23	Flag Pole		1998		787	52	15	52		707	23
24	Resurface/restripe parking lot		1998		4,977		10			4,977	24
25	Transfer 10 beds from shelter care		1998		2,260	57	40	57		745	25
26	1st floor lobby tile		1999		12,153		10			12,154	26
27	Parking lot repair		2000		3,740		10			3,740	27
28	Roof repair		2000		10,770		10			10,771	28
29	Automatic door		2000		1,300		10			1,300	29
30	Kitchen rehab		2000		16,886		10			16,887	30
31	Compressor		2001		4,350	218	10	218		4,350	31
32	Boiler vent		2001		3,228	161	10	161		3,228	32
33	Fire pump		2001		1,766	88	10	88		1,766	33
34	Kitchen rehab		2001		721	37	10	37		721	34
35	Elevator infrared curtains		2001		4,500	225	10	225		4,500	35
36	Therapy Room Rehab		2004		64,473	3,224	20	3,224		23,641	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 Lake Zurich, Inc.

0039768

Report Period Beginning:

1/1/2011

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	
37	Elevator Upgrade	2004	\$ 3,487	\$ 174	20	\$ 174		\$ 1,234	37
38	HVAC Compressor	2004	11,845	592	20	592		4,293	38
39	Sidewalk, raise and support	2005	700	35	20	35		222	39
40	Pavement for parking lot	2005	6,650	333	20	333		2,190	40
41	Water softner	2005	2,635	132	20	132		912	41
42	Plumbing and sprinkler	2005	4,469	223	20	223		1,544	42
43	Lobby and lounge rehab	2005	44,560	2,228	20	2,228		15,410	43
44	Therapy room rehab	2005	1,721	86	20	86		538	44
45	First floor therapy room	2005	42,424	2,121	20	2,121		14,181	45
46	Transitional unit	2005	9,898	495	20	495		3,135	46
47	Countertop	2005	845	56	5	56		901	47
48	Wallcovering	2005	439	66	5	66		505	48
49	Panel Brick Replacement	2006	16,001	800	20	800		4,334	49
50	Landscaping Improvement	2006	4,640	464	5	464		4,640	50
51	HVAC	2006	3,999	400	10	400		2,033	51
52	Kitchen Rehab	2006	2,553	255	10	255		1,467	52
53	Wall Mounted Cabinets	2006	10,451	1,045	10	1,045		5,574	53
54	Therapy room rehab	2006	2,829	283	10	283		1,462	54
55	Solo step install	2006	3,689	369	10	369		1,906	55
56	Transitional unit	2006	31,685	1,584	20	1,584		8,053	56
57	Employee Lunchroom rehab	2006	1,766	177	10	177		943	57
58	Fine Dining	2006	22,517	1,126	20	1,126		6,005	58
59	Land Improvements	2006	5,374	358	15	358		1,880	59
60	Emergency AC	2006	7,564	756	10	756		3,781	60
61	Wood Flooring	2006	1,526		10	153	153	764	61
62	HVAC	2007	2,716	272	10	272		1,223	62
63	Emergency AC	2007	18,731	1,873	10	1,873		8,429	63
64	First floor remodel-carpentry, flooring, plumbing, painting,	2007	701,565		40	17,539	17,539	83,310	64
65	fixtures								65
66	Landscaping	2008	15,920	1,061	15	1,061		4,156	66
67	Parking Lot Repairs	2008	4,224	211	20	211		686	67
68	Roof	2008	33,700	1,685	20	1,685		6,038	68
69	Employee Locker Rooms	2008	3,732	93	40	93		302	69
70	TOTAL (lines 4 thru 69)		\$ 7,723,467	\$ 25,404		\$ 204,549	\$ 179,145	\$ 3,166,113	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 Lake Zurich, Inc.

0039768

Report Period Beginning:

1/1/2011

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		\$ 7,723,467	\$ 25,404		\$ 204,549	\$ 179,145	\$ 3,166,113	1
2	Second floor remodel - carpentry, electrical, flooring,	2008	555,633		27	20,205	20,205	69,034	2
3	painting								3
4	Irrigation System	2009	15,335	1,022	15	1,022		2,385	4
5	Landscaping Enhancements	2009	8,276	552	15	552		1,334	5
6	Quick connects	2009	7,611	381	20	381		889	6
7	HVAC Chiller	2009	102,185	5,109	20	5,109		12,773	7
8	HVAC-1st floor admin office	2009	7,295	365	20	365		760	8
9	2nd floor remodel	2009	9,331	339	27	339		1,017	9
10	Basement Office	2009	2,755	100	27	100		225	10
11	Patio Pergola	2009	8,905	445	20	445		1,038	11
12	3rd floor remodel-Carpentry,plumbing,electrical,handrails	2009	398,350		27	14,485	14,485	31,384	12
13	painting,alarm system								13
14									14
15									15
16									16
17	Med Room Remodel-painting,flooring	2010	5,531	202	27	202		252	17
18	Office carpentry,flooring,electrical,painting,plumbing,signs	2010	51,465	4,149	27	4,149		4,149	18
19	Exhaust System	2010	83,215	3,035	27	3,035		3,035	19
20	Office spot cooler	2010	3,456	126	27	126		137	20
21	Ceiling insulations	2010	2,640	96	27	96		128	21
22	Remodel pantry-shelves	2010	4,402	161	27	161		201	22
23	Paint over bed lights	2010	5,512	201	27	201		201	23
24	Exterior Door	2010	2,618	95	27	95		103	24
25	Remodel Library/Lounge and physician office-flooring,	2010	7,796	284	27	284		315	25
26	art framing,flooring								26
27	2nd floor remodel-carpentry,plumbing,electrical	2010	4,838	176	27	176		309	27
28	Concrete repair-ramp & railing	2010	10,029	669	15	669		836	28
29	Office remodel-doors, carpentry, locks	2011	20,714	324	27	324		324	29
30	Landscaping Enhancements	2011	4,987	249	15	249		249	30
31	Fire pump and drain line	2011	8,360	26	27	26		26	31
32	Laundry room remodel-painting, tile	2011	7,835	95	27	95		95	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,062,541	\$ 43,605		\$ 257,440	\$ 213,835	\$ 3,297,312	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,062,541	\$ 43,605		\$ 257,440	\$ 213,835	\$ 3,297,312	1
2	Locker Room-paint, cabinets	2011	7,504	91	27	91		91	2
3	2nd floor remodel-doors and locks	2011	17,692	214	27	214		214	3
4	HVAC Chiller	2011	99,609		27	1,509	1,509	1,509	4
5	Parking lot-Stripe and seal	2011	51,148		20	639	639	639	5
6									6
7	Building - management company	2002	276,331		40	8,392	8,392	81,511	7
8	HVAC, electrical, security system - management company	2003	2,427		30	481	481	1,413	8
9	Key card system - management company	2004	381		20	19	19	141	9
10	VAV TX controls - management company	2005	116		20	6	6	40	10
11	Building improvements - management company	2006	84		20	6	6	29	11
12	Building improvements - management company	2008	13,390		20	717	717	2,767	12
13	Building improvements - management company	2009	2,500		15	47	47	331	13
14	Building improvements - management company	2010	2,436		15	103	103	252	14
15	Building improvements - management company	2011	1,720		15	39	39	39	15
16									16
17									17
18	Reconcile book depreciation			132			(132)		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)		\$ 9,537,879	\$ 44,042		\$ 269,703	\$ 225,661	\$ 3,386,288	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	\$ 1,415,174	\$ 98,131	\$ 235,152	\$ 137,021	5	\$ 800,401	71
72	Current Year Purchases	179,937	17,231	17,231		5	17,231	72
73	Fully Depreciated Assets	87,304					87,304	73
74	Allocated from management co.	321,910		32,924	32,924	5	250,975	74
75	TOTALS	\$ 2,004,325	\$ 115,362	\$ 285,307	\$ 169,945		\$ 1,155,911	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	Allocated from management co.			45,285		4,718	4,718		35,086	79
80	TOTALS			\$ 45,285	\$	\$ 4,718	\$ 4,718		\$ 35,086	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)	\$ 12,102,458	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 159,404	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 559,728	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 400,324	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,577,285	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			N/A		89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	Allocated from Management Company			4,115			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: \$ 90,994 Description: Copier-\$10,939;Med Equip-\$32,960;Oxygen-\$45,724;Mailing System-\$183;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 Management Company			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	\$	7,278	\$ 375,929	\$ 4,300	7,278	\$ 380,229	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,629	136,102		2,629	136,102	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,989	588,909		9,989	588,909	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				610,890		610,890	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39(3)					4,306		4,306	12
13	Other (specify):									13
14	TOTAL			\$	19,896	\$ 1,100,940	\$ 619,496	19,896	\$ 1,720,436	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 Lake Zurich, Inc.# 0039768Report Period Beginning: 1/1/2011Ending: 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	\$ 450,700	\$ 465,243	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>394,135</u>)	3,671,309	3,671,309	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(47,595)	30,965	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,074,414	\$ 4,167,517	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,906	8,906	12
13	Land		514,969	13
14	Buildings, at Historical Cost		6,418,908	14
15	Leasehold Improvements, at Historical Cost	1,009,732	3,118,971	15
16	Equipment, at Historical Cost	871,545	2,049,610	16
17	Accumulated Depreciation (book methods)	(727,821)	(4,577,285)	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>		29,127	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,162,362	\$ 7,563,206	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,236,776	\$ 11,730,723	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 533,550	\$ 533,550	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,260,000	1,260,000	29
30	Accrued Salaries Payable	358,249	358,249	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,587	14,587	31
32	Accrued Real Estate Taxes(Sch.IX-B)		157,200	32
33	Accrued Interest Payable		38,938	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	4,387,549	2,331,261	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,553,935	\$ 4,693,785	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,698,172	1,698,172	39
40	Mortgage Payable		6,981,558	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)	\$ 1,698,172	\$ 8,679,730	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,252,107	\$ 13,373,515	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,015,331)	\$ (1,642,792)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,236,776	\$ 11,730,723	48

*(See instructions.)

Lexington Health Care Center of Lake Zurich, Inc.
1/1/11-12/31/11
Provider # 0039768

XV. Balance Sheet

C. Current Liabilities

Line 36.

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
PA Audit Settlement	184,416	184,416
Due from remodeling	78,560	78,560
Due to Republic Construction of Illinois, Inc	(39,503)	(39,503)
Accrued Expenses	12,702	12,702
Accrued resident tax	178,810	178,810
Accrued Rent	3,455,423	-
Accrued Insurance	169,092	169,092
Due to patient trust fund	37,817	37,817
Escrow Insurance	27,150	27,150
Deferred Income	270,499	270,499
Due to Royal Operations	38,337	38,337
Due to Lake Zurich		
Interest Rate Swap Liability		1,399,135
Advance-Bi-weekly Part A Payments	(4,536)	(4,536)
Uncollectible Part A Co. Pvts	(21,218)	(21,218)
	<u>4,387,549</u>	<u>2,331,261</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,703,615)	1
2	Restatements (describe):		2
3	Post closing adjustment	(78,941)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,782,556)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(231,097)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,678)	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)	\$ (232,775)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,015,331)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington Health Care Center of Lake Zurich, Inc. # 0039768 Report Period Beginning: 1/1/2011Ending: 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	\$ 20,095,987	1
2	Discounts and Allowances for all Levels	(8,786,730)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,309,257	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,867,921	6
7	Oxygen	29,622	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,897,543	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	13,528	12
13	Barber and Beauty Care	27,652	13
14	Non-Patient Meals	330	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	489,056	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	174,072	19
20	Radiology and X-Ray		20
21	Other Medical Services	262,558	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 967,196	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	731	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 731	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc. Income/Recovery write off</u>	155	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 155	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,174,882	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,786,565	31
32	Health Care	7,028,809	32
33	General Administration	3,618,129	33
B. Capital Expense			
34	Ownership	1,757,625	34
C. Ancillary Expense			
35	Special Cost Centers	924,815	35
36	Provider Participation Fee	290,036	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,405,979	40
41	Income before Income Taxes (line 30 minus line 40)**	(231,097)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (231,097)	43

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

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

*** 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 Lake Zurich, Inc.**

0039768

Report Period Beginning: **1/1/2011**

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	1,289	1,648	\$ 94,327	\$ 57.24	1
2	Assistant Director of Nursing	27,909	34,366	955,024	27.79	2
3	Registered Nurses	33,049	38,813	1,290,817	33.26	3
4	Licensed Practical Nurses	25,394	31,533	861,567	27.32	4
5	CNAs & Orderlies	115,478	135,429	1,633,094	12.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,081	8,249	104,000	12.61	8
9	Activity Director					9
10	Activity Assistants	18,876	21,465	261,659	12.19	10
11	Social Service Workers	8,178	7,964	130,168	16.34	11
12	Dietician					12
13	Food Service Supervisor	1,341	1,625	31,737	19.53	13
14	Head Cook	1,683	2,119	34,707	16.38	14
15	Cook Helpers/Assistants	11,042	13,582	134,234	9.88	15
16	Dishwashers	16,490	19,550	169,157	8.65	16
17	Maintenance Workers	1,988	2,259	41,844	18.52	17
18	Housekeepers	32,663	38,024	351,000	9.23	18
19	Laundry	10,968	12,306	107,086	8.70	19
20	Administrator	1,533	2,313	103,308	44.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,005	15,056	224,916	14.94	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	1,671	2,083	34,913	16.76	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,956	3,478	123,976	35.65	33
34	TOTAL (lines 1 - 33)	329,594	391,862	\$ 6,687,534 *	\$ 17.07	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	\$ 27,675	1(3)	35
36	Medical Director	Monthly	89,500	9(3)	36
37	Medical Records Consultant	Monthly	969	10(3)	37
38	Nurse Consultant	Monthly	39,954	10(3)	38
39	Pharmacist Consultant	Monthly	12,243	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	30	7,473	11(3)	44
45	Social Service Consultant	96	4,853	12(3)	45
46	Other(specify) <u>Psychosocial</u>	12	3,004	12(3)	46
47	<u>Pulmonary</u>	Monthly	47,198	10(3)	47
48	<u>Medical Consultant</u>	Monthly	3,779	10(7)	48
49	TOTAL (lines 35 - 48)	138	\$ 236,648		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

C. Professional Fees

Vendor/Payee	Type	Amount
Ability Network	Computer Consulting	870
ACTION COMPUTER ENTERPRISES	Computer Consulting	1,554
AVTECH	Computer Consulting	174
BSKLIVE INC. (Staffknex)	Computer Consulting	1,055
Efax Corporate	Computer Consulting	2,105
E-Health Data Solutions	Computer Consulting	2,400
Elton Designs Inc	Computer Consulting	2,375
FACILITY WIZARD	Computer Consulting	358
Information Control	Computer Consulting	1,336
Lintech L LC	Computer Consulting	5,050
My Innerview	Computer Consulting	6,033
National Datacare	Computer Consulting	2,357
On Shift	Computer Consulting	3,968
Paragon	Computer Consulting	1,100
Question Pro	Computer Consulting	67
SilverChair Learning Systems	Computer Consulting	7,728
Softchoice Corp	Computer Consulting	2,895
Telemedicine Solutions	Computer Consulting	6,282
Vision Share, Inc.	Computer Consulting	85
XO Communications	Computer Consulting	1,046
Right now technologies	Computer Consulting	8,927.40
Microsoft License	Computer Consulting	1,898.01
System Design	Computer Consulting	44.10
Brook Electric	Computer Consulting	156
Kronos	Computer Consulting	1,400
Tympani	Computer Consulting	115
Telemedicine	Computer Consulting	1,800
Survey Analytics LLC-B/O	Computer Consulting	300
		63,477
Total Schedule V, line 19 column 3		155,796
Less Collections		(7,251)
Out of period legal		
Sambell of Lake Zurich		
James Samatas		100
Allocated from Management Co.		
Katten, Muchin, Rosenman	Legal	429
Much Shelist	Legal	388
Laner Muchin	Legal	16
Syfarth 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	1,070

Computer Services	Computer Consulting	17,230
		<u>23,244</u>
Allocated from Samvest of Lombard		
Accounting		250
Legal		230
Total Schedule V, line 19, column 8		<u><u>172,369</u></u>

