



Facility Name & ID Number Lexington of Lake Zurich

# 0039768 Report Period Beginning: 1/1/00 Ending: 12/31/00

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 12/1/2000

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>193</u>	Skilled (SNF)	<u>203</u>	<u>70,948</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>17</u>	Sheltered Care (SC)	<u>8</u>	<u>5,943</u>	5
6		ICF/DD 16 or Less			6
7	<u>210</u>	TOTALS	<u>211</u>	<u>76,891</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>14,459</u>	<u>1,150</u>	<u>5,187</u>	<u>20,796</u>	8
9	SNF/PED					9
10	ICF	<u>33,296</u>	<u>4,460</u>	<u>238</u>	<u>37,994</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>47,755</u>	<u>5,610</u>	<u>5,425</u>	<u>58,790</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.46%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES  NO

I. On what date did you start providing long term care at this location? Date started 8/20/94

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

K. Was the facility certified for Medicare during the reporting year? YES  NO  If YES, enter number of beds certified 35 and days of care provided 4,918

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Lake Zurich # 0039768 Report Period Beginning: 1/1/00 Ending: 12/31/00

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	271,538	34,087	10,369	315,994		315,994		315,994		1
2	Food Purchase		268,241		268,241		268,241	(11,579)	256,662		2
3	Housekeeping	248,986	30,131		279,117		279,117		279,117		3
4	Laundry	62,942	25,655		88,597		88,597	(4,123)	84,474		4
5	Heat and Other Utilities			206,630	206,630		206,630	2,134	208,764		5
6	Maintenance	67,017		120,221	187,238		187,238	2,118	189,356		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	650,483	358,114	337,220	1,345,817		1,345,817	(11,450)	1,334,367		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	2,243,738	177,436	15,962	2,437,136		2,437,136		2,437,136		10
10a	Therapy			385,905	385,905		385,905		385,905		10a
11	Activities	142,193	17,022	4,186	163,401		163,401	16	163,417		11
12	Social Services	33,985		3,039	37,024		37,024		37,024		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,419,916	194,458	424,692	3,039,066		3,039,066	16	3,039,082		16
	<b>C. General Administration</b>										
17	Administrative	135,614		284,538	420,152		420,152	(284,538)	135,614		17
18	Directors Fees										18
19	Professional Services			36,290	36,290		36,290	142	36,432		19
20	Dues, Fees, Subscriptions & Promotions			83,175	83,175		83,175	3,336	86,511		20
21	Clerical & General Office Expenses	306,153	32,128	20,568	358,849		358,849	17,350	376,199		21
22	Employee Benefits & Payroll Taxes			475,833	475,833		475,833	53,440	529,273		22
23	Inservice Training & Education							265	265		23
24	Travel and Seminar			3,232	3,232		3,232	471	3,703		24
25	Other Admin. Staff Transportation							8,302	8,302		25
26	Insurance-Prop.Liab.Malpractice			45,214	45,214		45,214	1,695	46,909		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	441,767	32,128	948,850	1,422,745		1,422,745	(199,537)	1,223,208		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,512,166	584,700	1,710,762	5,807,628		5,807,628	(210,971)	5,596,657		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.

\*\* See schedule of adjustments attached at end of cost report.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			28,237	28,237		28,237	218,761	246,998		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			104,000	104,000		104,000	322,637	426,637		32
33	Real Estate Taxes							114,252	114,252		33
34	Rent-Facility & Grounds			1,312,784	1,312,784		1,312,784	(1,312,784)			34
35	Rent-Equipment & Vehicles			467	467		467	361	828		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,445,488	1,445,488		1,445,488	(656,773)	788,715		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		97,523	19,414	116,937		116,937		116,937		39
40	Barber and Beauty Shops			24,799	24,799		24,799		24,799		40
41	Coffee and Gift Shops			6,611	6,611		6,611		6,611		41
42	Provider Participation Fee			106,423	106,423		106,423		106,423		42
43	Other (specify):* <b>Nonallowable costs</b>			37,673	37,673		37,673	(37,673)			43
44	<b>TOTAL Special Cost Centers</b>		97,523	194,920	292,443		292,443	(37,673)	254,770		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,512,166	682,223	3,351,170	7,545,559		7,545,559	(905,417)	6,640,142		45

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

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning: 1/1/00

Ending: 12/31/00

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(273)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,123)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,872)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(781)	43		13
14	Non-Care Related Interest	(99,128)	32		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	(200)	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	(26,719)	43		24
25	Fund Raising, Advertising and Promotional	(9,973)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(6,892)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (152,971)</b>		<b>\$</b>	<b>30</b>

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(752,446)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (752,446)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (905,417)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0039768  
 Report Period Beginning: 1/1/00  
 Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1			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
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23			23
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25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
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34			34
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36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
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70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90 Total		0	90

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending:

12/31/00

## 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
James Samatas	33.33%			Lexington Health Care Systems of		
John Samatas	33.33%	See attached Schedule B		Lake Zurich Ltd Ptsp	Lake Zurich	Real estate ptsp.
Cynthia Thiem	33.34%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C. II	Lombard	Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental expense	\$ 1,312,784	Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	\$	\$ (1,312,784)	1
2	V	30 Depreciation		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	206,988	206,988	2
3	V	32 Interest expense		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	421,121	421,121	3
4	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	3,577	3,577	4
5	V	33 Property taxes		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	112,784	112,784	5
6	V	21 Bank charges		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	155	155	6
7	V	19 Professional fees		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	83	83	7
8	V	21 Office supplies expense		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	180	180	8
9	V	43 State replacement tax		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	10	10	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,312,784			\$ 744,898	\$ * (567,886)	14

\*\* The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Lexington Health Care Systems of Lake Zurich Limited Partnership.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning: 1/1/00

Ending: 12/31/00

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 FICA	\$	Royal Management Corp.	**	\$	\$ 22,669
16	V	22 FUTA		Royal Management Corp.	**		471
17	V	22 SUTA		Royal Management Corp.	**		1,264
18	V	22 Insurance - W/C		Royal Management Corp.	**		267
19	V	22 Insurance - Hospitalization		Royal Management Corp.	**		11,465
20	V	22 401 (k) and other emp. Benefits		Royal Management Corp.	**		5,998
21	V	30 Depreciation - vehicles		Royal Management Corp.	**		3,775
22	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**		2,096
23	V	30 Depreciation - equipment		Royal Management Corp.	**		5,902
24	V	33 Property taxes		Royal Management Corp.	**		1,468
25	V	6 Repairs & maintenance		Royal Management Corp.	**		1,209
26	V	26 Insurance - general		Royal Management Corp.	**		1,695
27	V	6 Scavenger & exterminating		Royal Management Corp.	**		547
28	V	5 Utilities - gas & electric		Royal Management Corp.	**		1,782
29	V	5 Utilities - water & sewer		Royal Management Corp.	**		352
30	V	11 Activities Consultant		Royal Management Corp.	**		16
31	V	35 Equipment rental		Royal Management Corp.	**		361
32	V	20 Advertising - help wanted		Royal Management Corp.	**		3,494
33	V	25 Auto expense		Royal Management Corp.	**		8,302
34	V	21 Bank charges		Royal Management Corp.	**		263
35	V	19 Computer consultant & supplies		Royal Management Corp.	**		5,138
36	V	20 Dues & subscriptions		Royal Management Corp.	**		552
37	V	21 Office supplies & printing		Royal Management Corp.	**		6,667
38	V	21 Postage		Royal Management Corp.	**		2,489
39	Total		\$			\$ 0	\$ * 88,242

\*\* Certain owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Lexington Health Care Systems of Lake Zurich Limited Partnership.

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional fees	\$	Royal Management Corp.	**	\$	\$ 1,202
16	V	6 Security service		Royal Management Corp.	**		12
17	V	21 Telephone		Royal Management Corp.	**		7,117
18	V	21 Communications		Royal Management Corp.	**		511
19	V	24 Travel & seminar		Royal Management Corp.	**		690
20	V	32 Interest		Royal Management Corp.	**		1,939
21	V	23 Training & education		Royal Management Corp.	**		265
22	V	17 Management fees	284,538	Royal Management Corp.	**		(284,538)
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 284,538			\$ 0	\$ * (272,802)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning: 1/1/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning: 1/1/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Lexington of Lake Zurich      #      0039768      Report Period Beginning:      1/1/00      Ending:      12/31/00

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	4	8.00%	Salary	\$ 26,314	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33%	See Schedule C	2	4.00%	Salary	11,695	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	5.00%	Salary	14,618	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4.00%	Salary	4,678	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	12.50%	Salary	7,776	L17, C1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 65,081		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768 Report Period Beginning: 1/1/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Royal Management Corp.  
 Street Address 1300 S. Main Street  
 City / State / Zip Code Lombard, IL 60148  
 Phone Number ( 630) 495-1700  
 Fax Number ( 630) 495-4424

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

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	22	FICA	Bed Days	788,945	11	\$ 232,594	\$ 76,891	\$ 22,669	1
2	22	FUTA	Bed Days	788,945	11	4,830	76,891	471	2
3	22	SUTA	Bed Days	788,945	11	12,967	76,891	1,264	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735	76,891	267	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633	76,891	11,465	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535	76,891	5,998	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735	76,891	3,775	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505	76,891	2,096	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561	76,891	5,902	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061	76,891	1,468	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408	76,891	1,209	11
12	26	Insurance - general	Bed Days	788,945	11	17,396	76,891	1,695	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608	76,891	547	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291	76,891	1,782	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608	76,891	352	15
16	11	Activity consultant	Bed Days	788,945	11	167	76,891	16	16
17	35	Equipment rental	Bed Days	788,945	11	3,709	76,891	361	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848	76,891	3,494	18
19	25	Auto expense	Bed Days	788,945	11	85,184	76,891	8,302	19
20	21	Bank charges	Bed Days	788,945	11	2,695	76,891	263	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718	76,891	5,138	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668	76,891	552	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404	76,891	6,667	23
24	21	Postage	Bed Days	788,945	11	25,535	76,891	2,489	24
25	TOTALS					\$ 905,395	\$	\$ 88,242	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Royal Management Corp.  
 Street Address 1300 S. Main Street  
 City / State / Zip Code Lombard, IL 60148  
 Phone Number ( 630) 495-1700  
 Fax Number ( 630) 495-4424

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

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	19	Professional fees	Bed Days	788,945	11	\$ 12,334	\$ 76,891	\$ 1,202	1
2	6	Security Service	Bed Days	788,945	11	127	76,891	12	2
3	21	Telephone	Bed Days	788,945	11	73,022	76,891	7,117	3
4	21	Communications	Bed Days	788,945	11	5,248	76,891	511	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077	76,891	690	5
6	32	Interest	Bed Days	788,945	11	19,899	76,891	1,939	6
7	23	Training & Education	Bed Days	788,945	11	2,716	76,891	265	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	TOTALS					\$ 120,423	\$	\$ 11,736	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

1/1/00

Ending:

12/31/00

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Lexington Financial					\$	\$			\$	1									
2	Services, L.L.C. II	X		Mortgage	\$49,259	12/29/98	6,478,000	6,164,215	12/29/08	0.0675	421,121	2								
3											3									
4											4									
5											5									
	<b>Working Capital</b>																			
6	Shareholders	X		Working Capital	None	Varies	27,033	1,841,944	Demand	0.0550	104,000	6								
7											7									
8											8									
9	TOTAL Facility Related				\$49,259.00		\$ 6,505,033	\$ 8,006,159			\$ 525,121	9								
	<b>B. Non-Facility Related*</b>																			
10								Amortization of loan costs			3,577	10								
11								Interest income offset			(4,872)	11								
12								Allocated from management company			1,939	12								
13								Non-allowable interest			(99,128)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (98,484)	14								
15	TOTALS (line 9+line14)						\$ 6,505,033	\$ 8,006,159			\$ 426,637	15								

\* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Lexington of Lake Zurich# 0039768 Report Period Beginning:1/1/00 Ending:12/31/00

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,901 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/AF. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>250,344</u>	<u>1990</u>	<u>\$ 495,000</u>	1
2					2
3	<b>TOTALS</b>	<b>250,344</b>		<b>\$ 495,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	211	1994	1994	\$ 6,418,908	\$	40	\$ 160,473	\$ 160,473	\$ 1,016,327	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Land Improvements		1994	10,701		10	1,070	1,070	6,956	9
10	Land Improvements		1994	13,329	1,333	10	1,333		8,665	10
11	Leasehold Improvements		1994	4,737	316	15	316		2,053	11
12	Leasehold Improvements		1995	4,005	267	15	267		1,469	12
13	Land Improvements		1995	3,221		10	323	323	1,772	13
14	Building Improvements		1995	3,019		40	75	75	415	14
15	Building Improvements		1995	64,500	1,654	39	1,654		9,442	15
16	Patio		1996	1,168	78	15	78		351	16
17	Compressor		1996	5,145	514	10	514		2,315	17
18	Road sidewalk		1997	18,094		20	905	905	3,166	18
19	Foundation/Sprinkler		1997	2,068	59	35	59		207	19
20	Flagpoles		1997	1,573	105	15	105		367	20
21	Basement rehab		1998	12,867	1,287	10	1,287		3,217	21
22	MDS Telnet wiring		1998	3,365	337	10	337		841	22
23	Flag Pole		1998	787	52	15	52		131	23
24	Resurface/restripe parking lot		1998	4,976	498	10	498		1,244	24
25	Transfer 10 beds from shelter care		1998	2,259	56	40	56		122	25
26	1st floor lobby tile		1999	12,153	1,216	10	1,216		1,823	26
27	Parking lot repair		2000	3,740	187	10	187		187	27
28	Roof repair		2000	10,770	538	10	538		538	28
29	Automatic door		2000	1,300	65	10	65		65	29
30	Kitchen rehab		2000	16,887	844	10	844		844	30
31										31
32										32
33										33
34										34
35										35
36	<b>TOTAL (lines 4 thru 35)</b>			\$ 6,619,572	\$ 9,406		\$ 172,252	\$ 162,846	\$ 1,062,517	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 ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9				
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
4					\$	\$		\$	\$	\$	4		
5											5		
6											6		
7											7		
8											8		
	<b>Improvement Type**</b>												
9	Allocated from management company		1995		9,921		35	307	307	1,559	9		
10	Allocated from management company		1996		8,074		35	250	250	1,038	10		
11	Allocated from management company		1989		278		31	9	9	113	11		
12	Allocated from management company - HVAC		1998		209		35	6	6	18	12		
13	Allocated from management company - offices		1999		528		35	16	16	23	13		
14	Allocated from management company - offices		2000		250		35	8	8	5	14		
15	Allocated from management company		1987		46,376		31	1,434	1,434	18,838	15		
16	Allocated from management company		1993		25		39	1	1	5	16		
17	Allocated from management company		1995		1,045		39	32	32	146	17		
18	Allocated from management company		1996		209		39	6	6	23	18		
19	Allocated from management company - Sidewalk		1998		437		39	14	14	27	19		
20	Allocated from management company - Roof		1998		16		15	1	1	4	20		
21	Allocated from management company - Awnings		1999		270		39	8	8	39	21		
22	Allocated from management company - Parking lot		1999		123		15	4	4	5	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	<b>TOTAL (lines 4 thru 35)</b>				\$	67,761	\$	2,096	\$	2,096	\$	21,843	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.

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	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 ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/00

Ending:

12/31/00

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	
37	Purchased in Prior Years	\$ 564,427	\$ 17,527	\$ 61,669	\$ 44,142	5-10 years	\$ 320,494	37
38	Current Year Purchases	18,040	1,304	1,304		5-10 years	1,304	38
39	Fully Depreciated Assets	3,853					3,853	39
40	Allocated from management company	58,151		5,902	5,902		41,152	40
41	TOTALS	\$ 644,471	\$ 18,831	\$ 68,875	\$ 50,044		\$ 366,803	41

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	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45	Allocated from management company			25,194		3,775	3,775		15,484	45
46	TOTALS			\$ 25,194	\$	\$ 3,775	\$ 3,775		\$ 15,484	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 7,851,998	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 28,237	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 246,998	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 218,761	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,466,647	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 828 Description: Copier: \$467; Allocation from management company: \$361  
 (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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p><i>It is the policy of this facility to only hire certified nurses aides.</i></p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Units	Cost						
					Units	Cost								
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	14,977	\$	133,239				14,977	\$	133,239	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		3,177		34,960				3,177		34,960	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	L10A, C3	hrs		19,049		217,706				19,049		217,706	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	L39, C2	# of prescripts							97,523			97,523	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Oxygen Other (specify): <u>Lab, Clinitron beds</u>	L39, C3 L39, C3					6,598 12,816						6,598 12,816	13
14	<b>TOTAL</b>			\$	37,203	\$	405,319	\$	97,523		37,203	\$	502,842	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning: 1/1/00

Ending:

12/31/00

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 5,582	\$ 3,874	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 264,161 )	1,474,230	1,474,230	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	30,047	30,047	6
7 Other Prepaid Expenses	413	413	7
8 Accounts Receivable (owners or related parties)	1,448	1,448	8
9 Other(specify): Escrow		31,362	9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,511,720	\$ 1,541,374	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments	5,257	5,257	12
13 Land		495,000	13
14 Buildings, at Historical Cost		6,418,908	14
15 Leasehold Improvements, at Historical Cost	165,630	268,425	15
16 Equipment, at Historical Cost	144,891	669,665	16
17 Accumulated Depreciation (book methods)	(75,535)	(1,466,647)	17
18 Deferred Charges		1,753	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): Unamortized mortgage costs		64,394	23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 240,243	\$ 6,456,755	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,751,963	\$ 7,998,129	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 235,594	\$ 235,594	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	1,841,944	1,841,944	29
30 Accrued Salaries Payable	120,453	120,453	30
31 Accrued Taxes Payable (excluding real estate taxes)	3,988	3,988	31
32 Accrued Real Estate Taxes(Sch.IX-B)		117,000	32
33 Accrued Interest Payable		34,674	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 See attached Schedule D	719,036	193,414	36
37			37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,921,015	\$ 2,547,067	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable		6,164,215	40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,164,215	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,921,015	\$ 8,711,282	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,169,052)	\$ (713,153)	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,751,963	\$ 7,998,129	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (1,251,050)	1
2	Restatements (describe):	63,954	2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (1,187,096)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	18,044	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 18,044	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,169,052)	24 *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning: 1/1/00

Ending:

12/31/00

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,229,755	1
2	Discounts and Allowances for all Levels	(618,200)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,611,555	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	658,632	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 658,632	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	11,922	12
13	Barber and Beauty Care	32,341	13
14	Non-Patient Meals	273	14
15	Telephone, Television and Radio	280	15
16	Rental of Facility Space		16
17	Sale of Drugs	133,178	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,076	19
20	Radiology and X-Ray		20
21	Other Medical Services	92,301	21
22	Laundry	4,123	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 286,494	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,872	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,872	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See attached Schedule D	2,050	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,050	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,563,603	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,345,817	31
32	Health Care	3,039,066	32
33	General Administration	1,422,745	33
<b>B. Capital Expense</b>			
34	Ownership	1,445,488	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	186,020	35
36	Provider Participation Fee	106,423	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,545,559	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	18,044	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 18,044	43

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

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

\*\*\* 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 Lake Zurich**

# **0039768**

Report Period Beginning: **1/1/00**

Ending: **12/31/00**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,979	2,100	\$ 81,077	\$ 38.61	1
2	Assistant Director of Nursing	3,474	3,550	87,025	24.51	2
3	Registered Nurses	41,634	44,018	934,346	21.23	3
4	Licensed Practical Nurses	10,950	11,394	224,397	19.69	4
5	Nurse Aides & Orderlies	73,036	75,052	847,400	11.29	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,278	5,451	69,493	12.75	8
9	Activity Director	1,786	1,786	24,037	13.46	9
10	Activity Assistants	14,720	15,002	118,156	7.88	10
11	Social Service Workers	1,607	1,683	33,985	20.19	11
12	Dietician	193	205	4,181	20.40	12
13	Food Service Supervisor	847	925	11,040	11.94	13
14	Head Cook	1,981	1,981	19,573	9.88	14
15	Cook Helpers/Assistants	18,495	19,007	151,191	7.95	15
16	Dishwashers	13,396	13,861	85,553	6.17	16
17	Maintenance Workers	4,434	4,685	67,017	14.30	17
18	Housekeepers	36,896	37,948	248,986	6.56	18
19	Laundry	9,935	10,295	62,942	6.11	19
20	Administrator	1,823	2,147	70,533	32.85	20
21	Assistant Administrator					21
22	Other Administrative	631	648	65,081	100.43	22
23	Office Manager					23
24	Clerical	18,556	19,599	306,153	15.62	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	261,651	271,337	\$ 3,512,166 *	\$ 12.94	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 10,369	L1, C3	35
36	Medical Director	Monthly	15,600	L9, C3	36
37	Medical Records Consultant	24	1,200	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,186	L11, C3	44
45	Social Service Consultant	Monthly	3,039	L11, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	24	\$ 35,594		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses			51	
52	Nurse Aides	23	347	L10, C3	52
53	TOTAL (lines 50 - 52)	23	\$ 347		53

SEE ACCOUNTANTS' COMPILATION REPORT



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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	
1	Deferred maintenance	Sep-00	\$ 2,103	3	\$	\$		\$ 350	\$ 701	\$ 701	\$ 351	\$	\$	
2														
3														
4														
5														
6														
7														
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15														
16														
17														
18														
19														
20	TOTALS		\$ 2,103		\$	\$	\$	\$ 350	\$ 701	\$ 701	\$ 351	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

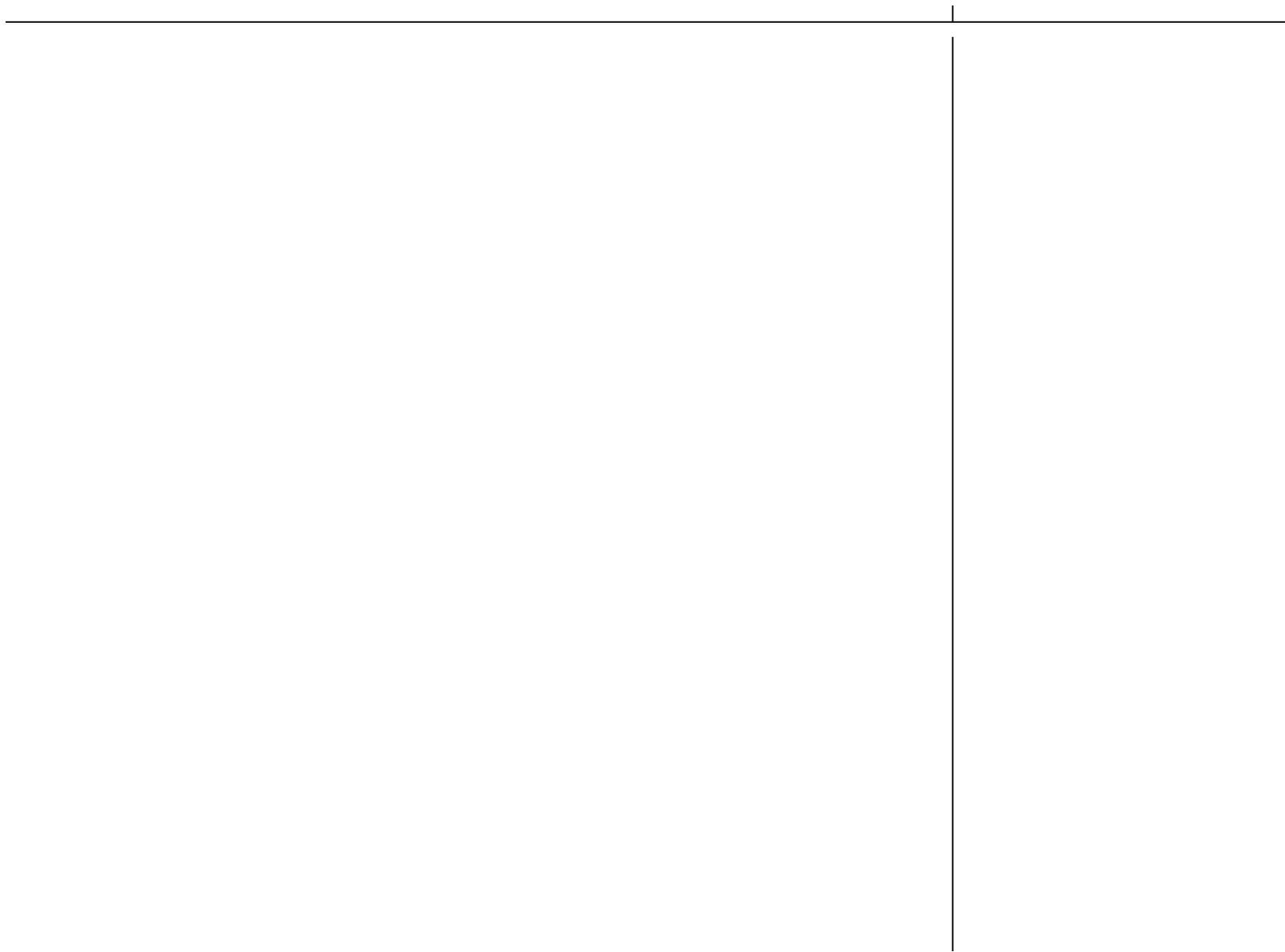
1/1/00

Ending:

12/31/00**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? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,919 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 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 of Public Aid during this cost report period. \$ 106,423  
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 of Public Aid, 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. \$ 11,306 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 273
- (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 are 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**



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