



Facility Name & ID Number Lexington Health Care Center-Bloomington

# 0035188 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/27/07

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>172</u>	Skilled (SNF)	<u>166</u>	<u>62,750</u>	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	<u>172</u>	TOTALS	<u>166</u>	<u>62,750</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	<u>3,535</u>	<u>310</u>	<u>6,923</u>	<u>10,768</u>	8	
9	SNF/PED					9	
10	ICF	<u>36,318</u>	<u>6,901</u>	<u>1,902</u>	<u>45,121</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>39,853</u>	<u>7,211</u>	<u>8,825</u>	<u>55,889</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.07%

D. How many bed-hold days during this year were paid by the Department? 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  Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?  
 Date started 05/01/89

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

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified 166 and days of care provided 6,786

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Bloomingdale, Inc.**  
**Provider # 0035188**  
**1/1/07-12/31/07**

**Schedule 2A**

Licensed Bed Days

<u>Start Date</u>	<u>End Date</u>	<u># of Days</u>	<u># of Beds</u>	<u>Licensed Bed Days</u>
1/1/2007	12/27/2007	360	172	61,920
12/27/2007	12/31/2007	5	166	830
Total Licensed Bed Days				<u>62,750</u>
Total Census				<u>55,889</u>
Percent Occupancy				<u><u>89.07%</u></u>

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	324,633	32,205	13,743	370,581		370,581		370,581		1
2	Food Purchase		240,161		240,161		240,161	(10,731)	229,430		2
3	Housekeeping	254,022	30,316		284,338		284,338	249	284,587		3
4	Laundry	63,753	15,508		79,261		79,261		79,261		4
5	Heat and Other Utilities			204,220	204,220		204,220	4,585	208,805		5
6	Maintenance	30,684		121,920	152,604		152,604	35,695	188,299		6
7	Other (specify):* <b>Mgmt Co - Allocated</b>							4,467	4,467		7
8	<b>TOTAL General Services</b>	673,092	318,190	339,883	1,331,165		1,331,165	34,265	1,365,430		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			37,200	37,200		37,200		37,200		9
10	Nursing and Medical Records	2,889,083	165,014	8,460	3,062,557		3,062,557	9,490	3,072,047		10
10a	Therapy			659,668	659,668		659,668		659,668		10a
11	Activities	255,308	19,672	6,078	281,058		281,058		281,058		11
12	Social Services	88,202		6,860	95,062		95,062		95,062		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Mgmt Co - Allocated</b>							848	848		15
16	<b>TOTAL Health Care and Programs</b>	3,232,593	184,686	718,266	4,135,545		4,135,545	10,338	4,145,883		16
	<b>C. General Administration</b>										
17	Administrative	99,759		861,675	961,434		961,434	(783,045)	178,389		17
18	Directors Fees										18
19	Professional Services			67,238	67,238		67,238	4,482	71,720		19
20	Dues, Fees, Subscriptions & Promotions			31,290	31,290		31,290	838	32,128		20
21	Clerical & General Office Expenses	239,882	22,710	20,252	282,844		282,844	281,086	563,930		21
22	Employee Benefits & Payroll Taxes			626,513	626,513		626,513	10,731	637,244		22
23	Inservice Training & Education			667	667		667		667		23
24	Travel and Seminar			7,338	7,338		7,338	394	7,732		24
25	Other Admin. Staff Transportation			8,049	8,049		8,049	7,476	15,525		25
26	Insurance-Prop.Liab.Malpractice			167,536	167,536		167,536	2,939	170,475		26
27	Other (specify):* <b>Mgmt Co - Allocated</b>							53,029	53,029		27
28	<b>TOTAL General Administration</b>	339,641	22,710	1,790,558	2,152,909		2,152,909	(422,070)	1,730,839		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,245,326	525,586	2,848,707	7,619,619		7,619,619	(377,467)	7,242,152		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			129,496	129,496		129,496	189,892	319,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,530	13,530		13,530	243,972	257,502			32
33	Real Estate Taxes							134,427	134,427			33
34	Rent-Facility & Grounds			1,182,532	1,182,532		1,182,532	(1,179,472)	3,060			34
35	Rent-Equipment & Vehicles			46,797	46,797		46,797	9,493	56,290			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,372,355	1,372,355		1,372,355	(601,688)	770,667			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		270,672	6,352	277,024		277,024		277,024			39
40	Barber and Beauty Shops			17,472	17,472		17,472		17,472			40
41	Coffee and Gift Shops			2,450	2,450		2,450		2,450			41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):* <b>Non-allowable Cos</b>			82,099	82,099		82,099	(82,099)				43
44	<b>TOTAL Special Cost Centers</b>		270,672	202,543	473,215		473,215	(82,099)	391,116			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,245,326	796,258	4,423,605	9,465,189		9,465,189	(1,061,254)	8,403,935			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 Health Care Center-Bloomington

# 0035188

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,641)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,042	30		9
10	Interest and Other Investment Income	(14,051)	43		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(157)	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	(1,550)	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	(39,199)	43		24
25	Fund Raising, Advertising and Promotional	(14,773)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,670)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(73,918)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (150,917)		\$	30

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)	(910,337)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (910,337)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,061,254)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center-Bloomingtondale

ID# 0035188

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Shareholder Interest	\$ (159)	32	1
2	Radiology	(10,151)	43	2
3	Laboratory	(9,659)	43	3
4	Personal Item Replacement	(1,393)	43	4
5	Trust Fees	(85)	43	5
6	Collection Fees	(7,778)	19	6
7	Legal Expenses	(338)	19	7
8	Chamber of Commerce	(175)	20	8
9	Nonallowable Marketing Salaries	(44,180)	21	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				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(73,918)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington Health Care Center-Bloomington# 0035188

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	249	0	0	0	0	0	0	0	0	249	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,585	0	0	0	0	0	0	0	0	4,585	5
6	Maintenance	0	0	35,695	0	0	0	0	0	0	0	0	35,695	6
7	Other (specify):*	0	0	4,467	0	0	0	0	0	0	0	0	4,467	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>44,996</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44,996</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	9,490	0	0	0	0	0	0	0	0	9,490	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	848	0	0	0	0	0	0	0	0	848	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>10,338</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10,338</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	78,631	(861,675)	0	0	0	0	0	0	0	(783,044)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,116)	0	12,598	0	0	0	0	0	0	0	0	4,482	19
20	Fees, Subscriptions & Promotions	(175)	0	1,013	0	0	0	0	0	0	0	0	838	20
21	Clerical & General Office Expenses	(44,180)	0	320,349	4,916	0	0	0	0	0	0	0	281,085	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	394	0	0	0	0	0	0	0	394	24
25	Other Admin. Staff Transportation	0	0	0	13,455	0	0	0	0	0	0	0	13,455	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,939	0	0	0	0	0	0	0	2,939	26
27	Other (specify):*	0	0	0	53,029	0	0	0	0	0	0	0	53,029	27
28	<b>TOTAL General Administration</b>	<b>(52,471)</b>	<b>0</b>	<b>412,591</b>	<b>(786,942)</b>	<b>0</b>	<b>(426,822)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(52,471)</b>	<b>0</b>	<b>467,925</b>	<b>(786,942)</b>	<b>0</b>	<b>(371,488)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,042	148,995	0	39,855	0	0	0	0	0	0	0	189,892	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(159)	247,230	0	10,952	0	0	0	0	0	0	0	258,023	32
33	Real Estate Taxes	0	131,532	0	2,895	0	0	0	0	0	0	0	134,427	33
34	Rent-Facility & Grounds	0	(1,182,532)	0	3,060	0	0	0	0	0	0	0	(1,179,472)	34
35	Rent-Equipment & Vehicles	0	0	0	3,514	0	0	0	0	0	0	0	3,514	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>883</b>	<b>(654,775)</b>	<b>0</b>	<b>60,276</b>	<b>0</b>	<b>(593,616)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(99,329)	3,179	0	0	0	0	0	0	0	0	0	(96,150)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(99,329)</b>	<b>3,179</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(96,150)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(150,917)</b>	<b>(651,596)</b>	<b>467,925</b>	<b>(726,666)</b>	<b>0</b>	<b>(1,061,254)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B				Sambell of Bloomingtondale		
				Limited Partnership Bloomingtondale		Real estate ptsp.
				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	\$ 1,182,532	Sambell of Bloomingtondale Limited Partnership	**	\$	\$ (1,182,532)	1	
2	V	30 Depreciation		Sambell of Bloomingtondale Limited Partnership	**	148,995	148,995	2	
3	V	32 Interest Expense		Sambell of Bloomingtondale Limited Partnership	**	242,600	242,600	3	
4	V	32 Amortization of mortgage costs		Sambell of Bloomingtondale Limited Partnership	**	4,630	4,630	4	
5	V	33 Property taxes		Sambell of Bloomingtondale Limited Partnership	**	131,532	131,532	5	
6	V	43 State replacement tax		Sambell of Bloomingtondale Limited Partnership	**	3,094	3,094	6	
7	V	43 Trust fees		Sambell of Bloomingtondale Limited Partnership	**	85	85	7	
8	V							8	
9	V							9	
10	V							10	
11	V			** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc. own 100% of Sambell of Bloomingtondale Limited Partnership					11
12	V							12	
13	V							13	
14	Total		\$ 1,182,532			\$ 530,936	\$ * (651,596)	14	

\* 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	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 249	\$	249	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,808		3,808	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	95		95	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	682		682	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	32,630		32,630	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	2,915		2,915	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	143		143	21
22	V	6 Security service		Royal Management Corp.	**	7		7	22
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	4,467		4,467	23
24	V	10 Medical consultant		Royal Management Corp.	**	3,295		3,295	24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	6,195		6,195	25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	848		848	26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	78,631		78,631	27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	9,738		9,738	28
29	V	19 Professional fees		Royal Management Corp.	**	2,860		2,860	29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	411		411	30
31	V	21 Communications		Royal Management Corp.	**	97		97	31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	602		602	32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	308,759		308,759	33
34	V	21 Bank charges		Royal Management Corp.	**	875		875	34
35	V	21 Office supplies & printing		Royal Management Corp.	**	7,776		7,776	35
36	V	21 Postage		Royal Management Corp.	**	2,842		2,842	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Bloomington, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 467,925	\$ *	467,925	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
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	21 Telephone	\$	Royal Management Corp.	**	\$ 4,916	\$ 4,916
16	V	24 Travel & seminar		Royal Management Corp.	**	394	394
17	V	25 Auto expense		Royal Management Corp.	**	13,455	13,455
18	V	26 Insurance general		Royal Management Corp.	**	2,939	2,939
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	53,029	53,029
20	V	30 Depreciation		Royal Management Corp.	**	39,855	39,855
21	V	32 Interest		Royal Management Corp.	**	10,932	10,932
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	20	20
23	V	33 Property taxes		Royal Management Corp.	**	2,895	2,895
24	V	34 Rent expense		Royal Management Corp.	**	3,060	3,060
25	V	35 Equipment rental		Royal Management Corp.	**	886	886
26	V	17 Management fees	861,675	Royal Management Corp.	**		(861,675)
27	V	35 Auto Lease		Royal Management Corp.	**	2,628	2,628
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 861,675			\$ 135,009	\$ * (726,666)

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Bloomingdale, Inc.**

**Provider # 0035188**

**1/1/07 - 12/31/07**

**Schedule B**

VII. Related Parties

Owners

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

VII. Related Parties

Related Nursing Homes

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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 7A	3	6.00	Salary	\$ 26,510	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	2	4.00	Salary	18,935	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	2	4.00	Salary	18,935	L17, C7	3
4	Jason Samatas	VP of Operations	Administrative	0.00	See Schedule 7A	4	8.00	Salary	14,250	L17, C7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	2	4.00	Salary	3,035	L21, C7	5
6											6
7											7
8											8
9						All individuals work in excess of 40 hours per week.					9
10											10
11											11
12											12
13								TOTAL	\$ 81,665		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 Health Care Center-Bloomington

# 0035188

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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

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

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

1	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	3	Housekeeping supplies	Bed Days	748,545	10	\$ 2,970	\$ 62,750	\$ 249	1	
2	5	Utilities - gas & electric	Bed Days	748,545	10	45,421	62,750	3,808	2	
3	5	Utilities - water & sewer	Bed Days	748,545	10	1,129	62,750	95	3	
4	5	Utilities - maintenance office	Bed Days	748,545	10	8,141	62,750	682	4	
5	6	Management allocation - salaries	Bed Days	748,545	10	389,246	389,246	62,750	32,630	5
6	6	Repairs & maintenance	Bed Days	748,545	10	34,773	62,750	2,915	6	
7	6	Scavenger & exterminating	Bed Days	748,545	10	1,705	62,750	143	7	
8	6	Security service	Bed Days	748,545	10	78	62,750	7	8	
9	7	Management allocation - employee	Bed Days	748,545	10	53,283	62,750	4,467	9	
10	10	Medical consultant	Bed Days	748,545	10	39,304	62,750	3,295	10	
11	10	Management allocation - salaries	Bed Days	748,545	10	73,905	73,905	62,750	6,195	11
12	15	Management allocation - employee	Bed Days	748,545	10	10,117	62,750	848	12	
13	17	Management allocation - salaries	Bed Days	748,545	10	937,986	937,986	62,750	78,631	13
14	19	Computer consultant & supplies	Bed Days	748,545	10	116,160	62,750	9,738	14	
15	19	Professional fees	Bed Days	748,545	10	34,111	62,750	2,860	15	
16	20	Dues & subscriptions	Bed Days	748,545	10	4,903	62,750	411	16	
17	21	Communications	Bed Days	748,545	10	1,161	62,750	97	17	
18	20	Advertising - help wanted	Bed Days	748,545	10	7,177	62,750	602	18	
19	21	Management allocation - salaries	Bed Days	748,545	10	3,683,186	3,683,186	62,750	308,759	19
20	21	Bank charges	Bed Days	748,545	10	10,433	62,750	875	20	
21	21	Office supplies & printing	Bed Days	748,545	10	92,754	62,750	7,776	21	
22	21	Postage	Bed Days	748,545	10	33,908	62,750	2,842	22	
23	21	Telephone	Bed Days	748,545	10	58,647	62,750	4,916	23	
24	24	Travel and Seminar	Bed Days	748,545	10	4,702	62,750	394	24	
25	TOTALS					\$ 5,645,200	\$ 5,084,323	\$ 473,235	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

# 0035188

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 665 W. North Avenue, Suite 500  
 City / State / Zip Code Lombard, IL 60148  
 Phone Number (630) 458-4700  
 Fax Number (630) 458-4796

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	25	Auto expense	Bed Days	748,545	10	\$ 160,505	\$ 62,750	\$ 13,455	1
2	26	Insurance general	Bed Days	748,545	10	35,055	62,750	2,939	2
3	27	Management allocation - employee	Bed Days	748,545	10	632,578	62,750	53,029	3
4	30	Depreciation	Bed Days	748,545	10	475,433	62,750	39,855	4
5	32	Interest	Bed Days	748,545	10	130,405	62,750	10,932	5
6	32	Amortization of mortgage costs	Bed Days	748,545	10	242	62,750	20	6
7	33	Property taxes	Bed Days	748,545	10	34,533	62,750	2,895	7
8	34	Rent expense	Bed Days	748,545	10	36,507	62,750	3,060	8
9	35	Equipment rental	Bed Days	748,545	10	10,570	62,750	886	9
10	35	Auto Lease	Bed Days	748,545	10	31,346	62,750	2,628	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,547,174	\$	\$ 129,699	25

SEE ACCOUNTANTS' COMPILATION REPORT



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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	<b>138,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	<b>129,132</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(8,868)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>140,400</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	Allocated from Management Company		<b>2,895</b>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>134,427</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>125,102</b>	8
	2003	<b>106,875</b>	9
	2004	<b>111,257</b>	10
	2005	<b>131,254</b>	11
	2006	<b>129,132</b>	12

**Accrual Calculation**

See Schedule Attached

Use: **\$140,400**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lexington Health Care Center-Bloomingtondale COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-15-401-003</u>	<u>Land &amp; Building</u>	\$ <u>129,132.36</u>	\$ <u>129,132.36</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land &amp; Building</u>	\$ <u>132,282.00</u>	\$ <u>2,895.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>261,414.36</u>	\$ <u>132,027.36</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	<u>1</u>
2	<u>Management Company allocation</u>			<u>13,578</u>	<u>2</u>
3	<b>TOTALS</b>	<b>43,000</b>		<b>\$ 416,126</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington Health Care Center-Bloomington

# 0035188

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	88	1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 1,590,251	4
5	9	1992	1992	178,974		35	5,114	5,114	81,818	5
6	75	1994	1994	2,022,894		35	57,797	57,797	780,258	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Capitalized repairs		1989	9,080		10			9,080	9
10	Building Improvements		1990	3,674		10			3,674	10
11	Building Improvements		1991	2,586		10			2,586	11
12	Building Improvements		1992	3,154		10			2,997	12
13	Building Improvements		1993	1,582		10			1,503	13
14	Building Improvements		1994	15,734		10			15,734	14
15	Land Improvements		1994	1,381		10			1,381	15
16	Land Improvements		1995	1,074		15	72	72	895	16
17	Building Improvements		1995	1,288		35	37	37	477	17
18	Building Improvements		1995	9,433	270	35	270		3,375	18
19	Building Improvements		1995	43,839	1,252	35	1,252		15,650	19
20	Concrete flooring, fire doors, tile, sprinkler heads,									20
21	and basement renovation		1996	8,706	260	10-35	260		3,346	21
22	Land improvements		1996	7,858		15	524	524	6,025	22
23										23
24	Resident room heaters		1997	3,563	102	35	102		1,120	24
25	Automatic doors		1997	12,950	370	35	370		3,731	25
26	Basement renovation		1997	58,806	5,936	10	5,936		58,806	26
27	Land Improvement - outdoor flagpoles		1997	1,574	105	15	105		1,101	27
28	1st Floor Remodel (Nurses Station/Lounge)		1998	76,487	7,649	10	7,649		72,663	28
29	Wiring for MDS		1998	4,506	451	10	451		4,281	29
30	Flag Pole		1998	787	79	10	79		747	30
31	Resurface/Stripe Parking Lot		1998	9,777	978	10	978		9,288	31
32	Kitchen tile/paint		1999	718	72	10	72		610	32
33	1st Floor Remodel		1999	3,296	330	10	330		2,966	33
34	Roof repairs		2000	5,748	383	15	383		2,874	34
35	Sump pump		2000	2,534	253	10	253		1,900	35
36	Sump pump basin repair		2000	6,307	631	10	631		4,731	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington Health Care Center-Bloomington

# 0035188

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Automatic door closers	2000	\$ 1,300	\$ 87	15	\$ 87		\$ 650	37
38	Infrared curtains for elevator doors	2001	3,000	300	10	300		1,950	38
39	Ejector pump	2002	3,050	51	5	51		3,050	39
40	Lift station pump	2002	3,359	448	5	448		3,359	40
41	New asphalt parking lot	2003	16,450	1,645	10	1,645		6,854	41
42	Roof repairs	2003	2,900	290	10	290		1,184	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		884	43
44	Kitchen remodel	2003	7,188	359	20	359		1,587	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		14,878	45
46	Floor tile	2003	16,305	815	20	815		4,076	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		15,471	47
48	Rehab-floor tile	2003	8,117	406	20	406		1,657	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		8,718	49
50	Foundation repair	2003	4,800	240	20	240		1,060	50
51	Parking lot	2004	24,550	2,455	10	2,455		8,388	51
52	Kitchen walk-in cooler floor	2004	7,161	716	10	716		2,387	52
53	Old Towne rehab	2004	13,967	698	20	698		2,269	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		32,211	54
55	Create first floor therapy room	2004	185	9	20	9		9	55
56	Transitional unit	2005	213	11	20	11		11	56
57	Landscaping	2005	8,814	441	20	441		955	57
58	Roof repairs	2005	3,250	163	20	163		353	58
59	HVAC upgrade	2005	7,048	352	20	352		821	59
60	Kitchen repair	2005	1,631	82	20	82		204	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		1,990	61
62	Window treatments	2005	3,606	721	5	721		1,685	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		1,074	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		4,215	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		3,898	65
66	Basement renovation	2005	14,176	709	20	709		1,419	66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 6,126,369	\$ 54,925		\$ 203,661	\$ 148,736	\$ 2,811,135	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,126,369	\$ 54,925		\$ 203,661	\$ 148,736	\$ 2,811,135	1
2	Landscaping Enhancement	2006	7,084	472	15	472		630	2
3	Install Kitchen Sink	2006	2,915	146	20	146		255	3
4	Common area rehab	2006	2,382	119	20	119		198	4
5	Paint Building Exterior	2006	19,500	3,900	5	3,900		5,525	5
6	Patio	2006	53,305	3,554	15	3,554		3,850	6
7	Retaining Wall	2007	2,950	131	15	131		131	7
8	Roof Repair	2007	17,050	639	20	639		639	8
9	Air Conditioning units	2007	4,338	199	20	199		199	9
10	Paver walk and stairway	2007	10,500	350	20	350		350	10
11	Fire exit stairways	2007	9,379	78	20	78		78	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	Land improvements - management company	2002	21,400		15	357	357	8,441	24
25	Building - management company	2002	166,493		40	1,040	1,040	24,627	25
26	HVAC, electrical, security system - management company	2003	1,650		30	29	29	501	26
27	Key card system - management company	2004	259		20	3	3	44	27
28	VAV TX controls - management company	2005	79		20	1	1	11	28
29	Interior Signs - management company	2006	57		5			5	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,445,710	\$ 64,513		\$ 214,679	\$ 150,166	\$ 2,856,619	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 466,551	\$ 59,526	\$ 59,785	\$ 259	5-10	\$ 259,745	71
72	Current Year Purchases	74,577	6,499	6,499		5-10	6,499	72
73	Fully Depreciated Assets	3,459				3-5	3,459	73
74	Allocated from Mgmt. Co.	205,657		34,577	34,577		104,484	74
75	TOTALS	\$ 750,244	\$ 66,025	\$ 100,861	\$ 34,836		\$ 374,187	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from Mgmt. Co.			32,622		3,848	3,848		21,387	79
80	TOTALS			\$ 32,622	\$	\$ 3,848	\$ 3,848		\$ 21,387	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,644,702	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,538	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 319,388	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 188,850	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,252,193	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	First Floor Renovation	\$ 176,464	92
93			93
94			94
95		\$ 176,464	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from management company				3,060			6
7	TOTAL				\$ 3,060			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

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

**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: \$ 47,683 Description: Copier-\$7,263; Mailing-\$179; Medical Equip-\$30,108; Oxygen Equip-\$9,244; Alloc from Man Co-\$889

(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	Administrative		\$ 548.31	\$ 5,979	17
18					18
19					19
20	Allocation from Management Co			2,628	20
21	TOTAL		\$ 548.31	\$ 8,607	21

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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>2. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	10A(3)	hrs	\$	4,106	\$ 210,302	\$	4,106	\$ 210,302	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		969	72,733		969	72,733	2
3	Licensed Recreational Therapist	10A(3)	hrs		4,674	376,309		4,674	376,309	3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	39(3)	visits			275			275	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				270,672		270,672	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Respiratory Therapist Other (specify): <u>Wound Therapy</u>	10A(3) 39(3)				324 6,077			324 6,077	13
14	<b>TOTAL</b>			\$	9,749	\$ 666,020	\$ 270,672	9,749	\$ 936,692	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

# 0035188

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 555,411	\$ 556,263	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 386,958 )	1,146,151	1,146,151	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,728	39,728	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,389	1,399	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,743,679	\$ 1,743,541	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,949	64,949	12
13	Land		416,126	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	1,052,827	1,262,979	15
16	Equipment, at Historical Cost	541,990	782,866	16
17	Accumulated Depreciation (book methods)	(620,876)	(3,252,193)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec CIP	176,464	176,464	22
23	Other(specify): Mortgage Cost, net		63,510	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,215,354	\$ 4,697,432	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,959,033	\$ 6,440,973	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 199,348	\$ 199,348	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	480,000	480,000	29
30	Accrued Salaries Payable	199,168	199,168	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,416	3,416	31
32	Accrued Real Estate Taxes(Sch.IX-B)		140,400	32
33	Accrued Interest Payable		16,318	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule 17A	499,390	367,322	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,381,322	\$ 1,405,972	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,786,662	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,786,662	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,381,322	\$ 5,192,634	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,577,711	\$ 1,248,339	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,959,033	\$ 6,440,973	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington Health Care Center of Bloomingdale, Inc.

Provider #0035188

1/1/07-12/31/07

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other current liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to Royal	(21,837)	(21,837)
Accrued PTO	(113,585)	(113,585)
Accrued 401K	(18,412)	(18,412)
Due to Streamwood	(994)	(994)
Due to Lexington Financial Service	(250)	(250)
Due to Republic Construction	(18,836)	(18,836)
Accrued Expenses	(171,282)	(171,282)
Accrued Royal Gen Mgmt Fees	133	133
Accrued Rent	(132,068)	-
Accrued Wage Assignments	644	644
Advance Bi-Weekly Payments	(22,903)	(22,903)
	<u>(499,390)</u>	<u>(367,322)</u>

**See Accountants' Compilation Report**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,756,000</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post Closing Adjustment</b>	<b>(40,301)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,715,699</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>627,012</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(765,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(137,988)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,577,711</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,990,722	1
2	Discounts and Allowances for all Levels	(4,483,649)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,507,073	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,013,359	6
7	Oxygen	6,503	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,019,862	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,359	12
13	Barber and Beauty Care	20,573	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	357,610	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,429	19
20	Radiology and X-Ray	19,011	20
21	Other Medical Services	117,234	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 545,216	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,051	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,051	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	1,602	28
28a	<u>Investment Income</u>	4,397	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,999	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,092,201	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,331,165	31
32	Health Care	4,135,545	32
33	General Administration	2,152,909	33
<b>B. Capital Expense</b>			
34	Ownership	1,372,355	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	379,045	35
36	Provider Participation Fee	94,170	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,465,189	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	627,012	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 627,012	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 is a cash basis taxpayer

\*\*\* 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 Health Care Center-Bloomington

# 0035188

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,828	1,933	\$ 97,190	\$ 50.28	1
2	Assistant Director of Nursing	2,053	2,217	77,067	34.76	2
3	Registered Nurses	45,695	49,842	1,530,509	30.71	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	82,567	88,539	1,059,863	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,606	8,238	114,876	13.94	8
9	Activity Director	2,004	2,164	32,434	14.99	9
10	Activity Assistants	18,876	20,456	222,874	10.90	10
11	Social Service Workers	4,098	4,357	88,202	20.24	11
12	Dietician	1,963	2,066	31,379	15.19	12
13	Food Service Supervisor	1,963	2,145	38,077	17.75	13
14	Head Cook	1,708	1,814	22,030	12.14	14
15	Cook Helpers/Assistants	13,835	14,904	111,322	7.47	15
16	Dishwashers	12,475	13,459	121,825	9.05	16
17	Maintenance Workers	2,092	2,233	30,684	13.74	17
18	Housekeepers	29,538	31,970	254,022	7.95	18
19	Laundry	7,276	7,971	63,753	8.00	19
20	Administrator	1,805	2,023	99,759	49.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,001	16,267	239,882	14.75	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	668	710	9,578	13.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,051	273,308	\$ 4,245,326 *	\$ 15.53	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	240	\$ 13,743	1(3)	35
36	Medical Director	Monthly	37,200	9(3)	36
37	Medical Records Consultant	21	1,265	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	103	4,841	11(3)	44
45	Social Service Consultant	96	4,800	12(3)	45
46	Other(specify) <u>Psychosocial</u>	41	2,060	12(3)	46
47	<u>Medical Consultant</u>	Monthly	3,295	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	501	\$ 69,604		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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		
Jeff Baker	Administrator	0	\$ 99,759	Workers' Compensation Insurance	\$ 65,914	IDPH License Fee	\$		
				Unemployment Compensation Insurance	34,358	Advertising: Employee Recruitment	24,496		
				FICA Taxes	310,846	Health Care Worker Background Check	990		
				Employee Health Insurance	169,920	(Indicate # of checks performed 99 )			
				Employee Meals	10,731	Patient Background Checks	2,010		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	2,315		
				401(k) Contributions	18,412	Miscellaneous Dues & Subscriptions	1,304		
				Life Insurance	3,368				
				Other Employee Benefits	23,695				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 99,759						
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees (Eliminated in Column 7)			\$ 861,675				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 861,675	TOTAL (agree to Schedule V, line 22, col.8)			\$ 637,244	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
Cassidy Schade LLP	Legal	\$ 6,257							
James Samatas, Atty. At Law	Legal	137							
McGladrey & Pullen	Accounting	21,836							
Personnel Planners	U/C Consulting	840							
Reed Smith/Sachnoff & Weaver	Legal	1,720							
RSM McGladrey	Accounting	4,148							
Scott & Krause	Legal	171							
Systematic Mgmt Systems	Billing Services	4,672					Seminar Expense		
Grabowski Law Center	Collections	7,778					7,338		
ING	Pension Consulting	1,027							
See attached Schedule 21C		18,652					Management Company Allocation		
							394		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 67,238	TOTAL			\$	Entertainment Expense ( )	
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)		
							TOTAL \$ 7,732		

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Lexington Health Care Center of Bloomingdale, Inc.**

**Provider # 0035188**

**1/1/06 - 12/31/06**

**Schedule 21C**

XIX. Support Schedules

C. Professional Services

Vendor/Payee

Ehealth Data Solutions	Computer Consulting	2,400
Lanac	Computer Consulting	3,626
National Datacare Corporation	Computer Consulting	1,733
Information Controls	Computer Consulting	434
AAOD	Computer Consulting	512
Alperian Technology	Computer Consulting	215
Lintech	Computer Consulting	3,137
Action Computer Service	Computer Consulting	324
Microsoft	Computer Consulting	4,322
Krakau	Computer Consulting	617
Visual Click	Computer Consulting	97
CDW	Computer Consulting	218
Royal/Computer Svc Website	Computer Consulting	311
Royal/Internet Marketing	Computer Consulting	650
Royal/Andrew Campbell Photography	Computer Consulting	55
		<u>18,652</u>

Total, Agrees to Schedule V, Line 19, Column 3 67,238

Allocated from management co.

James Samatas	Legal-filing fees	6
Sachnoff & Weaver	Legal	126
McGladrey & Pullen LLP	Accounting	289
RSM McGladrey	Accounting	422
Aronberg, Goldgehn Davis	Accounting	238
Gilson Labus & Silverman	Accounting	388
ING Life & Annuity	Pension Consulting	4
Elizabeth Schwarz	Physician Credentialing Consultant	140
Pension Administrators, Inc.	401(k) Administration	393
Addison Search	Recruitment Consulting	39
Gene Whitehorn	Medicaid Reimb. Specialist	707
Lintech	Computer Consulting	3,408
Lanac Consulting	Computer Consulting	2,921
Lifecare Software, Inc.	Computer Consulting	1,948
CDW Direct	Computer Consulting	1,461

Allocated from Samvest of Lombard II  
Gilson, Labus & Silverman Accounting 108

Nonallowable legal fees (338)  
Nonallowable collection fees (7,778)

Total, Agrees to Schedule V, Line 19, Column 3 71,720  
71,720

**See accountants' compilation report**

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**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								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington# 0035188Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,563 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 94,170  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 10,731 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - 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
  - What percent of all travel expense relates to transportation of nurses and patients? 0
  - Have vehicle usage logs been maintained? Adequate records have been maintained.
  - Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees