FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0042739

Facility Name: Lexington of Chicago Ridge

Address: 10300 Southwest Highway (Number) Chicago Ridge (City) 60415 (Zip Code)

County: Cook

Telephone Number: (708) 425-1100 **Fax #** (708) 425-0779

HFS ID Number:

Date of Initial License for Current Owners: 5/27/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			15,637	15,637	8
9	SNF/PED					9
10	ICF	40,627	12,900		53,527	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,627	12,900	15,637	69,164	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.35%

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 [X] 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 [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 203 and days of care provided 11,396

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	424,592	33,917	25,577	484,086		484,086		484,086			1
2	Food Purchase		349,337		349,337		349,337	(18,154)	331,183			2
3	Housekeeping	423,923	43,963		467,886		467,886	380	468,266			3
4	Laundry	93,493	23,725		117,218		117,218		117,218			4
5	Heat and Other Utilities			259,675	259,675		259,675	9,791	269,466			5
6	Maintenance	45,485		149,916	195,401		195,401	57,826	253,227			6
7	Other (specify):* Alloc. From Mgmt. Co							6,612	6,612			7
8	TOTAL General Services	987,493	450,942	435,168	1,873,603		1,873,603	56,455	1,930,058			8
	B. Health Care and Programs											
9	Medical Director			64,147	64,147		64,147		64,147			9
10	Nursing and Medical Records	4,451,632	486,463	50,050	4,988,145		4,988,145	60,115	5,048,260			10
10a	Therapy			1,657,646	1,657,646		1,657,646		1,657,646			10a
11	Activities	246,638	23,491	13,792	283,921		283,921		283,921			11
12	Social Services	326,963		45,492	372,455		372,455		372,455			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt. Co							8,240	8,240			15
16	TOTAL Health Care and Programs	5,025,233	509,954	1,831,127	7,366,314		7,366,314	68,355	7,434,669			16
	C. General Administration											
17	Administrative	148,506		1,385,237	1,533,743		1,533,743	(1,358,562)	175,181			17
18	Directors Fees											18
19	Professional Services			228,392	228,392		228,392	735	229,127			19
20	Dues, Fees, Subscriptions & Promotions			23,437	23,437		23,437	8,078	31,515			20
21	Clerical & General Office Expenses	395,132	42,199	38,020	475,351		475,351	384,679	860,030			21
22	Employee Benefits & Payroll Taxes			932,124	932,124		932,124	18,154	950,278			22
23	Inservice Training & Education			12,354	12,354		12,354	1,046	13,400			23
24	Travel and Seminar			7,458	7,458		7,458	(1,478)	5,980			24
25	Other Admin. Staff Transportation			1,609	1,609		1,609	19,853	21,462			25
26	Insurance-Prop.Liab.Malpractice			292,935	292,935		292,935	4,053	296,988			26
27	Other (specify):* Alloc. From Mgmt. Co							72,484	72,484			27
28	TOTAL General Administration	543,638	42,199	2,921,566	3,507,403		3,507,403	(850,958)	2,656,445			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,556,364	1,003,095	5,187,861	12,747,320		12,747,320	(726,148)	12,021,172			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Chicago Ridge #0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			169,214	169,214		169,214	357,269	526,483			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,863	2,863		2,863	431,958	434,821			32
33	Real Estate Taxes							308,882	308,882			33
34	Rent-Facility & Grounds			1,623,194	1,623,194		1,623,194	(1,619,206)	3,988			34
35	Rent-Equipment & Vehicles			60,074	60,074		60,074	3,196	63,270			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,855,345	1,855,345		1,855,345	(517,901)	1,337,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		734,387		734,387		734,387		734,387			39
40	Barber and Beauty Shops			23,249	23,249		23,249		23,249			40
41	Coffee and Gift Shops			7,059	7,059		7,059		7,059			41
42	Provider Participation Fee			111,142	111,142		111,142		111,142			42
43	Other (specify):* Non-Allowable Cos			172,440	172,440		172,440	(172,440)				43
44	**TOTAL Special Cost Centers**		734,387	313,890	1,048,277		1,048,277	(172,440)	875,837			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,556,364	1,737,482	7,357,096	15,650,942		15,650,942	(1,416,489)	14,234,453			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(6,246)	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	(276)	30		9
10	Interest and Other Investment Income	(313)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,842)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,100)	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	(41,984)	43		24
25	Fund Raising, Advertising and Promotional	(29,012)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,967)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(459,651)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (552,391)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	(864,098)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (864,098)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,416,489)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Lexington of Chicago Ridge

ID# **0042739**

Report Period Beginning: **01/01/2010**

Ending: **12/31/2010**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (26,214)	43	1
2	X-Rays-Part A	(31,733)	43	2
3	Diagnostics Managed Care	(22,402)	43	3
4	Marketing Salary	(111,989)	21	4
5	Trust Fees	(75)	43	5
6	Collection Fees	(5,263)	19	6
7	Out of period legal	(15,512)	19	7
8	Reclass LHI under 2500	4,794	6	8
9	Travel and seminar marketing	(3,348)	24	9
10	Dues & Subscriptions marketing	(315)	20	10
11	Unrealized loss on FMV swap	(247,522)	43	11
12	Miscellanoues Income	(72)	21	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(459,651)		49

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Sambell of Chicago Ridge Limited Partnership	**	$ 200	$ 200	1
2	V	30	Depreciation		Sambell of Chicago Ridge Limited Partnership	**	311,971	311,971	2
3	V	32	Interest expense		Sambell of Chicago Ridge Limited Partnership	**	414,630	414,630	3
4	V	32	Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	1,288	1,288	4
5	V	33	Real estate tax		Sambell of Chicago Ridge Limited Partnership	**	303,194	303,194	5
6	V	34	Rental expense	1,623,194	Sambell of Chicago Ridge Limited Partnership	**		(1,623,194)	6
7	V	43	Trust fees		Sambell of Chicago Ridge Limited Partnership	**	75	75	7
8	V	43	State Replacement Taxes		Sambell of Chicago Ridge Limited Partnership	**	60	60	8
9	V	43	Unrealized loss on FMV swap		Sambell of Chicago Ridge Limited Partnership	**	247,522	247,522	9
10	V								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			$ 1,623,194			$ 1,278,940	$ * (344,254)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 380	$ 380	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	8,701	8,701	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	248	248	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	842	842	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	44,506	44,506	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	8,129	8,129	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	397	397	21
22	V	6	Security service		Royal Management Corp.	**			22
23	V	7	Management allocation - employee benefits		Royal Management Corp.	**	6,612	6,612	23
24	V	10	Medical consultant		Royal Management Corp.	**	4,654	4,654	24
25	V	10	Management allocation - salaries		Royal Management Corp.	**	55,461	55,461	25
26	V	15	Management allocation - employee benefits		Royal Management Corp.	**	8,240	8,240	26
27	V	17	Management allocation - salaries		Royal Management Corp.	**	26,675	26,675	27
28	V	19	Computer consultant & supplies		Royal Management Corp.	**	14,744	14,744	28
29	V	19	Professional fees		Royal Management Corp.	**	6,566	6,566	29
30	V	20	Dues & subscriptions		Royal Management Corp.	**	665	665	30
31	V	23	Inservice Training		Royal Management Corp.	**	1,046	1,046	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	7,728	7,728	32
33	V	21	Management allocation - salaries		Royal Management Corp.	**	461,208	461,208	33
34	V	21	Bank charges		Royal Management Corp.	**	9,134	9,134	34
35	V	21	Office supplies & printing		Royal Management Corp.	**	12,022	12,022	35
36	V	21	Postage		Royal Management Corp.	**	4,319	4,319	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			$			$ 682,277	$ * 682,277	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Telephone	$	Royal Management Corp.	**	$ 10,057	$ 10,057	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,870	1,870	16
17	V	25	Auto expense		Royal Management Corp.	**	19,853	19,853	17
18	V	26	Insurance general		Royal Management Corp.	**	4,053	4,053	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	72,484	72,484	19
20	V	30	Depreciation		Royal Management Corp.	**	45,574	45,574	20
21	V	32	Interest		Royal Management Corp.	**	16,317	16,317	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	36	36	22
23	V	33	Property taxes		Royal Management Corp.	**	5,688	5,688	23
24	V	34	Rent expense		Royal Management Corp.	**	3,988	3,988	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,184	1,184	25
26	V	17	Management fees	1,385,237	Royal Management Corp.	**		(1,385,237)	26
27	V	35	Auto Lease		Royal Management Corp.	**	2,012	2,012	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			$ 1,385,237			$ 183,116	$ * (1,202,121)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider #0036996
1/1/10-12/31/10

Schedule 6B

VII. Related Parties
Related Nursing Homes
Owners

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

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Orland Park, Inc.	Orland Park

Other Related Business Entities

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

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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	$ 9,631	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,301	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,743	L17, C7	3
4											4
5	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,501	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	$ 29,176		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 of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: ((630) 458-4700
Fax Number: ((630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	720,658	10	$ 3,682	$	74,095	$ 379	1
2	5	Utilities - gas & electric	Bed Days	720,658	10	84,318		74,095	8,669	2
3	5	Utilities - water & sewer	Bed Days	720,658	10	2,399		74,095	247	3
4	5	Utilities - maintenance office	Bed Days	720,658	10	8,161		74,095	839	4
5	6	Management allocation - salaries	Bed Days	720,658	10	431,278		74,095	44,342	5
6	6	Repairs & maintenance	Bed Days	720,658	10	78,772		74,095	8,099	6
7	6	Scavenger & exterminating	Bed Days	720,658	10	3,848		74,095	396	7
8	6	Security service	Bed Days	720,658	10			74,095	0	8
9	7	Management allocation - employee	Bed Days	720,658	10	64,074		74,095	6,588	9
10	10	Medical consultant	Bed Days	720,658	10	45,100		74,095	4,637	10
11	10	Management allocation - salaries	Bed Days	720,658	10	537,439		74,095	55,257	11
12	15	Management allocation - employee	Bed Days	720,658	10	79,846		74,095	8,209	12
13	17	Management allocation - salaries	Bed Days	720,658	10	258,489		74,095	26,577	13
14	19	Computer consultant & supplies	Bed Days	720,658	10	142,872		74,095	14,689	14
15	19	Professional fees	Bed Days	720,658	10	63,628		74,095	6,542	15
16	20	Dues & subscriptions	Bed Days	720,658	10	6,440		74,095	662	16
17	23	Inservice Training	Bed Days	720,658	10	10,139		74,095	1,042	17
18	20	Advertising - help wanted	Bed Days	720,658	10	74,892		74,095	7,700	18
19	21	Management allocation - salaries	Bed Days	720,658	10	4,469,291		74,095	459,514	19
20	21	Bank charges	Bed Days	720,658	10	88,508		74,095	9,100	20
21	21	Office supplies & printing	Bed Days	720,658	10	116,497		74,095	11,978	21
22	21	Postage	Bed Days	720,658	10	41,854		74,095	4,303	22
23	21	Telephone	Bed Days	720,658	10	97,454		74,095	10,020	23
24	24	Travel and Seminar	Bed Days	720,658	10	18,117		74,095	1,863	24
25	TOTALS					$ 6,727,098	$		$ 691,652	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	718,010	10	$ 192,388	$	74,095	$ 19,853	1
2	26	Insurance general	Bed Days	718,010	10	39,272		74,095	4,053	2
3	27	Management allocation - employee	Bed Days	718,010	10	702,398		74,095	72,484	3
4	30	Depreciation	Bed Days	718,010	10	441,627		74,095	45,574	4
5	32	Interest	Bed Days	718,010	10	158,122		74,095	16,317	5
6	32	Amortization of mortgage costs	Bed Days	718,010	10	346		74,095	36	6
7	33	Property taxes	Bed Days	718,010	10	55,117		74,095	5,688	7
8	34	Rent expense	Bed Days	718,010	10	38,647		74,095	3,988	8
9	35	Equipment rental	Bed Days	718,010	10	11,478		74,095	1,184	9
10	35	Auto Lease	Bed Days	718,010	10	19,500		74,095	2,012	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,658,895	$		$ 171,189	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial	X		Mortgage	Varies	4/30/07	$ 6,908,000	$ 6,483,056	5/1/17	0.0625	$ 414,630	1
2	Services II, L.L.C.											2
3												3
4												4
5							Interest on Financing insurance premium				2,863	5
	Working Capital											
6	JP Morgan Chase		X	Line of Credit	Varies	4/30/07	1,400,000		6/30/11	Libor +1		6
7												7
8												8
9	TOTAL Facility Related						$ 8,308,000	$ 6,483,056			$ 417,493	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			1,324	10
11								Interest income offset			(313)	11
12								Allocated from Management Co.			16,317	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 17,328	14
15	TOTALS (line 9+line14)						$ 8,308,000	$ 6,483,056			$ 434,821	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Chicago Ridge **#** 0042739 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 666,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ 486,131	2
3. Under or (over) accrual (line 2 minus line 1).		$ (179,869)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 501,600	4
Allocated from Mgmt. Co.		5,688	
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.**		$ 34,178	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** $ 52,715 **For** 2007 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (52,715)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 308,882	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	516,365	8
2006	535,404	9
2007	555,313	10
2008	663,869	11
2009	486,131	12

See attached accrual sheet

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

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.**

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Chicago Ridge 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 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-200-030-0000	Land & Building	$ 473,987.30	$ 473,987.30
2.	24-07-311-012-0000	Land & Building	$ 12,143.87	$ 12,143.87
3.	Royal Management Corp(Samvest of Lombard II)		$	$
4.	05-01-202-019	Land & Building	$ 227,778.04	$ 5,688.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 713,909.21	$ 491,819.17

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Resident Care	31,000	1989	$ 505,000	1
2	Allocation from Management company			21,560	2
3	TOTALS	31,000		$ 526,560	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	203		1991	1991	$ 5,143,342	$	35	$ 146,951	$ 146,951	$ 2,877,814	4
5			1995	1995	97,352	2,781	35	2,781		43,112	5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	2,694	77	35	77		1,348	9
10	Leasehold Improvements			1994	6,581	188	35	188		3,103	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		747	15
16	Resurface & restripe parking lot			1998	4,450		10			4,451	16
17	Fire wall			1998	2,169	62	35	62		775	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		561	20
21	Roof repairs			2000	6,240	312	10	312		6,240	21
22	Electrical wiring			2000	3,986	114	35	114		1,196	22
23	Electrical wiring			2000	2,536	72	35	72		760	23
24	Kitchen rehab			2000	6,623	221	35	221		2,319	24
25	Automatic doors			2000	1,300	65	10	65		1,300	25
26	Elevator eye sensors			2000	4,500	300	15	300		3,150	26
27	Resurface & restripe parking lot			2001	3,319	332	10	332		3,153	27
28	Door releases			2001	5,200	520	10	520		4,940	28
29	Carpeting			2001	10,022	1,002	10	1,002		9,521	29
30	Roof repairs			2002	25,600	1,280	20	1,280		11,307	30
31	Elevator upgrade			2002	9,865	986	10	986		8,466	31
32	Painting/decorating/carpet/wallpaper			2003	38,165	1,908	20	1,908		15,265	32
33	Rehab/new office			2003	26,733	1,337	20	1,337		10,694	33
34	Facility rehab - construction costs, painting & decorating			2003	257,174	12,859	20	12,859		96,441	34
35	Facility rehab - electrical			2003	12,840	642	20	642		4,815	35
36	Facility rehab - carpeting			2003	7,800	780	10	780		5,850	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 of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Facility rehab - floor tile	2003	$ 3,548	$ 177	20	$ 177	$	$ 1,329	37
38									38
39	Kickplates/Door protectors	2004	4,095	410	10	410		2,732	39
40	Kitchen Fire Protection Upgrade	2004	1,427	143	10	143		952	40
41	Parking Lot - Paving and Sealcoating	2005	4,375	219	20	219		1,167	41
42	Kitchen Rehab	2005	19,228	961	20	961		4,966	42
43	Lobby/Lounge Reception Area	2005	36,503	1,825	20	1,825		10,190	43
44	Sidewalk - Raise and Support	2005	1,330	67	20	67		351	44
45	Lower Level Therapy Rehab	2005	52,525	2,626	20	2,626		14,006	45
46	Transitional Unit	2005	1,020	51	20	51		259	46
47	Basement Renovation	2005	3,754	188	20	188		971	47
48	Landscaping Enhancement	2006	6,463	431	15	431		1,832	48
49	Lhi-Hvac	2006	4,333	217	20	217		886	49
50	Rehab Common Areas	2006	7,661	383	20	383		1,724	50
51	Modular Units attached to wall	2006	10,316	516	20	516		2,236	51
52	Cubical Curtains	2006	1,578	316	5	316		1,526	52
53	Landscaping	2007	5,000	333	15	333		1,138	53
54	Parking lot	2007	35,969		20	1,819	1,819	5,457	54
55	HVAC	2007	4,580	229	20	229		840	55
56	Emergency A/C	2007	30,293	1,515	20	1,515		5,050	56
57	Portable A/C	2007	3,768	188	20	188		643	57
58	Employee Lunch Room	2007	3,671	184	20	184		583	58
59	Painting	2007	16,150	808	20	808		2,693	59
60	1st floor remodel-carpentry, flooring, plumbing, electrical fixtures	2007	641,616		40	16,225	16,225	48,675	60
61	painting,								61
62	Create first floor therapy	2007	185	9	20	9		36	62
63	Landscaping	2008	19,600	1,307	15	1,307		3,158	63
64	Parking Lot-paving,sealcoating and repairs	2008	44,050	2,203	20	2,203		4,957	64
65	HVAC Sport Coolers	2008	3,790	95	40	95		190	65
66	Plumbing & Sprinkler Shower room	2008	9,668	483	20	483		966	66
67	Common areas-doors and locks	2008	3,162	158	20	158		448	67
68	Basement Renovation	2008	7,569	189	40	189		536	68
69	2nd Floor Remodel-Carpentry, Flooring, Electrical, painting	2008	578,270		27	21,028	21,028	43,808	69
70	TOTAL (lines 4 thru 69)		$ 7,326,941	$ 42,179		$ 228,202	$ 186,023	$ 3,361,928	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 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 12A, Carried Forward		$ 7,326,941	$ 42,179		$ 228,202	$ 186,023	$ 3,361,928	1
2	Land improvements	2009	15,180	1,012	15	1,012		1,265	2
3	Landscaping	2009	3,693	246	15	246		349	3
4	Chiller	2009	178,462	8,923	20	8,923		14,128	4
5	Quick connectors/spot cooler	2009	10,244	512	20	512		845	5
6	Plumbing & Sprinkler	2009	6,172	154	40	154		193	6
7	Chiller Fence	2009	5,350	268	20	268		268	7
8	Land improvements-patio pergola	2009	7,930	397	20	397		529	8
9	Land improvements patio fence	2009	14,308	715	20	715		775	9
10	3rd floor remodel-Carpentry,flooring,electrical,	2009	670,689		27	24,389	2,032	26,421	10
11	painting,sprinkler system								11
12	Landscaping Enhancements	2010	4,560	51	15	51		51	12
13	Office Conversions	2010	82,988		27				13
14	Tree removal	2010	12,094	269	15	269		269	14
15	Seal Crack Filing and Striping	2010	3,000	67	15	67		67	15
16	Parking lot signage,posts and lamps	2010	30,501		27				16
17	HVAC Quick connects	2010	4,043	12	27	12		12	17
18	Pantries-Tile,shelves	2010	2,855	26	27	26		26	18
19	Paint rooms	2010	8,090		27				19
20	1st floor rehab-cabinets,library lounge-art,flooring	2010	4,725	40	27	40		40	20
21	2nd floor rehab-painting,flooring	2010	61,521		27				21
22									22
23	Land improvements - management company	2002	298,343		40	8,263		79,130	23
24									24
25	HVAC, electrical, security system - management company	2003	2,620		30	441		1,343	25
26	Key card system - management company	2004	412		20	19		131	26
27	VAV TX controls - management company	2005	125		20	6		37	27
28	Interior Signs- management company	2006	91		5	6		25	28
29	Building - management company	2008	9,908		5	706		1,693	29
30	Building - management company	2009	745		15	46	46	63	30
31	Building - management company	2010	899		15	67	67	73	31
32									32
33	Reconcile to book depreciation			282			(282)		33
34	TOTAL (lines 1 thru 33)		$ 8,766,489	$ 55,153		$ 274,837	$ 187,886	$ 3,489,661	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 8,766,489	$ 55,153		$ 274,837	$ 219,684	$ 3,489,661	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,766,489	$ 55,153		$ 274,837	$ 219,684	$ 3,489,661	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,270,396	$ 102,543	$ 204,108	$ 101,565	5	$ 634,519	71
72	Current Year Purchases	168,055	11,518	11,518		5	11,518	72
73	Fully Depreciated Assets	68,082					68,082	73
74	Allocated from Mgmt. Co.	317,168		30,150	30,150	5	249,360	74
75	TOTALS	$ 1,823,701	$ 114,061	$ 245,776	$ 131,715		$ 963,479	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Alloc. From Mgmt Co.			46,725		5,870	5,870	5	32,892	79
80	TOTALS			$ 46,725	$	$ 5,870	$ 5,870		$ 32,892	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,163,475	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 169,214	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 526,483	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 357,269	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,486,032	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	CIP-Payroll office	$ 26,069	92
93	CIP-Payroll office	1,660	93
94			94
95		$ 27,729	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.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.				3,988			6
7	TOTAL				$ 3,988 **			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: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 61,258 Description: Copier-$15,629;Med Equip-$14,196;Oxygen-$30,249;Alloc. Mgmt Co.-$1,184
(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.			2,012	20
21	TOTAL		$	$ 2,012	21

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge STATE OF ILLINOIS # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	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	$	10,603	$ 404,035	$	10,603	$ 404,035	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,896	130,983		4,896	130,983	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		16,994	1,122,628		16,994	1,122,628	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				734,387		734,387	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			$	32,493	$ 1,657,646	$ 734,387	32,493	$ 2,392,033	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,049,487	$ 1,238,514	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 302,445)	2,250,847	2,250,847	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	557	557	6
7	Other Prepaid Expenses	61,834	61,834	7
8	Accounts Receivable (owners or related parties)	27,607	107,400	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,390,332	$ 3,659,152	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		526,560	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	1,388,254	3,623,147	15
16	Equipment, at Historical Cost	858,990	1,870,426	16
17	Accumulated Depreciation (book methods)	(823,822)	(4,486,032)	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):	27,729	27,729	22
23	Other(specify): Mortgage cost net		27,791	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,451,151	$ 6,732,963	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,841,483	$ 10,392,115	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 689,645	$ 689,645	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	561,558	561,558	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,540	9,540	31
32	Accrued Real Estate Taxes(Sch.IX-B)		501,600	32
33	Accrued Interest Payable		37,620	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	776,842	1,297,075	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,037,585	$ 3,097,038	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,483,056	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)**	$	$ 6,483,056	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,037,585	$ 9,580,094	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,803,898	$ 812,021	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,841,483	$ 10,392,115	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/10-12/31/10

Schedule 17A
XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Due from remodeling	25,600	25,600
Due to Republic Construction of Illinois, Inc.	4,527	4,527
Accrued expenses	81,527	81,527
Accrued Rent	497,463	-
Due to patient trust fund	39,694	39,694
Deferred income	92,285	92,285
Due to Royal Operations	34,071	34,071
Due to Chicago Ridge	1,359	1,359
Interest Rate Swap Liability	-	1,017,696
Advance Bi-weekly part A payments	31,794	31,794
Uncollectible Part A Co. Pvts	(31,478)	(31,478)
	776,842	1,297,075

See Accountants' Compilation

Facility Name & ID Number Lexington of Chicago Ridge **#** 0042739 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,562,770	1
2	Restatements (describe):		2
3	**Post closing adjustment**	(54,621)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,508,149	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,295,749	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	( )	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)**	$ 1,295,749	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)**	$ 2,803,898	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 20,477,478	1
2	Discounts and Allowances for all Levels	(6,921,469)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,556,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,750,011	6
7	Oxygen	101	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,750,112	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	2,035	12
13	Barber and Beauty Care	22,801	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	410,312	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	94,290	19
20	Radiology and X-Ray		20
21	Other Medical Services	110,640	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 640,078	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	420	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 420	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	72	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 72	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,946,691	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,873,603	31
32	Health Care	7,366,314	32
33	General Administration	3,507,403	33
	B. Capital Expense		
34	Ownership	1,855,345	34
	C. Ancillary Expense		
35	Special Cost Centers	937,135	35
36	Provider Participation Fee	111,142	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,650,942	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,295,749	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,295,749	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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,170	2,254	$ 138,135	$ 61.28	1
2	Assistant Director of Nursing	10,367	11,094	392,975	35.42	2
3	Registered Nurses	33,978	37,480	1,203,332	32.11	3
4	Licensed Practical Nurses	42,791	46,019	1,088,244	23.65	4
5	CNAs & Orderlies	118,511	128,347	1,464,397	11.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,415	8,359	117,933	14.11	8
9	Activity Director					9
10	Activity Assistants	17,178	18,502	246,638	13.33	10
11	Social Service Workers	17,211	18,271	326,963	17.90	11
12	Dietician	2,151	2,252	39,467	17.53	12
13	Food Service Supervisor	1,960	2,120	43,531	20.53	13
14	Head Cook	1,960	2,080	33,850	16.27	14
15	Cook Helpers/Assistants	11,747	12,865	130,431	10.14	15
16	Dishwashers	19,869	21,156	177,313	8.38	16
17	Maintenance Workers	2,305	2,453	45,485	18.54	17
18	Housekeepers	40,996	44,539	423,923	9.52	18
19	Laundry	9,014	9,925	93,493	9.42	19
20	Administrator	2,082	2,196	148,506	67.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,094	17,011	283,143	16.64	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	2,582	2,867	46,616	16.26	31
32	Other Health C: Marketing	2,400	2,823	111,989	39.67	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	362,781	392,613	$ 6,556,364 *	$ 16.70	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	463	$ 25,577	1(3)	35
36	Medical Director	Monthly	64,147	9(3)	36
37	Medical Records Consultant	26	1,455	10(3)	37
38	Nurse Consultant	Monthly	6,615	10(3)	38
39	Pharmacist Consultant	Monthly	12,180	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	104	9,699	11(3)	44
45	Social Service Consultant	88	4,464	12(3)	45
46	Other(specify) Psychosocial	48	2,304	12(3)	46
47	Medical Consultant	Monthly	4,654	10(7)	47
48	10(3)	Monthly	29,800	10(7)	48
49	TOTAL (lines 35 - 48)	729	$ 160,895		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy McDonald	Administrator	0%	$ 148,506
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 148,506

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 880,425
Management Fees-Vesta Mgmt.	504,812
(Eliminated in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,385,237
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Action Computer Service	Computer Consulting	$ 849
Bridgepoint Technologies	Computer Consulting	1,247
BSKLive, Inc.	Computer Consulting	3,164
Cimco	Computer Consulting	2,269
E-Fax Corporate	Computer Consulting	2,201
E-Health Data Solutions	Computer Consulting	2,400
Elton Designs, Inc.	Computer Consulting	1,265
Enterprise Agreement-2010	Computer Consulting	5,622
Information Control	Computer Consulting	1,156
Krakau Business	Computer Consulting	349
Lanac Technology	Computer Consulting	2,846
See Schedule 21C		205,024
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 228,392

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,423
Unemployment Compensation Insurance	109,060
FICA Taxes	472,528
Employee Health Insurance	190,255
Employee Meals	18,154
Illinois Municipal Retirement Fund (IMRF)*	
401K	18,991
Uniform Allowance	4,737
Other Employee Benefits	34,130
TOTAL (agree to Schedule V, line 22, col.8)	$ 950,278

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,875
Health Care Worker Background Check	
(Indicate # of checks performed 125)	1,503
Patient Background Checks 376	4,510
Miscellaneous Licenses & Fees	3,234
Miscellaneous Dues & Subscriptions	315
Less: marketing	(315)
Alloc. From Mgmt. Co.	8,393
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,515

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,110
Alloc. From Mgmt. Co.	1,870
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,980

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Chicago Ridge
12/31/2009
Section XIX.

C. Professional Fees Schedule 21C

Vendor/Payee	Type	Amount
Lintech LLC	Computer Consulting	5,638
Lintech LLC	Computer Consulting	330
National Datacare	Computer Consulting	2,286
On Shift	Computer Consulting	1,055
Red Sky Technologies	Computer Consulting	273
RSM McGladrey	Computer Consulting	8,486
Silver Chair Learning Systems	Computer Consulting	4,200
SPM Marketing & Communications	Computer Consulting	877
Telemedicine Solutions	Computer Consulting	5,350
TouchPoint Care	Computer Consulting	400
Vision Share, Inc.	Computer Consulting	1,039
Xclutel Communications	Computer Consulting	287
XO Communications	Computer Consulting	1,211
MNJ Technology	Computer Consulting	585
Warehouse Direct	Computer Consulting	108
TouchPoint Care	Computer Consulting	400
Shaker Recruitment Advertising	Computer Consulting	30
Grabowski Law Center	Collections	5,263
Cassiday Schade	Legal	107,509
Duane Morris, LLP	Legal	740
IL Secretary of State	Filing Fees	100
McGladrey & Pullen	Accounting	26,687
Medcor	Health Care	250
Much Shelist	Legal	19,433
Pension Administrators, Inc.	Pension Administration	1,017
Personnel Planners	U/C Consulting	2,590
RSM McGladrey	Accounting	6,145
Serpico, Petrosino & Dipiero	Legal	2,721
Gene Whitehorn	Medicaid Reim. Specialist	14
		205,024

Schedule V, line 19 column 7	228,392
To disallow collection fees	(5,263)
Out of period legal	(15,512)
Legal allocated from Real Estate	
Secretary of State	200
Samvest of Lombard	
Legal	270
Accounting	100
Total	370

Allocated from Mgmt Co.		
Serpico, Petrosino, Dipiero	Legal	113
Duane Morris	Legal	228
McGladrey & Pullen	Accounting	918
RSM McGladrey	Accounting	750
Illinois Secretary of State	Filing Fees	47
LaSalle Network	Recruiting/Finance	1,133
Gilson Labus & Silverman	KEP	728
KMZ Rosenmann	KEP	118
Pension Administrators, Inc.	401K Administration	208
Aijilon Professional Staffing	Accounting	925
Personnel Planners	Unemployment Consulting	24
Quattrochi and Parker	Social Service Consulting	23
Gene Whitehorn	Medicaid Reimb Specialist	981
Computer Consulting	Computer Services	14,744
		20,940
Schedule V, line 19, column 8		229,127

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

-1 Are nursing employees (RN,LPN,NA) represented by a union? **No**

-2 Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

-3 Did the nursing home make political contributions or payments to a political action organization? **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. $ **66,419** 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. $ **111,142**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

-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. $ **18,154** 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.