

Facility Name & ID Number Lexington of Streamwood

0037002 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	224	Skilled (SNF)	224	81,984	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	224	TOTALS	224	81,984	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	Private Pay	4 Other	Total	
8	SNF	34,281	5,759	6,242	46,282	8
9	SNF/PED					9
10	ICF	18,990	2,490	419	21,899	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,271	8,249	6,661	68,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.16%

D. How many bed-hold days during this year were paid by Public Aid? 0 (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 7/8/91

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 34 and days of care provided 5,688

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCURAL 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 Streamwood # 0037002 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				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
A. General Services											
1	Dietary	292,041	30,574	15,254	337,869		337,869		337,869		1
2	Food Purchase		263,353		263,353		263,353	(10,628)	252,725		2
3	Housekeeping	284,276	41,380		325,656		325,656		325,656		3
4	Laundry	46,327	20,604		66,931		66,931	(8,303)	58,628		4
5	Heat and Other Utilities			180,353	180,353		180,353	2,275	182,628		5
6	Maintenance	72,694		118,432	191,126		191,126	3,454	194,580		6
7	Other (specify):*										7
8	TOTAL General Services	695,338	355,911	314,039	1,365,288		1,365,288	(13,202)	1,352,086		8
B. Health Care and Programs											
9	Medical Director			8,100	8,100		8,100		8,100		9
10	Nursing and Medical Records	2,450,480	295,895	282,086	3,028,461		3,028,461		3,028,461		10
10a	Therapy			359,951	359,951		359,951		359,951		10a
11	Activities	166,032	17,528	2,576	186,136		186,136	17	186,153		11
12	Social Services	50,707		2,460	53,167		53,167		53,167		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,667,219	313,423	655,173	3,635,815		3,635,815	17	3,635,832		16
C. General Administration											
17	Administrative	150,905		370,466	521,371		521,371	(370,466)	150,905		17
18	Directors Fees										18
19	Professional Services			52,893	52,893		52,893	266	53,159		19
20	Dues, Fees, Subscriptions & Promotions			33,628	33,628		33,628	3,789	37,417		20
21	Clerical & General Office Expenses	350,453	27,440	19,184	397,077		397,077	22,556	419,633		21
22	Employee Benefits & Payroll Taxes			477,901	477,901		477,901	55,371	533,272		22
23	Inservice Training & Education							282	282		23
24	Travel and Seminar			3,544	3,544		3,544	407	3,951		24
25	Other Admin. Staff Transportation							8,852	8,852		25
26	Insurance-Prop.Liab.Malpractice			41,499	41,499		41,499	1,808	43,307		26
27	Other (specify):*										27
28	TOTAL General Administration	501,358	27,440	999,115	1,527,913		1,527,913	(277,135)	1,250,778		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,863,915	696,774	1,968,327	6,529,016		6,529,016	(290,320)	6,238,696		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 Streamwood

#0037002

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			36,064	36,064		36,064	204,599	240,663			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,000	27,000		27,000	326,665	353,665			32
33	Real Estate Taxes							457,105	457,105			33
34	Rent-Facility & Grounds			1,648,359	1,648,359		1,648,359	(1,648,359)				34
35	Rent-Equipment & Vehicles			564	564		564	385	949			35
36	Other (specify):*											36
37	TOTAL Ownership			1,711,987	1,711,987		1,711,987	(659,605)	1,052,382			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,854	82,601	189,455		189,455		189,455			39
40	Barber and Beauty Shops			18,533	18,533		18,533		18,533			40
41	Coffee and Gift Shops			3,183	3,183		3,183		3,183			41
42	Provider Participation Fee			122,976	122,976		122,976		122,976			42
43	Other (specify):* Nonallowable costs			176,605	176,605		176,605	(176,605)				43
44	TOTAL Special Cost Centers		106,854	403,898	510,752		510,752	(176,605)	334,147			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,863,915	803,628	4,084,212	8,751,755		8,751,755	(1,126,530)	7,625,225			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 Streamwood

0037002

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	(178)	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	(8,303)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15,525)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,128)	43		13
14	Non-Care Related Interest	(11,475)	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	(50)	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	(148,036)	43		24
25	Fund Raising, Advertising and Promotional	(11,391)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,084)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(5,968)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (218,138)		\$	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)	(908,392)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (908,392)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,126,530)		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.

		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

Lexington of Streamwood

ID# 0037002

Report Period Beginning: 1/1/00

Ending: 12/31/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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
22			22
23			23
24			24
25			25
26			26
27			27
28			28
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30			30
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37			37
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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 & ID Number Lexington of Streamwood

0037002

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	22.33%			Sambell of Streamwood		
John Samatas	22.33%	See attached Schedule B		Limited Partnership	Streamwood	Real estate ptsp.
Cynthia Thiem	22.34%			Royal Mgmt. Corp	Lombard	Mgmt. Co.
Jeffrey Bell, James Bell Declaration of Trust, Larry Bell and David Bell each owning 8.25%	33.00%			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.

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)		
1	V	34	Rental expense	\$ 1,648,359	Sambell of Streamwood Limited Partnership	**	\$	\$ (1,648,359)	1
2	V	30	Depreciation		Sambell of Streamwood Limited Partnership	**	192,046	192,046	2
3	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	347,146	347,146	3
4	V	32	Amortization of mortgage costs		Sambell of Streamwood Limited Partnership	**	4,451	4,451	4
5	V	33	Property taxes		Sambell of Streamwood Limited Partnership	**	448,359	448,359	5
6	V	43	State replacement tax		Sambell of Streamwood Limited Partnership	**	84	84	6
7	V	21	Bank charges		Sambell of Streamwood Limited Partnership	**	100	100	7
8	V	21	Office supplies expense		Sambell of Streamwood Limited Partnership	**	4,339	4,339	8
9	V	19	Professional fees		Sambell of Streamwood Limited Partnership	**	7,314	7,314	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,648,359				\$ 1,003,839	\$ * (644,520)	14

**The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Sambell of Streamwood 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	22 FICA	\$	Royal Management Corp.	**	\$	\$ 24,170 15
16	V	22 FUTA		Royal Management Corp.	**		502 16
17	V	22 SUTA		Royal Management Corp.	**		1,347 17
18	V	22 Insurance - W/C		Royal Management Corp.	**		284 18
19	V	22 Insurance - Hospitalization		Royal Management Corp.	**		12,224 19
20	V	22 401 (k) and other emp. Benefits		Royal Management Corp.	**		6,394 20
21	V	30 Depreciation - vehicles		Royal Management Corp.	**		4,025 21
22	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**		2,235 22
23	V	30 Depreciation - equipment		Royal Management Corp.	**		6,293 23
24	V	33 Property taxes		Royal Management Corp.	**		1,565 24
25	V	6 Repairs & maintenance		Royal Management Corp.	**		1,289 25
26	V	26 Insurance - general		Royal Management Corp.	**		1,808 26
27	V	6 Scavenger & exterminating		Royal Management Corp.	**		583 27
28	V	5 Utilities - gas & electric		Royal Management Corp.	**		1,900 28
29	V	5 Utilities - water & sewer		Royal Management Corp.	**		375 29
30	V	11 Activities Consultant		Royal Management Corp.	**		17 30
31	V	35 Equipment rental		Royal Management Corp.	**		385 31
32	V	20 Advertising - help wanted		Royal Management Corp.	**		3,725 32
33	V	25 Auto expense		Royal Management Corp.	**		8,852 33
34	V	21 Bank charges		Royal Management Corp.	**		280 34
35	V	19 Computer consultant & supplies		Royal Management Corp.	**		5,478 35
36	V	20 Dues & subscriptions		Royal Management Corp.	**		589 36
37	V	21 Office supplies & printing		Royal Management Corp.	**		7,108 37
38	V	21 Postage		Royal Management Corp.	**		2,653 38
39	Total		\$			\$ 0	\$ * 94,081 39

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

* 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	19 Professional fees	\$	Royal Management Corp.	**	\$	\$	1,282 15
16	V	6 Security service		Royal Management Corp.	**			13 16
17	V	21 Telephone		Royal Management Corp.	**			7,588 17
18	V	21 Communications		Royal Management Corp.	**			545 18
19	V	24 Travel & seminar		Royal Management Corp.	**			735 19
20	V	32 Interest		Royal Management Corp.	**			2,068 20
21	V	23 Training & education		Royal Management Corp.	**			282 21
22	V	17 Management fees	370,466	Royal Management Corp.	**			(370,466) 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		\$ 370,466			\$ 0	\$ *	(357,953) 39

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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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		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.

Facility Name & ID Number Lexington of Streamwood

0037002

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: Adjustments for Related Organization Costs (7 minus 4)	
		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 Streamwood

0037002

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 Streamwood

0037002

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: Adjustments for Related Organization Costs (7 minus 4)	
		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 Streamwood

0037002

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: Adjustments for Related Organization Costs (7 minus 4)	
		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 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.

Facility Name & ID Number Lexington of Streamwood

0037002

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 Streamwood # 0037002 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	22.33%	See Schedule C	5	10.00%	Salary	\$ 28,057	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	4.00%	Salary	12,470	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	5.00%	Salary	15,587	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4.00%	Salary	4,988	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	12.50%	Salary	8,291	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 69,393		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 Streamwood

0037002 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	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	22	FICA	Bed Days	788,945	11	\$ 232,594	\$ 81,984	\$ 24,170	1
2	22	FUTA	Bed Days	788,945	11	4,830	81,984	502	2
3	22	SUTA	Bed Days	788,945	11	12,967	81,984	1,347	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735	81,984	284	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633	81,984	12,224	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535	81,984	6,394	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735	81,984	4,025	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505	81,984	2,235	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561	81,984	6,293	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061	81,984	1,565	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408	81,984	1,289	11
12	26	Insurance - general	Bed Days	788,945	11	17,396	81,984	1,808	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608	81,984	583	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291	81,984	1,900	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608	81,984	375	15
16	11	Activity consultant	Bed Days	788,945	11	167	81,984	17	16
17	35	Equipment rental	Bed Days	788,945	11	3,709	81,984	385	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848	81,984	3,725	18
19	25	Auto expense	Bed Days	788,945	11	85,184	81,984	8,852	19
20	21	Bank charges	Bed Days	788,945	11	2,695	81,984	280	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718	81,984	5,478	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668	81,984	589	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404	81,984	7,108	23
24	21	Postage	Bed Days	788,945	11	25,535	81,984	2,653	24
25	TOTALS					\$ 905,395	\$	\$ 94,081	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002 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	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	19	Professional fees	Bed Days	788,945	11	\$ 12,334	\$ 81,984	\$ 1,282	1
2	6	Security Service	Bed Days	788,945	11	127	81,984	13	2
3	21	Telephone	Bed Days	788,945	11	73,022	81,984	7,588	3
4	21	Communications	Bed Days	788,945	11	5,248	81,984	545	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077	81,984	735	5
6	32	Interest	Bed Days	788,945	11	19,899	81,984	2,068	6
7	23	Training & Education	Bed Days	788,945	11	2,716	81,984	282	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	\$	\$ 12,513	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002 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 Streamwood

0037002 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 Streamwood

0037002 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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						\$	\$			\$	1
2	Services, L.L.C.	x		Mortgage	Varies	2/01/96	5,985,000	5,347,084	2/06/2026	Variable	347,146	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	x		Working capital	None	Various	1,154,048	362,592	Demand	0.0550	27,000	6
7												7
8												8
9	TOTAL Facility Related						\$ 7,139,048	\$ 5,709,676			\$ 374,146	9
	B. Non-Facility Related*											
10									Amortization of mortgage costs		4,451	10
11									Interest income offset		(15,525)	11
12									Allocated from management company		2,068	12
13									Non-allowable interest		(11,475)	13
14	TOTAL Non-Facility Related						\$	\$			\$ (20,481)	14
15	TOTALS (line 9+line14)						\$ 7,139,048	\$ 5,709,676			\$ 353,665	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 Streamwood

0037002 Report Period Beginning:

1/1/00 Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 B. General Construction Type: Exterior Concrete block Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>30,000</u>	<u>1991</u>	<u>\$ 211,400</u>	1
2					2
3	TOTALS	30,000		\$ 211,400	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002

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	200	1991	1991	\$ 5,248,322	\$	35	\$ 149,952	\$ 149,952	\$ 1,424,545	4
5	10	1993	1993	105,236		35	3,007	3,007	22,550	5
6	14	1995	1995	82,650	2,361	35	2,361		12,988	6
7										7
8										8
Improvement Type**										
9	Building Improvement	1993		7,336		35	210	210	1,575	9
10	Land Improvements	1995		7,000	467	15	467		2,567	10
11	Kitchen & Nurses Station	1996		12,316	352	35	352		1,584	11
12	Piping	1996		3,139	90	35	90		404	12
13	Basement remodeling	1997		20,204	2,020	10	2,020		6,734	13
14	Floor Repairs	1997		555	56	10	56		172	14
15	Corner Guards	1997		998	100	10	100		308	15
16	Corner Guards	1998		3,563	356	10	356		890	16
17	Wiring	1998		2,050	205	10	205		513	17
18	Tile	1998		11,696	1,170	10	1,170		2,340	18
19	Patio	1999		12,011	801	15	801		868	19
20	Parking lot	2000		1,773	89	10	89		89	20
21	110-ton A/C Unit	2000		6,922	346	10	346		346	21
22	Rods for bedside curtains	2000		5,872	294	10	294		294	22
23	Automatic Doors	2000		1,300	65	10	65		65	23
24	Rehab project: carpeting, wallcovering, handrails, painting, and labor	2000		85,196	4,260	10	4,260		4,260	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)			\$ 5,618,139	\$ 13,032		\$ 166,201	\$ 153,169	\$ 1,483,092	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Streamwood

0037002

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
Improvement Type**										
9	Allocated from management company	1995		10,578		35	327	327	1,662	9
10	Allocated from management company	1996		8,608		35	266	266	1,107	10
11	Allocated from management company	1989		297		31	9	9	121	11
12	Allocated from management company - HVAC	1998		223		35	7	7	19	12
13	Allocated from management company - offices	1999		562		35	17	17	24	13
14	Allocated from management company - offices	2000		267		35	8	8	6	14
15	Allocated from management company	1987		49,448		31	1,531	1,531	20,086	15
16	Allocated from management company	1993		26		39	1	1	5	16
17	Allocated from management company	1995		1,114		39	34	34	156	17
18	Allocated from management company	1996		223		39	7	7	25	18
19	Allocated from management company - Sidewalk	1998		466		39	14	14	28	19
20	Allocated from management company - Roof	1998		17		15	1	1	4	20
21	Allocated from management company - Awnings	1999		288		39	9	9	42	21
22	Allocated from management company - Parking lot	1999		131		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	TOTAL (lines 4 thru 35)			\$ 72,248	\$		\$ 2,235	\$ 2,235	\$ 23,290	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Streamwood

0037002

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
9	Improvement Type**										
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	\$ 559,449	\$ 22,521	\$ 61,398	\$ 38,877	5-10 years	\$ 446,581	37
38	Current Year Purchases	7,695	511	511		5-10 years	511	38
39	Fully Depreciated Assets	6,387					6,387	39
40	Allocated from Mgmt. Co.	62,003		6,293	6,293		43,878	40
41	TOTALS	\$ 635,534	\$ 23,032	\$ 68,202	\$ 45,170		\$ 497,357	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 Mgmt. Co.			26,863		4,025	4,025		16,509	45
46	TOTALS			\$ 26,863	\$	\$ 4,025	\$ 4,025		\$ 16,509	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)	\$ 6,564,184	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 36,064	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 240,663	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 204,599	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,020,248	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.

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	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. /2001 \$

13. /2002 \$

14. /2003 \$

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: \$ 949 Description: Postage meter: \$564; Allocated from Management Company: \$385

(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.

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 (c)	\$			

- (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.

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	

- (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

Facility Name & ID Number Lexington of Streamwood# 0037002 Report Period Beginning:

1/1/00

Ending:

12/31/00

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	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	12,460	\$ 166,479						12,460	\$ 166,479	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,500	28,767						2,500	28,767	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	L10A, C3	hrs		17,678	164,705						17,678	164,705	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 prescrpts							106,854			106,854	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Clinitron Beds Other (specify): <u>Oxygen, Laboratory</u>	L39, C3 L39, C3				30,647 51,954							30,647 51,954	13
14	TOTAL			\$	32,638	\$ 442,552	\$	106,854				32,638	\$ 549,406	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 & ID Number Lexington of Streamwood

0037002

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 140,872	\$ 148,995	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 710,444)	1,572,086	1,572,086	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,244	28,244	6
7	Other Prepaid Expenses	410	410	7
8	Accounts Receivable (owners or related parties)	63,631	89,625	8
9	Other(specify): See attached Schedule D		7,181	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,805,243	\$ 1,846,541	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	109,744	109,744	12
13	Land		211,400	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	257,246	336,829	15
16	Equipment, at Historical Cost	184,757	662,397	16
17	Accumulated Depreciation (book methods)	(122,549)	(2,020,248)	17
18	Deferred Charges		1,396	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 loan costs		89,763	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 429,198	\$ 4,744,839	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,234,441	\$ 6,591,380	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 269,385	\$ 276,566	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	362,592	362,592	29
30	Accrued Salaries Payable	143,211	143,211	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,264	3,264	31
32	Accrued Real Estate Taxes(Sch.IX-B)		468,000	32
33	Accrued Interest Payable		20,404	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule D	524,326	78,541	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,302,778	\$ 1,352,578	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,347,084	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,347,084	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,302,778	\$ 6,699,662	46
47	TOTAL EQUITY(page 18, line 24)	\$ 931,663	\$ (108,282)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,234,441	\$ 6,591,380	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		I Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 186,379	1
2	Restatements (describe):		2
3	Prior year audit adjustments	253,077	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 439,456	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	492,207	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 492,207	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)	\$ 931,663	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002

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	\$ 8,846,043	1
2	Discounts and Allowances for all Levels	(663,129)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,182,914	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	621,209	6
7	Oxygen	3,843	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 625,052	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	5,102	12
13	Barber and Beauty Care	24,349	13
14	Non-Patient Meals	178	14
15	Telephone, Television and Radio	177	15
16	Rental of Facility Space		16
17	Sale of Drugs	165,107	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,536	19
20	Radiology and X-Ray		20
21	Other Medical Services	192,590	21
22	Laundry	8,303	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 414,342	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,525	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,525	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule D	6,129	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,129	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,243,962	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,365,288	31
32	Health Care	3,635,815	32
33	General Administration	1,527,913	33
B. Capital Expense			
34	Ownership	1,711,987	34
C. Ancillary Expense			
35	Special Cost Centers	387,776	35
36	Provider Participation Fee	122,976	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,751,755	40
41	Income before Income Taxes (line 30 minus line 40)**	492,207	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 492,207	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 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 Streamwood

0037002

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	2,109	2,186	\$ 70,629	\$ 32.31	1
2	Assistant Director of Nursing	3,296	3,395	85,041	25.05	2
3	Registered Nurses	50,243	53,694	1,162,455	21.65	3
4	Licensed Practical Nurses	2,590	2,662	52,197	19.61	4
5	Nurse Aides & Orderlies	85,626	88,917	976,137	10.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,190	8,896	104,021	11.69	8
9	Activity Director	2,003	2,091	35,655	17.05	9
10	Activity Assistants	14,820	15,396	130,377	8.47	10
11	Social Service Workers	3,766	3,976	50,707	12.75	11
12	Dietician	205	219	4,458	20.36	12
13	Food Service Supervisor	1,962	2,083	30,583	14.68	13
14	Head Cook	1,946	2,091	26,038	12.45	14
15	Cook Helpers/Assistants	13,625	14,465	118,964	8.22	15
16	Dishwashers	17,211	17,946	111,998	6.24	16
17	Maintenance Workers	4,563	4,843	72,694	15.01	17
18	Housekeepers	42,293	44,334	284,276	6.41	18
19	Laundry	7,209	7,674	46,327	6.04	19
20	Administrator	1,926	2,280	81,512	35.75	20
21	Assistant Administrator					21
22	Other Administrative	674	691	69,393	100.42	22
23	Office Manager					23
24	Clerical	20,103	21,534	350,453	16.27	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)	284,360	299,373	\$ 3,863,915 *	\$ 12.91	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	\$ 15,254	L1, C3	35
36	Medical Director	Monthly	8,100	L9, C3	36
37	Medical Records Consultant	41	2,050	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	2,576	L11, C3	44
45	Social Service Consultant	Monthly	2,460	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	41	\$ 31,640		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	7,301	\$ 178,885	L10, C3	50
51	Licensed Practical Nurses	15	333	L10, C3	51
52	Nurse Aides	5,468	90,214	L10, C3	52
53	TOTAL (lines 50 - 52)	12,784	\$ 269,432		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries	Name	Function	Ownership %	Amount
	Chris Anderson	Administrator	0.00%	\$ 33,420
	Mary Ann Collins	Administrator	0.00%	48,092
	John Samatas	Admin/Plant Ops	22.33%	12,470
	James Samatas	Administrative	22.33%	28,057
	Cynthia Thiem	Administrative	22.34%	15,587
	George Samatas	Administrative	0.00%	4,988
	Jason Samatas	Administrative	0.00%	8,291
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 150,905

B. Administrative - Other	Description	Amount
	Management fees (eliminated in column 7)	\$ 370,466
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$ 370,466

C. Professional Services	Vendor/Payee	Type	Amount
	Aetna Life Insurance & Annuity Co.	401(k) Administration	\$ 420
	Altschuler, Melvoin & Glasser, LLP	Accounting	17,596
	American Express Tax & Bus. Svcs.	Accounting	5,931
	Christine Toolan, R.R.A.	Consulting	60
	Holleb & Coff	Legal	584
	James Samatas	Legal	50
	Personnel Planners	U/C Consulting	705
	Royal Management	Website Development	338
	Sachnoff & Weaver	Legal	1,077
	Systematic Management	Billing Consultant	16,373
	Commitment Consulting	Collections	2,586
	See attached Schedule E		7,173
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 52,893

D. Employee Benefits and Payroll Taxes	Description	Amount
	Workers' Compensation Insurance	\$ 40,132
	Unemployment Compensation Insurance	26,274
	FICA Taxes	285,316
	Employee Health Insurance	90,832
	Employee Meals	10,450
	Illinois Municipal Retirement Fund (IMRF)*	
	401(k) Contribution	13,043
	CNA Transportation	57,798
	Other Employee Benefits	9,427
TOTAL (agree to Schedule V, line 22, col.8)		\$ 533,272

E. Schedule of Non-Cash Compensation Paid to Owners or Employees	Description	Line #	Amount
			\$
TOTAL			\$

F. Dues, Fees, Subscriptions and Promotions	Description	Amount
	IDPH License Fee	\$ 400
	Advertising: Employee Recruitment	29,590
	Health Care Worker Background Check (Indicate # of checks performed 97)	1,170
	Miscellaneous Licenses, Permits	1,491
	Miscellaneous Dues & Subs	452
	Allocated from management company	4,314
	Less: Public Relations Expense	()
	Non-allowable advertising	()
	Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 37,417

G. Schedule of Travel and Seminar**	Description	Amount
	Out-of-State Travel	\$
	In-State Travel	
	Seminar Expense	3,216
	Allocated from management company	735
	Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,951

* 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.)

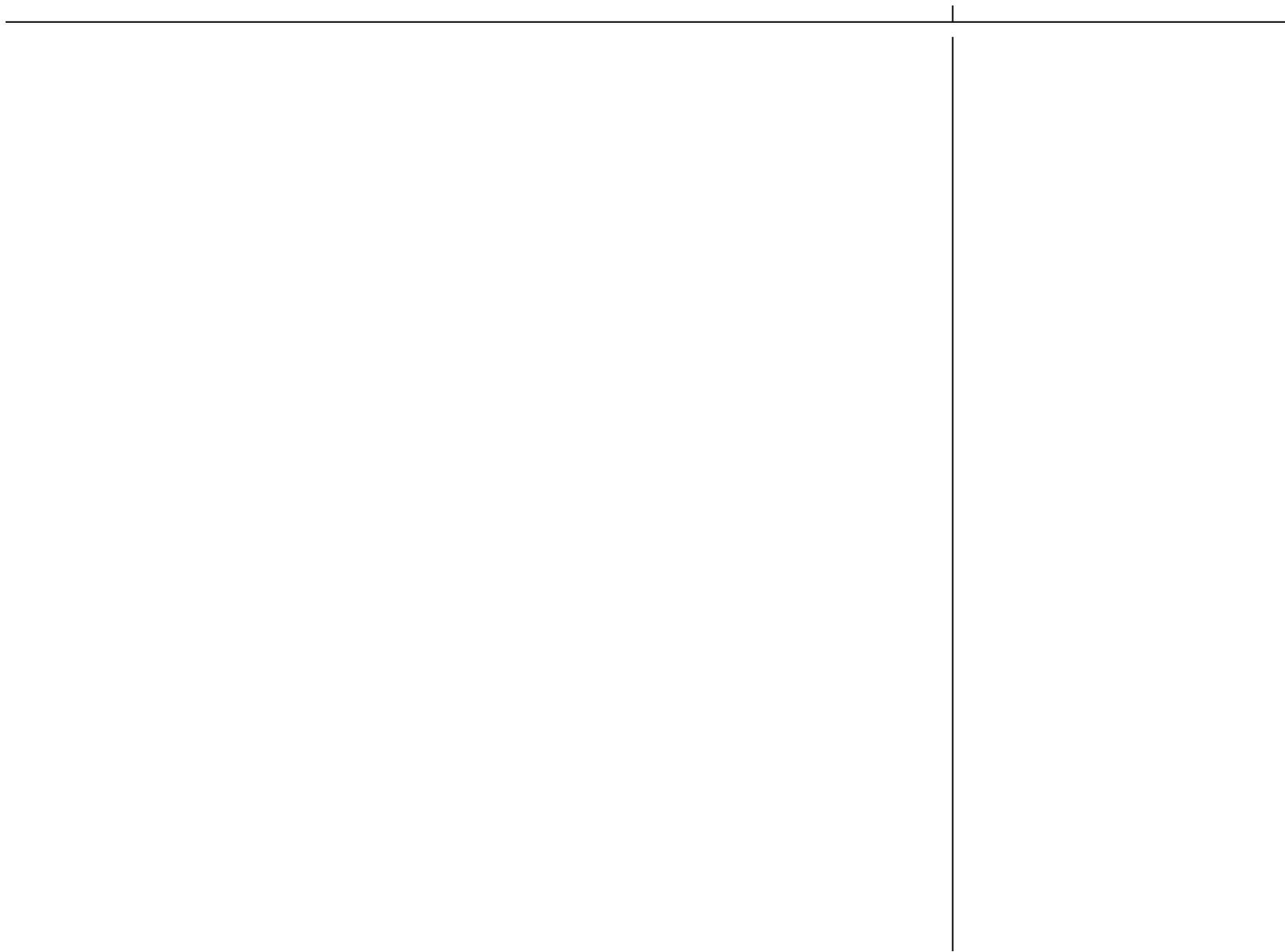
1	2	3	4	5	6	7	8	9	10	11	12	13											
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year						
																	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003
1	Deferred maintenance	Various 1997	\$ 3,823	3	\$ 637	\$ 1,274	\$ 1,274	\$ 638	\$ 931	\$ 465													
2	Deferred maintenance	Dec-99	2,792	3			465	931	931	465													
3																							
4																							
5																							
6																							
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18																							
19																							
20	TOTALS		\$ 6,615		\$ 637	\$ 1,274	\$ 1,739	\$ 1,569	\$ 931	\$ 465	\$	\$	\$										

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. \$ 59,976 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. \$ 122,976
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. \$ 10,450 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 178
- (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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