FOR BHF USE

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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.

I. IDPH License ID Number: 0038083

Facility Name: Lexington Health Care Center of LaGrange, Inc.

Address: 4735 Willow Springs Road (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 352-6900 **Fax #** (708) 482-0239

HFS ID Number:

Date of Initial License for Current Owners: 7/31/92

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 1/1/11 to 12/31/11 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' PREPARATION 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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 04/12/2011

	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	110	Skilled (SNF)	120	42,790	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	110	TOTALS	120	42,790	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			24,655	24,655	8
9	SNF/PED					9
10	ICF	6,109	5,103		11,212	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,109	5,103	24,655	35,867	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.82%

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 7/31/92

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 120 and days of care provided 24,409

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: 12/31/11 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 LaGrange, I # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	319,013	14,397	36,603	370,013		370,013		370,013			1
2	Food Purchase		194,407		194,407		194,407	(12,185)	182,222			2
3	Housekeeping	281,549	25,061		306,610		306,610	214	306,824			3
4	Laundry	63,616	13,465		77,081		77,081		77,081			4
5	Heat and Other Utilities			194,309	194,309		194,309	5,861	200,170			5
6	Maintenance	40,193		105,828	146,021		146,021	40,593	186,614			6
7	Other (specify):* Alloc. Mgmt Co. Bene							5,285	5,285			7
8	**TOTAL General Services**	704,371	247,330	336,740	1,288,441		1,288,441	39,768	1,328,209			8
	B. Health Care and Programs											
9	Medical Director			143,250	143,250		143,250		143,250			9
10	Nursing and Medical Records	3,766,481	372,045	106,870	4,245,396		4,245,396	36,238	4,281,634			10
10a	Therapy			2,209,309	2,209,309		2,209,309		2,209,309			10a
11	Activities	127,945	29,803	7,412	165,160		165,160		165,160			11
12	Social Services	189,531		7,696	197,227		197,227		197,227			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Mgmt Co. Bene							5,012	5,012			15
16	**TOTAL Health Care and Programs**	4,083,957	401,848	2,474,537	6,960,342		6,960,342	41,250	7,001,592			16
	C. General Administration											
17	Administrative	97,021		1,124,596	1,221,617		1,221,617	(1,108,893)	112,724			17
18	Directors Fees											18
19	Professional Services			145,380	145,380		145,380	4,909	150,289			19
20	Dues, Fees, Subscriptions & Promotions			44,726	44,726		44,726	4,254	48,980			20
21	Clerical & General Office Expenses	203,308	33,715	36,452	273,475		273,475	349,138	622,613			21
22	Employee Benefits & Payroll Taxes			868,126	868,126		868,126	12,185	880,311			22
23	Inservice Training & Education			16,685	16,685		16,685	935	17,620			23
24	Travel and Seminar			2,260	2,260		2,260	(651)	1,609			24
25	Other Admin. Staff Transportation			2,156	2,156		2,156	11,337	13,493			25
26	Insurance-Prop.Liab.Malpractice			201,156	201,156		201,156	3,919	205,075			26
27	Other (specify):* Alloc. Mgmt Co. Bene							50,364	50,364			27
28	**TOTAL General Administration**	300,329	33,715	2,441,537	2,775,581		2,775,581	(672,503)	2,103,078			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,088,657	682,893	5,252,814	11,024,364		11,024,364	(591,485)	10,432,879			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 LaGrange, Inc. #0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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			132,214	132,214		132,214	319,454	451,668			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,453	1,453		1,453	362,440	363,893			32
33	Real Estate Taxes							253,602	253,602			33
34	Rent-Facility & Grounds			1,006,073	1,006,073		1,006,073	(1,003,697)	2,376			34
35	Rent-Equipment & Vehicles			84,563	84,563		84,563	1,917	86,480			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,224,303	1,224,303		1,224,303	(66,284)	1,158,019			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		951,291	8,515	959,806		959,806		959,806			39
40	Barber and Beauty Shops			25,758	25,758		25,758		25,758			40
41	Coffee and Gift Shops			2,035	2,035		2,035		2,035			41
42	Provider Participation Fee			104,587	104,587		104,587		104,587			42
43	Other (specify):* **Non-Allow Costs**	113,173		152,827	266,000		266,000	(266,000)				43
44	**TOTAL Special Cost Centers**	113,173	951,291	293,722	1,358,186		1,358,186	(266,000)	1,092,186			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,201,830	1,634,184	6,770,839	13,606,853		13,606,853	(923,769)	12,683,084			45

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	(4,620)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	542	30		9
10	Interest and Other Investment Income	(1,230)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,864)	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	(828)	43		18
19	Entertainment				19
20	Contributions	(6,750)	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	(701)	43		24
25	Fund Raising, Advertising and Promotional	(51,390)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(484)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(427,746)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (499,071)		$	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)	(424,698)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (424,698)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (923,769)		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

STATE OF ILLINOIS

Lexington Health Care Center of LaGrange, Inc.

ID# 0038083

Report Period Beginning: 1/1/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Reclass Repairs & Maintenance	$ 1,197	6	1
2	Labs-Part A	(7,719)	43	2
3	X-Rays-Part A	(42,860)	43	3
4	Diagnostics Managed Care	(3,024)	43	4
5	Trust Fees	(135)	43	5
6	Collections	(5,746)	19	6
7	Out of Period legal	(3,245)	19	7
8	Marketing Salary	(113,173)	43	8
9	Education & Seminar marketing	(2,260)	24	9
10	Unrealized loss on FMV swap	(222,194)	43	10
11	Valet Services	(27,676)	43	11
12	Personal Item Replacement	(911)	43	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**	(427,746)		49

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 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 LaGrange Limited Partnership	**	$ 200	$ 200	1
2	V	30	Depreciation		Sambell of LaGrange Limited Partnership	**	291,509	291,509	2
3	V	32	Interest Expense		Sambell of LaGrange Limited Partnership	**	353,008	353,008	3
4	V	32	Amortization of Mortgage Costs		Sambell of LaGrange Limited Partnership	**	1,339	1,339	4
5	V	33	Property Taxes		Sambell of LaGrange Limited Partnership	**	250,073	250,073	5
6	V	34	Rental Expense	1,006,073	Sambell of LaGrange Limited Partnership	**		(1,006,073)	6
7	V	43	Trust Fees		Sambell of LaGrange Limited Partnership	**	135	135	7
8	V	21	Office Supplies		Sambell of LaGrange Limited Partnership	**	34	34	8
9	V	43	Unrealized loss on FMV swap		Sambell of LaGrange Limited Partnership	**	222,194	222,194	9
10	V								10
11	V								11
12	V				** The owners of Lexington Health Care Center of La Grange, Inc. owns 100%				12
13	V				of Sambell of LaGrange Limited Partnership.				13
14	Total			$ 1,006,073			$ 1,118,492	$ * 112,419	14

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.	**	$ 214	$ 214	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	5,100	5,100	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	116	116	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	645	645	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	35,915	35,915	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	3,286	3,286	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	195	195	21
22	V	6	Security service		Royal Management Corp.	**			22
23	V	7	Management allocation - employee benefits		Royal Management Corp.	**	5,285	5,285	23
24	V	10	Medical consultant		Royal Management Corp.	**	2,182	2,182	24
25	V	10	Management allocation - salaries		Royal Management Corp.	**	34,056	34,056	25
26	V	15	Management allocation - employee benefits		Royal Management Corp.	**	5,012	5,012	26
27	V	17	Management allocation - salaries		Royal Management Corp.	**	15,703	15,703	27
28	V	19	Computer consultant & supplies		Royal Management Corp.	**	9,950	9,950	28
29	V	19	Professional fees		Royal Management Corp.	**	3,750	3,750	29
30	V	20	Dues & subscriptions		Royal Management Corp.	**	770	770	30
31	V	23	Inservice Training		Royal Management Corp.	**	935	935	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	3,484	3,484	32
33	V	21	Management allocation - salaries		Royal Management Corp.	**	326,521	326,521	33
34	V	21	Bank charges		Royal Management Corp.	**	6,246	6,246	34
35	V	21	Office supplies & printing		Royal Management Corp.	**	7,232	7,232	35
36	V	21	Postage		Royal Management Corp.	**	2,340	2,340	36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 468,937	$ * 468,937	39

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.	**	$ 6,765	$ 6,765	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,609	1,609	16
17	V	25	Auto expense		Royal Management Corp.	**	11,337	11,337	17
18	V	26	Insurance general		Royal Management Corp.	**	3,919	3,919	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	50,364	50,364	19
20	V	30	Depreciation		Royal Management Corp.	**	27,403	27,403	20
21	V	32	Interest		Royal Management Corp.	**	9,302	9,302	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	21	21	22
23	V	33	Property taxes		Royal Management Corp.	**	3,529	3,529	23
24	V	34	Rent expense		Royal Management Corp.	**	2,376	2,376	24
25	V	35	Equipment rental		Royal Management Corp.	**	686	686	25
26	V	17	Management fees	1,124,596	Royal Management Corp.	**		(1,124,596)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,231	1,231	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								38
39	Total			$ 1,124,596			$ 118,542	$ * (1,006,054)	39

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	22.34%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Vesta Mgmt.	Lombard	Mgmt. Company	3
4	Jeffrey J. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Group LLC			4
5	Lawrence W. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Sambell of	LaGrange	Real Estate	5
6	David S. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	LaGrange		Property	6
7	David S. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Ltd. Ptsp.			7
8	Jeffrey J. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Royal Mgmt.	Lombard	Mgmt. Company	8
9	Lawrence W. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Corporation			9
10					Lexington Financial	Lombard	Finance Company	10
11					Services II, LLC			11
12					Lexington Square	Lombard	Independent	12
13					Life Care of		and Assisted	13
14					Lombard, LLC		Living	14
15					Lexington Square	Elmhurst	Independent	15
16					Life Care of		Living Facility	16
17					Elmhurst, LLC			17
18					Samvest of Lombard	Lombard	Lessor	18
19					II, LLC			19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington Health Care Center of LaGrange, # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 5,759	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,858	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,086	L17, C7	3
4											4
5	Daniel Thiem	Executive VP	Administrative		See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,768	L21,C7	5
6											6
7											7
8											8
9				Certain Individuals work in excess of 40 hours per week.							9
10											10
11											11
12											12
13								TOTAL	$ 18,471		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 LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 Available	722,420	10	$ 3,612	$	42,790	$ 214	1
2	5	Utilities - gas & electric	Bed Days Available	722,420	10	86,099		42,790	5,100	2
3	5	Utilities - water & sewer	Bed Days Available	722,420	10	1,961		42,790	116	3
4	5	Utilities - maintenance office	Bed Days Available	722,420	10	10,885		42,790	645	4
5	6	Management allocation - salaries	Bed Days Available	722,420	10	606,344	606,344	42,790	35,915	5
6	6	Repairs & maintenance	Bed Days Available	722,420	10	55,471		42,790	3,286	6
7	6	Scavenger & exterminating	Bed Days Available	722,420	10	3,293		42,790	195	7
8	6	Security service	Bed Days Available	722,420	10			42,790	0	8
9	7	Management allocation - employee	Bed Days Available	722,420	10	89,234		42,790	5,285	9
10	10	Medical consultant	Bed Days Available	722,420	10	36,843		42,790	2,182	10
11	10	Management allocation - salaries	Bed Days Available	722,420	10	574,970	574,970	42,790	34,056	11
12	15	Management allocation - employee	Bed Days Available	722,420	10	84,616		42,790	5,012	12
13	17	Management allocation - salaries	Bed Days Available	722,420	10	265,116	265,116	42,790	15,703	13
14	19	Computer consultant & supplies	Bed Days Available	722,420	10	167,987		42,790	9,950	14
15	19	Professional fees	Bed Days Available	722,420	10	63,319		42,790	3,750	15
16	20	Dues & subscriptions	Bed Days Available	722,420	10	13,000		42,790	770	16
17	23	Inservice Training	Bed Days Available	722,420	10	15,778		42,790	935	17
18	20	Advertising - help wanted	Bed Days Available	722,420	10	58,818		42,790	3,484	18
19	21	Management allocation - salaries	Bed Days Available	722,420	10	5,512,623	5,512,623	42,790	326,521	19
20	21	Bank charges	Bed Days Available	722,420	10	105,454		42,790	6,246	20
21	21	Office supplies & printing	Bed Days Available	722,420	10	122,091		42,790	7,232	21
22	21	Postage	Bed Days Available	722,420	10	39,500		42,790	2,340	22
23	21	Telephone	Bed Days Available	722,420	10	114,221		42,790	6,765	23
24	24	Travel and Seminar	Bed Days Available	722,420	10	27,173		42,790	1,609	24
25	TOTALS					$ 8,058,408	$ 6,959,053		$ 477,311	25

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	25	Auto expense	Bed Days	722,420	10	$ 191,407	$	42,790	$ 11,337	1
2	26	Insurance general	Bed Days	722,420	10	66,156		42,790	3,919	2
3	27	Management allocation - employee	Bed Days	722,420	10	850,290		42,790	50,364	3
4	30	Depreciation	Bed Days	722,420	10	462,650		42,790	27,403	4
5	32	Interest	Bed Days	722,420	10	157,045		42,790	9,302	5
6	32	Amortization of mortgage costs	Bed Days	722,420	10	354		42,790	21	6
7	33	Property taxes	Bed Days	722,420	10	59,576		42,790	3,529	7
8	34	Rent expense	Bed Days	722,420	10	40,122		42,790	2,376	8
9	35	Equipment rental	Bed Days	722,420	10	11,581		42,790	686	9
10	35	Auto Lease	Bed Days	722,420	10	20,791		42,790	1,231	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					$ 1,859,972	$		$ 110,168	25

Facility Name & ID Number Lexington Health Care Center of LaGrange, I # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 5,991,000	$ 5,517,524	5/1/17	0.0625	$ 353,008	1
2	Sevices II, LLC											2
3												3
4												4
5							Interest on financing insurance premium				511	5
	Working Capital											
6	JP Morgan Chase		X	Line of Credit	Various	4/30/07	300,000	155,000	6/30/12	Libor +2.25%	942	6
7												7
8												8
9	TOTAL Facility Related						$ 6,291,000	$ 5,672,524			$ 354,461	9
	B. Non-Facility Related*											
10								Amortization of Loan Cost			1,339	10
11								Interest Income offset			(1,230)	11
12												12
13								Allocated from Mgmt. Co.			9,323	13
14	TOTAL Non-Facility Related						$	$			$ 9,432	14
15	TOTALS (line 9+line14)						$ 6,291,000	$ 5,672,524			$ 363,893	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.)**

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 249,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2010**	$ 244,173	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,427)	3
	Allocated from Mgmt. Co.	3,529	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 252,000	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.**		$ 3,500	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.		$ 253,602	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	222,226	8
	2007	226,830	9
	2008	219,332	10
	2009	241,653	11
	2010	244,173	12

See attached accrual worksheet

	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 LaGrange, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-08-207-017-0000	Land & Building	$ 130,864.91	$ 130,864.91
2.	18-08-207-018-0000	Land & Building	$ 113,308.28	$ 113,308.28
3.	Royal Management Corp. (Samvest of Lombard II)		$ 229,415.60	$ 3,529.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 473,588.79	$ 247,702.19

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.

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [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	40,000	1991	$ 500,000	1
2	Allocated from Management Co.			10,722	2
3	TOTALS	40,000		$ 510,722	3

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	120		1992	1992	$ 2,661,448	$	35	$ 76,041	$ 76,041	$ 1,482,805	4
5			1995	1995	79,363		10			79,363	5
6			2005	2005	2,321,014		21	110,524	110,524	718,408	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1992	1,152		20	58	58	1,124	9
10	Building Improvements			1992	2,714		31			2,714	10
11	Building Improvements			1993	2,901		35	83	83	1,575	11
12	Leasehold Improvements			1994	6,402		10			6,402	12
13	Leasehold Improvements - Corner Guards			1996	2,195		10			2,122	13
14	Wiring			1998	3,378		10			3,378	14
15	Resurface & Restripe Parking Lot			1998	3,753		10			3,753	15
16	Lobby Tile			1998	19,488		10			19,488	16
17	Resurface & Restripe Parking Lot			2000	1,997		10			1,998	17
18	Automatic Door			2000	1,300		10			1,300	18
19	Kitchen Rehab			2001	1,441	72	10	72		1,441	19
20	Infrared curtains for elevator			2001	3,000	150	10	150		3,000	20
21	Dining room, resident rooms, and corridors renovations			2002	150,083	7,505	20	7,505		68,166	21
22	Elevator upgrade			2002	5,398	540	10	540		5,219	22
23	Air conditioner compressor			2003	9,218	922	10	922		7,759	23
24	Sidewalk and fencing			2005	46,701	2,335	20	2,335		14,399	24
25	HVAC			2005	8,141	407	20	407		2,476	25
26	Wiring			2005	4,506	225	20	225		1,407	26
27	Lobby, lounge and reception renovations			2005	24,362	1,218	20	1,218		7,714	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors			2005	326,862		20	16,343	16,343	98,058	28
29	Wallcoverings			2005	10,822		5			10,822	29
30	Medical records room rehab			2006	19,739	987	20	987		4,935	30
31	Activity/PT Room Rehab			2006	1,158	58	20	58		290	31
32	Land scape enhancement			2006	8,726	582	15	582		3,104	32
33	Roof			2006	29,700	1,980	15	1,980		10,560	33
34	HVAC			2006	3,254	163	20	163		869	34
35	Plumbing and sprinkler system			2006	20,725	1,036	20	1,036		6,217	35
36	Laundry Combustion Air			2006	16,814	841	20	841		4,835	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 LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	
37	Lobby/Lounge/Reception rehab	2006	$ 14,033	$ 1,403	10	$ 1,403	$	$ 7,717	37
38	Cubicle curtains/drapery	2006	6,955	177	5	177		6,955	38
39	Cabinets/counters for 2nd FI library	2006	2,665	267	10	267		1,401	39
40	TCU rehab	2006	2,402	120	20	120		610	40
41	First floor remodel	2006	212,084		20	10,604	10,604	53,020	41
42	Kitchen rehab	2006	8,165	408	20	408		2,245	42
43	Bath fixtures-2nd foor	2006	2,076	208	10	208		1,213	43
44	Medical Records Room Rehab	2007	3,527	176	20	176		881	44
45	Landscaping	2007	3,862	257	15	257		1,178	45
46	HVAC	2007	58,326	2,916	20	2,916		12,879	46
47	Common Areas Remodel	2007	2,059	206	10	206		944	47
48	First Floor Remodel	2007	6,517		20	326	326	1,547	48
49	Garage	2007	16,487	824	20	824		3,365	49
50	Land Improvements	2008	3,745	250	15	250		771	50
51	Parking lot-paving	2008	8,720	436	20	436		1,490	51
52	HVAC-Spot Coolers	2008	5,589	140	40	140		420	52
53	2nd floor remodel-Carpentry trim, drywall;Flooring material, HV	2008	447,153		27	16,260	16,260	62,330	53
54	Plumbing, Electrical,painting.								54
55	Brick Replacement	2009	153,109	3,828	40	3,828		7,975	55
56	Irrigation System	2009	16,740	1,116	15	1,116		2,511	56
57	Landscaping	2009	10,321	688	15	688		1,548	57
58	Parking lot repairs	2009	3,500	175	20	175		452	58
59	HVAC Chiller	2009	2,594	130	20	130		314	59
60	Patio Pergola	2009	6,760	338	20	338		958	60
61	Stamped Concrete	2009	16,658	833	20	833		1,944	61
62	Fence	2009	4,084	204	20	204		425	62
63	Patio Wall	2009	8,212	411	20	411		925	63
64	HVAC Quick Connectors	2009	5,300	265	20	265		707	64
65									65
66	Brick Panel Replacement	2010	16,578	603	27	603		1,005	66
67	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	17,565	641	27	641		641	67
68	Landscaping Enhancements	2010	15,258	1,017	15	1,017		1,526	68
69	Drain tile,sewer concrete	2010	3,221	214	15	214		260	69
70	TOTAL (lines 4 thru 69)		$ 6,882,020	$ 37,272		$ 267,510	$ 230,238	$ 2,755,858	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 LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 12A, Carried Forward		$ 6,882,020	$ 37,272		$ 267,510	$ 230,238	$ 2,755,858	1
2	Retaining wall	2010	15,736	1,049	15	1,049		1,049	2
3	Canopy Installation	2010	4,466	163	27	163		190	3
4	Dining Room HVAC	2010	4,169	152	27	152		228	4
5	Pantry carpentry,flooring,plumbing	2010	2,911	106	27	106		141	5
6	Director of Nursing office painting	2010	4,245	155	27	155		155	6
7	Remodel Library/Lounge-art,painting,flooring	2010	6,477	236	27	236		236	7
8	2nd floor doors	2010	3,046	111	27	111		194	8
9	Office changes-carpentry, painting, flooring	2011	2,487	53	27	53		53	9
10	Fence	2011	2,750	31	15	31		31	10
11	Mulch and stone	2011	2,662	30	15	30		30	11
12	Laundry Room-Tile, Painting	2011	7,311	89	27	89		89	12
13	Locker Room	2011	2,573	55	27	55		55	13
14	Place beds back into service	2011	117,350	2,489	27	2,489		2,489	14
15									15
16	Reconcile book depreciation			(543)			543		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)		$ 7,058,203	$ 41,448		$ 272,229	$ 230,781	$ 2,760,798	34

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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		$ 7,058,203	$ 41,448		$ 272,229	$ 230,781	$ 2,760,798	1
2									2
3									3
4									4
5									5
6									6
7	Building - management company	2002	148,375		40	4,846	4,846	43,767	7
8	HVAC, electrical, security system - management company	2003	1,303		30	278	278	759	8
9	Key card system - management company	2004	205		20	11	11	76	9
10	VAV TX controls - management company	2005	62		20	3	3	21	10
11	Interior Signs-management company	2006	45		5	3	3	16	11
12	Building - management company	2008	7,189		5	414	414	1,486	12
13	Building - management company	2009	1,343		15	27	27	177	13
14	Building - management company	2010	1,307		15	59	59	135	14
15	Building - management company	2011	923		15	23	23	21	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)		$ 7,218,955	$ 41,448		$ 277,893	$ 236,445	$ 2,807,256	34

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 900,893	$ 81,834	$ 143,104	$ 61,270	5	$ 645,137	71
72	Current Year Purchases	92,500	8,932	8,932		5	8,932	72
73	Fully Depreciated Assets	46,067					46,067	73
74	Allocated from Mgmt. Co.	172,847		19,014	19,014	5	134,759	74
75	TOTALS	$ 1,212,307	$ 90,766	$ 171,050	$ 80,284		$ 834,895	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 Mgmt. Co.			24,316		2,725	2,725		18,839	79
80	TOTALS			$ 24,316	$	$ 2,725	$ 2,725		$ 18,839	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,966,300	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,214	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 451,668	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 319,454	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,660,990	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93		N/A	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.

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				2,376			6
7	TOTAL				$ 2,376 **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 85,249 Description: Copier-$8,075; Mailing Machine-$255; Med Equip.-$34,290; Oxygen-$41,943; Mgmt. Co.-$686
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Mgmt. Co.		$	$ 1,231	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,231	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.

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$	16,559	$ 878,081	$	16,559	$ 878,081	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,710	119,333		3,710	119,333	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		15,609	1,211,895		15,609	1,211,895	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				951,291		951,291	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)					8,515		8,515	12
13	Other (specify):									13
14	TOTAL			$	35,878	$ 2,209,309	$ 959,806	35,878	$ 3,169,115	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.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 898,764	$ 1,005,943	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 281,962)	2,097,849	2,097,849	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,190	105,190	6
7	Other Prepaid Expenses	1,158	126,504	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,102,961	$ 3,335,486	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,052	7,052	12
13	Land		510,722	13
14	Buildings, at Historical Cost		2,661,448	14
15	Leasehold Improvements, at Historical Cost	1,065,576	4,557,507	15
16	Equipment, at Historical Cost	637,347	1,236,623	16
17	Accumulated Depreciation (book methods)	(699,656)	(3,660,990)	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): Mortgage cost net		27,552	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,010,319	$ 5,339,914	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,113,280	$ 8,675,400	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 849,157	$ 849,157	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	155,000	155,000	29
30	Accrued Salaries Payable	298,867	298,867	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,763	9,763	31
32	Accrued Real Estate Taxes(Sch.IX-B)		252,000	32
33	Accrued Interest Payable		30,832	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	404,481	1,313,773	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,717,268	$ 2,909,392	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,517,524	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,517,524	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,717,268	$ 8,426,916	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,396,012	$ 248,484	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,113,280	$ 8,675,400	48

*(See instructions.)

Lexington Health Care Center of LaGrange
FYE 12/31/11
Provider # 0038083
Schedule 17A

XV. Balance Sheet

36. Other Current Liabilities

Description	Operating	After Consolidation
Due from Lexington Fin Serv	927	927
Accrued Expenses	21,229	21,229
Accrued Resident Tax	40,402	40,402
Accrued Royl/Vesta Mgmt	34,664	34,664
Accrued Rent	198,582	-
Accrued Insurance	76,811	76,811
Due to Patient Trust Fund	5,245	5,245
Deffered Income	73,098	73,098
Due to Royal Operating	43,100	43,100
Due to Republic Construction of Illinois, Inc	164	164
Advance bi-weekly part A payments	(40,996)	(40,996)
Uncollectible part A Co. Pvts	(48,745)	(48,745)
Interest Rate Swap Liability		1,107,874
	404,481	1,313,773

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,918,951	1
2	Restatements (describe):		2
3	**Post closing adjustments**	(34,837)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,884,114	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,889,757	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	(1,377,859)	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)**	$ 511,898	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)**	$ 2,396,012	24 *

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 13,451,392	1
2	Discounts and Allowances for all Levels	(5,683,628)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,767,764	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,010,961	6
7	Oxygen	89,705	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,100,666	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,074	12
13	Barber and Beauty Care	20,421	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	848,451	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	356,970	19
20	Radiology and X-Ray		20
21	Other Medical Services	396,454	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,626,370	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,635	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,635	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Recovery of write off	175	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 175	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,496,610	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,288,441	31
32	Health Care	6,960,342	32
33	General Administration	2,775,581	33
	B. Capital Expense		
34	Ownership	1,224,303	34
	C. Ancillary Expense		
35	Special Cost Centers	1,253,599	35
36	Provider Participation Fee	104,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,606,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,889,757	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,889,757	43

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

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

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

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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	1,569	1,852	$ 98,033	$ 52.93	1
2	Assistant Director of Nursing	32,641	40,329	1,078,634	26.75	2
3	Registered Nurses	27,608	35,778	1,066,156	29.80	3
4	Licensed Practical Nurses	16,718	21,964	561,838	25.58	4
5	CNAs & Orderlies	61,866	77,004	874,021	11.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,980	4,115	51,292	12.46	8
9	Activity Director					9
10	Activity Assistants	8,451	9,935	127,945	12.88	10
11	Social Service Workers	8,765	9,812	189,531	19.32	11
12	Dietician	198	226	3,994	17.67	12
13	Food Service Supervisor	1,797	2,165	55,812	25.78	13
14	Head Cook	1,462	1,736	25,641	14.77	14
15	Cook Helpers/Assistants	10,541	13,349	135,838	10.18	15
16	Dishwashers	9,636	11,097	97,728	8.81	16
17	Maintenance Workers	1,739	2,221	40,193	18.10	17
18	Housekeepers	24,624	29,357	281,549	9.59	18
19	Laundry	5,366	6,731	63,616	9.45	19
20	Administrator	1,438	2,374	97,021	40.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,278	14,296	203,308	14.22	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	1,724	2,153	36,507	16.96	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	3,031	3,356	113,173	33.72	33
34	TOTAL (lines 1 - 33)	231,432	289,850	$ 5,201,830 *	$ 17.95	34

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

** See instructions.

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	Monthly	$ 36,603	1(3)	35
36	Medical Director	Monthly	143,250	9(3)	36
37	Medical Records Consultant	25	1,380	10(3)	37
38	Nurse Consultant	Monthly	30,253	10(3)	38
39	Pharmacist Consultant	Monthly	6,735	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	4,673	11(3)	44
45	Social Service Consultant	104	5,391	12(3)	45
46	Other(specify) Psychosocial	48	2,304	12(3)	46
47	Pulmonary	Monthly	68,502	10(3)	47
48	Medical Consultant	Monthly	2,182	10(7)	48
49	TOTAL (lines 35 - 48)	273	$ 301,273		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

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Diane Androvich	Administrator	0%	$ 84,961
Michelle Pardun	Administrator	0%	12,060
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,021

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 621,551
Management Fees-Vesta Mgmt.	464,269
Royal Capital MGMT Fees	38,776
(Elminated on page 3,C7,L17)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,124,596
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center LLC	Collections	$ 5,746
Cassiday Schade	Legal	20,294
Duane Morris	Legal	3,888
Laner Muchin	Legal	425
Lexington Financial Services LLC	Accounting	839
McGladrey & Pullen	Accounting	25,101
Pension Administrators	401K Administration	551
Personnel Planners	U/C Consulting	2,040
Real Med	Workers Compensation	151
Much Shelist	Legal	6,159
RSM McGladrey	Accounting	5,039
See Schedule 21C		75,147
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 145,380

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,525
Unemployment Compensation Insurance	101,513
FICA Taxes	373,590
Employee Health Insurance	173,338
Employee Meals	12,185
Illinois Municipal Retirement Fund (IMRF)*	
401K	12,733
Other Employee Benefits	102,996
Unifrom Expense	2,300
TOTAL (agree to Schedule V, line 22, col.8)	$ 880,180

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	16,163
Health Care Worker Background Check	
(Indicate # of checks performed 259.8)	3,118
Patient Background Checks 866.8	10,402
Miscellaneous Licenses & Fees	7,360
Miscellaneous Dues & Subscriptions	3,703
Allocated from Mgmt. Co.	4,254
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,980

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from Mgmt. Co.	1,609
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,609

**See instructions.

Lexington Health Care Center of LaGrange
1/1/11-12/31/11
Section XIX.

C. Professional Fees **Schedule 21C**

Vendor/Payee	Type	Amount
Ability Network	Computer Consulting	941
BSKLIVE INC. (Staffknex)	Computer Consulting	1,055
C.D.W Government	Computer Consulting	177
Capital Salaries B/O	Computer Consulting	70
Efax Corporate	Computer Consulting	2,105
E-Health Data Solutions	Computer Consulting	2,400
Elton Designs Inc	Computer Consulting	2,203
Information Control	Computer Consulting	1,119
Lintech L LC	Computer Consulting	5,050
My Innerview	Computer Consulting	6,033
National Datacare	Computer Consulting	690
On Shift	Computer Consulting	3,968
Paragon	Computer Consulting	1,000
Question Pro	Computer Consulting	67
SilverChair Learning Systems	Computer Consulting	7,728
Softchoice Corp	Computer Consulting	1,934
Telemedicine Solutions	Computer Consulting	8,080
Vision Share, Inc.	Computer Consulting	85
XO Communications	Computer Consulting	1,046
MS License	Computer Consulting	8,675
Right Now Technologies	Computer Consulting	8,927
TWAT	Computer Consulting	150
ACE-Action Computer Enterprises	Computer Consulting	861
System Design	Computer Consulting	44
Kronos	Computer Consulting	1,400
TYMPANI	Computer Consulting	115
AVTECH	Computer Consulting	174
Facility Wizard Software	Computer Consulting	429
Survey Analytics LLC	Computer Consulting	300
Secretary of State	Filing Fees	100
Serpico, Petrosino & Dipiero, LTD	Legal	8,223
		75,147
Total Schedule V, line 19, column 3		145,380
Less collection fees		(5,746)
Out of period legal		(3,245)
Allocated from Sambell of LaGrange		
James Samatas		200
Samvest of Lombard II		
Legal		133
Accounting		144
		277
Allocated from Mgmt Co.		
Katten, Muchin, Rosenman	Legal	248
Much Shelist	Legal	224
Laner Muchin	Legal	10

Syfarth Shaw LLP	Legal	170
McGladrey & Pullen LLP	Accounting	844
Illinois Secretary of State	Filing Fees	23
LaSalle Network	Recruiting/Finance	1,038
Gilson Labus & Silverman	KEP	115
Pension Administrators, Inc.	401K Administration	160
Susan Parker	Social Service Consulting	17
M Werner Consulting	Financial Consultant	2
Christine Toolan	Social Service Consulting	4
Gene Whitehorn	Medicaid Reimb Specialist	618
Computer Services	Computer Consulting	9,950
		13,423

Total Schedule V, line 19 column 8	150,289

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 Report Period Beginning: 1/1/11 Ending: 12/31/11

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lexington Health Care Center of LaGrange, Inc. # 0038083 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

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

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

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,974** 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. $ **104,587**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,185** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.