

		FOR OHF USE				

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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

<p>I. IDPH Facility ID Number: <u>0041855</u></p> <p>Facility Name: <u>Lexington of Orland Park</u></p> <p>Address: <u>14601 S. John Humphrey Drive</u> <u>Orland Park</u> <u>60462</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 349-8300</u> Fax # <u>(708) 349-4093</u></p> <p>IDPA ID Number: <u>363923895001</u></p> <p>Date of Initial License for Current Owners: <u>07/08/96</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>312-634-3400</u> <u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Please send copies of any desk review or audit adjustments to the above address:

Facility Name & ID Number Lexington of Orland Park

0041855 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	260	Skilled (SNF)	260	95,160	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	260	TOTALS	260	95,160	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	23,283	3,460	7,224	33,967	8
9	SNF/PED					9
10	ICF	48,124	6,492	1,584	56,200	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,407	9,952	8,808	90,167	14

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

D. How many bed-hold days during this year were paid by Public Aid? 1,387 (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 7/8/96

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 40 and days of care provided 6,446

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCUAL 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 Orland Park # 0041855 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
A. General Services											
1	Dietary	335,323	45,076	17,980	398,379		398,379		398,379		1
2	Food Purchase		366,014		366,014		366,014	(14,506)	351,508		2
3	Housekeeping	319,179	42,133		361,312		361,312		361,312		3
4	Laundry	55,084	31,610		86,694		86,694	(4,534)	82,160		4
5	Heat and Other Utilities			213,175	213,175		213,175	2,641	215,816		5
6	Maintenance	91,158		121,002	212,160		212,160	356	212,516		6
7	Other (specify):*										7
8	TOTAL General Services	800,744	484,833	352,157	1,637,734		1,637,734	(16,043)	1,621,691		8
B. Health Care and Programs											
9	Medical Director			15,500	15,500		15,500		15,500		9
10	Nursing and Medical Records	3,078,606	297,432	9,679	3,385,717		3,385,717		3,385,717		10
10a	Therapy			585,373	585,373		585,373		585,373		10a
11	Activities	189,289	16,422	3,082	208,793		208,793	20	208,813		11
12	Social Services	50,489		2,393	52,882		52,882		52,882		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,318,384	313,854	616,027	4,248,265		4,248,265	20	4,248,285		16
C. General Administration											
17	Administrative	160,492		493,718	654,210		654,210	(493,718)	160,492		17
18	Directors Fees										18
19	Professional Services			86,663	86,663		86,663	(9,656)	77,007		19
20	Dues, Fees, Subscriptions & Promotions			12,161	12,161		12,161	5,008	17,169		20
21	Clerical & General Office Expenses	391,810	31,675	25,878	449,363		449,363	24,116	473,479		21
22	Employee Benefits & Payroll Taxes			524,226	524,226		524,226	66,168	590,394		22
23	Inservice Training & Education			470	470		470	328	798		23
24	Travel and Seminar			2,362	2,362		2,362	635	2,997		24
25	Other Admin. Staff Transportation							10,275	10,275		25
26	Insurance-Prop.Liab.Malpractice			55,902	55,902		55,902	2,098	58,000		26
27	Other (specify):*										27
28	TOTAL General Administration	552,302	31,675	1,201,380	1,785,357		1,785,357	(394,746)	1,390,611		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,671,430	830,362	2,169,564	7,671,356		7,671,356	(410,769)	7,260,587		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

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

Facility Name & ID Number Lexington of Orland Park

#0041855

Report Period Beginning:

1/1/00

Ending:

12/31/00

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	
	D. Ownership											
30	Depreciation			26,228	26,228		26,228	287,155	313,383			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							532,230	532,230			32
33	Real Estate Taxes							497,169	497,169			33
34	Rent-Facility & Grounds			1,925,461	1,925,461		1,925,461	(1,925,461)				34
35	Rent-Equipment & Vehicles			1,513	1,513		1,513	447	1,960			35
36	Other (specify):*											36
37	TOTAL Ownership			1,953,202	1,953,202		1,953,202	(608,460)	1,344,742			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121,928	43,143	165,071		165,071		165,071			39
40	Barber and Beauty Shops			35,636	35,636		35,636		35,636			40
41	Coffee and Gift Shops			2,383	2,383		2,383		2,383			41
42	Provider Participation Fee			142,740	142,740		142,740		142,740			42
43	Other (specify):* Nonallowable costs			28,904	28,904		28,904	(28,904)				43
44	TOTAL Special Cost Centers		121,928	252,806	374,734		374,734	(28,904)	345,830			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,671,430	952,290	4,375,572	9,999,292		9,999,292	(1,048,133)	8,951,159			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 Orland Park

0041855

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	(481)	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	(4,534)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(29,534)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,390)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,655)	43		24
25	Fund Raising, Advertising and Promotional	(7,859)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,000)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(41,866)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,319)		\$	30

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)	(942,814)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (942,814)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,048,133)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0041855
 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
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85			85
86			86
87			87
88			88
89			89
90 Total	0		90

Facility Name & ID Number Lexington of Orland Park # 0041855 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	30.00%			Lexington Health Care		
John Samatas	30.00%			Systems of Orland		
Cynthia Thiem	30.00%	See attached Schedule B		Park Ltd. Ptsp.	Orland Park	Real estate ptsp.
Dean Sweitzer	10.00%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	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	\$ 1,925,461	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	\$ (1,925,461)	1
2	V	30	Depreciation		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	272,583	2
3	V	32	Interest expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	561,035	3
4	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	5,748	4
5	V	33	Property taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	485,461	5
6	V	43	Administratvie expenses		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	3,000	6
7	V	21	Office supplies expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	75	7
8	V	19	Professional fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	32,148	8
9	V	32	Interest income		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	(7,419)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,925,461			\$ 1,352,631	\$ * (572,830)	14

**The owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Lexington Health Care Systems of Orland Park Ltd Ptsp.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park# 0041855Report Period Beginning: 1/1/00Ending: 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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.	**	\$	\$ 28,055	15
16	V	22	FUTA		Royal Management Corp.	**		583	16
17	V	22	SUTA		Royal Management Corp.	**		1,564	17
18	V	22	Insurance - W/C		Royal Management Corp.	**		330	18
19	V	22	Insurance - Hospitalization		Royal Management Corp.	**		14,189	19
20	V	22	401 (k) and other emp. Benefits		Royal Management Corp.	**		7,422	20
21	V	30	Depreciation - vehicles		Royal Management Corp.	**		4,672	21
22	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**		2,595	22
23	V	30	Depreciation - equipment		Royal Management Corp.	**		7,305	23
24	V	33	Property taxes		Royal Management Corp.	**		1,816	24
25	V	6	Repairs & maintenance		Royal Management Corp.	**		1,497	25
26	V	26	Insurance - general		Royal Management Corp.	**		2,098	26
27	V	6	Scavenger & exterminating		Royal Management Corp.	**		676	27
28	V	5	Utilities - gas & electric		Royal Management Corp.	**		2,206	28
29	V	5	Utilities - water & sewer		Royal Management Corp.	**		435	29
30	V	11	Activities Consultant		Royal Management Corp.	**		20	30
31	V	35	Equipment rental		Royal Management Corp.	**		447	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**		4,324	32
33	V	25	Auto expense		Royal Management Corp.	**		10,275	33
34	V	21	Bank charges		Royal Management Corp.	**		325	34
35	V	19	Computer consultant & supplies		Royal Management Corp.	**		6,359	35
36	V	20	Dues & subscriptions		Royal Management Corp.	**		684	36
37	V	21	Office supplies & printing		Royal Management Corp.	**		8,251	37
38	V	21	Postage		Royal Management Corp.	**		3,080	38
39	Total			\$			\$ 0	\$ * 109,208	39

** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

0041855

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item			Name of Related Organization					
15	V	19	Professional fees	\$	Royal Management Corp.	**	\$	\$	1,488	15
16	V	6	Security service		Royal Management Corp.	**			15	16
17	V	21	Telephone		Royal Management Corp.	**			8,808	17
18	V	21	Communications		Royal Management Corp.	**			633	18
19	V	24	Travel & seminar		Royal Management Corp.	**			854	19
20	V	32	Interest		Royal Management Corp.	**			2,400	20
21	V	23	Training & education		Royal Management Corp.	**			328	21
22	V	17	Management fees	493,718	Royal Management Corp.	**			(493,718)	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			\$ 493,718			\$ 0	\$ *	(479,192)	39

** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

0041855

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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 Orland Park

0041855

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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 Orland Park

0041855

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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 Orland Park

0041855

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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 Orland Park

0041855

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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 Orland Park

0041855

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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 Orland Park

0041855

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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 Orland Park # 0041855 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	30.00%	See Schedule C	5	10.00%	Salary	\$ 32,567	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00%	See Schedule C	2	4.00%	Salary	14,474	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	30.00%	See Schedule C	2	5.00%	Salary	18,092	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4.00%	Salary	5,790	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	12.50%	Salary	9,624	L17, C1	5
6	Dean Sweitzer	Owner*	Administrative	10.00%	95,365	5	10.00%	Salary	11,503	L21, C1	6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10		* Dean Sweitzer is an owner only in Lexington Health Care Center of Orland Park, Inc.									10
11		He is an employee of Royal Management Corp. and provides administrative services to Royal Management Corp.									11
12		His compensation has been allocated to all 10 Lexington facilities and Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence.									12
13								TOTAL	\$ 92,050		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 Orland Park # 0041855 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 Mangement 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	\$ 95,160	\$ 28,055	1
2	22	FUTA	Bed days	788,945	11	4,830	95,160	583	2
3	22	SUTA	Bed days	788,945	11	12,967	95,160	1,564	3
4	22	Insurance - W/C	Bed days	788,945	11	2,735	95,160	330	4
5	22	Insurance - Hospitalization	Bed days	788,945	11	117,633	95,160	14,189	5
6	22	401 (k) and other emp. Benefits	Bed days	788,945	11	61,535	95,160	7,422	6
7	30	Depreciation - vehicles	Bed days	788,945	11	38,735	95,160	4,672	7
8	30	Depreciation - leasehold improv.	Bed days	788,945	11	21,505	95,160	2,595	8
9	30	Depreciation - equipment	Bed days	788,945	11	60,561	95,160	7,305	9
10	33	Real estate taxes	Bed days	788,945	11	15,061	95,160	1,816	10
11	6	Repairs & maintenance	Bed days	788,945	11	12,408	95,160	1,497	11
12	26	Insurance - general	Bed days	788,945	11	17,396	95,160	2,098	12
13	6	Scavenger & exterminating	Bed days	788,945	11	5,608	95,160	676	13
14	5	Utilities - gas & electric	Bed days	788,945	11	18,291	95,160	2,206	14
15	5	Utilities - water & sewer	Bed days	788,945	11	3,608	95,160	435	15
16	11	Activity consultant	Bed days	788,945	11	167	95,160	20	16
17	35	Equipment rental	Bed days	788,945	11	3,709	95,160	447	17
18	20	Advertising - help wanted	Bed days	788,945	11	35,848	95,160	4,324	18
19	25	Auto expense	Bed days	788,945	11	85,184	95,160	10,275	19
20	21	Bank charges	Bed days	788,945	11	2,695	95,160	325	20
21	19	Computer consultant & supplies	Bed days	788,945	11	52,718	95,160	6,359	21
22	20	Dues & subscriptions	Bed days	788,945	11	5,668	95,160	684	22
23	21	Office supplies & printing	Bed days	788,945	11	68,404	95,160	8,251	23
24	21	Postage	Bed days	788,945	11	25,535	95,160	3,080	24
25	TOTALS					\$ 905,395	\$	\$ 109,208	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

0041855 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	\$ 95,160	\$ 1,488	1
2	6	Security Service	Bed Days	788,945	11	127	95,160	15	2
3	21	Telephone	Bed Days	788,945	11	73,022	95,160	8,808	3
4	21	Communications	Bed Days	788,945	11	5,248	95,160	633	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077	95,160	854	5
6	32	Interest	Bed Days	788,945	11	19,899	95,160	2,400	6
7	23	Training & Education	Bed Days	788,945	11	2,716	95,160	328	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	\$		\$ 14,526	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 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 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					\$	\$			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 Orland Park # 0041855 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 Orland Park # 0041855 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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lexington Financial Services					\$	\$			\$	1									
2	L.L.C.	x		Mortgage	Varies	12/29/98	9,000,000	8,722,500	12/1/28	Variable	561,035	2								
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	9,000,000	\$ 8,722,500			\$ 561,035	9								
B. Non-Facility Related*																				
10								Amortization of loan costs			5,748	10								
11								Interest income offset			(36,953)	11								
12								Allocated from management company			2,400	12								
13												13								
14	TOTAL Non-Facility Related					\$		\$			\$ (28,805)	14								
15	TOTALS (line 9+line14)					\$	9,000,000	\$ 8,722,500			\$ 532,230	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.)

Facility Name & ID Number Lexington of Orland Park# 0041855 Report Period Beginning:

1/1/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block and Pre-cast steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (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)

None

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. 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>152,460</u>	<u>1995</u>	<u>\$ 776,408</u>	1
2					2
3	TOTALS	152,460		\$ 776,408	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

0041855

Report Period Beginning:

1/1/00

Ending:

12/31/00

XL 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	250	1996	1996	\$ 8,455,949	\$	40	\$ 211,399	\$ 211,399	\$ 950,138	4
5	10	1998	1998	63,790	1,595	40	1,595		3,190	5
6										6
7										7
8										8
Improvement Type**										
9	Electrical wiring	1996		2,304	58	40	58		240	9
10	Paving	1997		11,589		40	773	773	2,704	10
11	Additional building costs	1996		113,337		40	2,833	2,833	11,332	11
12	Wiring	1998		3,932	393	10	393		983	12
13	Additional building costs - 10 bed addition	1999		1,808	45	40	45		90	13
14	Seal/restrip parking lot	1999		3,450	230	15	230		345	14
15	Wiring	1999		1,798	45	40	45		67	15
16	Roof repairs	2000		23,201	773	15	773		773	16
17	Electrical wiring	2000		5,732	82	35	82		82	17
18	Ceiling mount curtain rod hardware	2000		6,952	99	35	99		99	18
19	Automatic door closer/sensors	2000		3,624	121	15	121		121	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	TOTAL (lines 4 thru 35)			\$ 8,697,466	\$ 3,441		\$ 218,446	\$ 215,005	\$ 970,164	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 Orland Park

0041855

Report Period Beginning:

1/1/00

Ending:

12/31/00

XL 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
	Improvement Type**									
9	Allocated from management company	1995		12,278		35	380	380	1,929	9
10	Allocated from management company	1996		9,992		35	309	309	1,285	10
11	Allocated from management company	1989		344		31	11	11	140	11
12	Allocated from management company - HVAC	1998		258		35	8	8	22	12
13	Allocated from management company - Office	1999		654		35	20	20	28	13
14	Allocated from management company - Office	2000		310		35	10	10	7	14
15	Allocated from management company	1987		57,395		31	1,775	1,775	23,314	15
16	Allocated from management company	1993		30		39	1	1	6	16
17	Allocated from management company	1995		1,293		39	40	40	181	17
18	Allocated from management company	1996		259		39	8	8	28	18
19	Allocated from management company - Sidewall	1998		541		39	17	17	33	19
20	Allocated from management company - Roo	1998		19		15	1	1	5	20
21	Allocated from management company - Awning	1999		334		39	10	10	48	21
22	Allocated from management company - Parking lo	1999		152		15	5	5	6	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	TOTAL (lines 4 thru 35)			\$ 83,859	\$		\$ 2,595	\$ 2,595	\$ 27,032	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 Orland Park

0041855

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 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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

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	\$ 733,597	\$ 20,758	\$ 78,336	\$ 57,578	5-10 years	\$ 304,445	37
38	Current Year Purchases	36,538	2,029	2,029		5-10 years	2,029	38
39	Fully Depreciated Assets							39
40	Allocated from management company	71,968		7,305	7,305		50,930	40
41	TOTALS	\$ 842,103	\$ 22,787	\$ 87,670	\$ 64,883		\$ 357,404	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			31,180		4,672	4,672		19,162	45
46	TOTALS			\$ 31,180	\$	\$ 4,672	\$ 4,672		\$ 19,162	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)	\$ 10,431,016	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 26,228	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 313,383	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 287,155	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,373,762	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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 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	TOTAL				\$			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> </u> /2001	\$ <u> </u>
13.	<u> </u> /2002	\$ <u> </u>
14.	<u> </u> /2003	\$ <u> </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: \$ 1,960 Description: Postage meter: \$724; Copier: \$789; Allocated from management company: 447

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</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		Contract	Total
		1 Drop-outs	2 Completed		
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	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	L10A, C3	hrs	\$	16,973	\$ 246,696	\$	16,973	\$ 246,696	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		2,240	40,130		2,240	40,130	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		28,884	298,547		28,884	298,547	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				121,928		121,928	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Radiology, Laboratory Oxygen, Clinitron beds	L39,C3 L39,C3				10,063 33,080			10,063 33,080	13
14	TOTAL			\$	48,097	\$ 628,516	\$ 121,928	48,097	\$ 750,444	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

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	\$ 391,365	\$ 394,033	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 793,907)	3,150,868	3,150,868	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,252	33,252	6
7	Other Prepaid Expenses	413	413	7
8	Accounts Receivable (owners or related parties)	48,873	63,641	8
9	Other(specify): See attached Schedule D		19,785	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,624,771	\$ 3,661,992	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	153,440	153,440	12
13	Land		776,408	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	116,591	212,039	15
16	Equipment, at Historical Cost	194,353	873,283	16
17	Accumulated Depreciation (book methods)	(53,362)	(1,373,762)	17
18	Deferred Charges		1,832	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		132,195	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 411,022	\$ 9,344,721	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,035,793	\$ 13,006,713	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 324,015	\$ 324,015	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		12,500	29
30	Accrued Salaries Payable	263,055	263,055	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,250	6,250	31
32	Accrued Real Estate Taxes(Sch.IX-B)		457,000	32
33	Accrued Interest Payable		32,908	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See attached Schedule D	535,432	80,122	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,128,752	\$ 1,175,850	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,710,000	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)	\$	\$ 8,710,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,128,752	\$ 9,885,850	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,907,041	\$ 3,120,863	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,035,793	\$ 13,006,713	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,035,184	1
2	Restatements (describe):		2
3	Prior year post closing entries	(565,746)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,469,438	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,637,603	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	(2,200,000)	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)	\$ 437,603	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)	\$ 2,907,041	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

0041855

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,938,138	1
2	Discounts and Allowances for all Levels	(731,102)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,207,036	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	968,445	6
7	Oxygen	1,253	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 969,698	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,462	12
13	Barber and Beauty Care	45,173	13
14	Non-Patient Meals	481	14
15	Telephone, Television and Radio	189	15
16	Rental of Facility Space		16
17	Sale of Drugs	115,099	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,958	19
20	Radiology and X-Ray	7,240	20
21	Other Medical Services	234,945	21
22	Laundry	4,534	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 422,081	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	29,534	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,534	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule D	8,546	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,546	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,636,895	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,637,734	31
32	Health Care	4,248,265	32
33	General Administration	1,785,357	33
B. Capital Expense			
34	Ownership	1,953,202	34
C. Ancillary Expense			
35	Special Cost Centers	231,994	35
36	Provider Participation Fee	142,740	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,999,292	40
41	Income before Income Taxes (line 30 minus line 40)**	2,637,603	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,637,603	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 Orland Park

0041855

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	2,150	2,184	\$ 78,817	\$ 36.09	1
2	Assistant Director of Nursing	4,618	4,791	108,679	22.68	2
3	Registered Nurses	43,824	45,968	1,039,230	22.61	3
4	Licensed Practical Nurses	23,604	24,958	465,161	18.64	4
5	Nurse Aides & Orderlies	121,412	125,787	1,258,502	10.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,726	11,470	128,217	11.18	8
9	Activity Director	1,962	2,082	28,916	13.89	9
10	Activity Assistants	19,166	19,932	160,373	8.05	10
11	Social Service Workers	4,201	4,209	50,489	12.00	11
12	Dietician	238	254	5,175	20.37	12
13	Food Service Supervisor	2,107	2,107	28,251	13.41	13
14	Head Cook	1,978	2,112	22,932	10.86	14
15	Cook Helpers/Assistants	18,418	19,116	158,391	8.29	15
16	Dishwashers	18,887	19,377	120,574	6.22	16
17	Maintenance Workers	7,100	7,580	91,158	12.03	17
18	Housekeepers	46,705	49,115	319,179	6.50	18
19	Laundry	8,702	9,010	55,084	6.11	19
20	Administrator	2,080	2,104	79,945	38.00	20
21	Assistant Administrator					21
22	Other Administrative	786	806	80,547	99.93	22
23	Office Manager					23
24	Clerical	22,293	23,609	391,810	16.60	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)	360,957	376,571	\$ 4,671,430 *	\$ 12.41	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	\$ 17,980	L1,C3	35
36	Medical Director	Monthly	15,500	L9, C3	36
37	Medical Records Consultant	13	625	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	3,082	L11, C3	44
45	Social Service Consultant	Monthly	2,393	L12, C3	45
46	Other(specify)				46
47	Utilization Review	Monthly	75	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	13	\$ 40,855		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	16	320	L10,C3	51
52	Nurse Aides			52	
53	TOTAL (lines 50 - 52)	16	\$ 320		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

0041855

Report Period Beginning: 1/1/00

Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Janet Cantelo	Administrator	0.00%	\$ 79,945	Workers' Compensation Insurance	\$ 47,245	IDPH License Fee	\$ 400	
John Samatas	Admin/Plant Ops	30.00%	14,474	Unemployment Compensation Insurance	49,108	Advertising: Employee Recruitment	9,028	
James Samatas	Administrative	30.00%	32,567	FICA Taxes	344,604	Health Care Worker Background Check (Indicate # of checks performed <u>92</u>)	1,106	
Cynthia Thiem	Administrative	30.00%	18,092	Employee Health Insurance	112,667	Miscellaneous licenses, permits & inspec.	1,597	
George Samatas	Administrative	0.00%	5,790	Employee Meals	14,025	Miscellaneous subscriptions	30	
Jason Samatas	Administrative	0.00%	9,624	Illinois Municipal Retirement Fund (IMRF)*		Allocated from management company	5,008	
				401(k) contribution	12,101			
				Other employee benefits	10,644			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 160,492			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management fees (eliminated in column 7)			\$ 493,718					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 493,718	TOTAL (agree to Schedule V, line 22, col.8)	\$ 590,394	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,169	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
American Express Tax & Bus.Svs.	Accounting		\$ 5,926				Out-of-State Travel	\$
Altschuler, Melvoin & Glasser LLP	Accounting		19,240					
Aetna Life Insurance & Annuity	401(k)		480				In-State Travel	
Christine Toolan, R.R.A	Administrative Consulting		60					
Holleb & Coff	Legal		914					
James Samatas	Legal		50				Seminar Expense	2,143
Personnel Planners	U/C Consulting		845				Allocated from management company	854
Royal Management	Website Development		338					
Sachnoff & Weaver	Legal		13,732				Entertainment Expense	()
Systematic Management	Billing Consulting		24,145				(agree to Sch. V, line 24, col. 8)	
See attached Schedule E			20,933					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 86,663	TOTAL		\$	TOTAL	\$ 2,997

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	Painting & decorating	2000	\$ 2,198	3	\$	\$	\$	\$ 366	\$ 733	\$ 733	\$ 366	\$	\$	
2														
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17														
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19														
20	TOTALS		\$ 2,198		\$	\$	\$	\$ 366	\$ 733	\$ 733	\$ 366	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

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. \$ 100,373 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 of Public Aid during this cost report period. \$ 142,740
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department 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 benefit on Schedule V. \$ 14,025 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 481
- (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 service performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

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