

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860 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 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	81,760	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	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,624	873	9,950	13,447	8
9	SNF/PED					9
10	ICF	40,907	15,810	1,723	58,440	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,531	16,683	11,673	71,887	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.92%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES 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 10/09/84

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 224 and days of care provided 9,950

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL 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

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 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
	A. General Services										
1	Dietary	390,733	37,578	14,386	442,697		442,697		442,697		1
2	Food Purchase		325,610		325,610		325,610	(15,894)	309,716		2
3	Housekeeping	327,242	42,912		370,154		370,154	324	370,478		3
4	Laundry	88,095	19,826		107,921		107,921		107,921		4
5	Heat and Other Utilities			262,661	262,661		262,661	5,973	268,634		5
6	Maintenance	35,963		141,864	177,827		177,827	46,508	224,335		6
7	Other (specify):* Mgmt. Alloc. Benefits							5,820	5,820		7
8	TOTAL General Services	842,033	425,926	418,911	1,686,870		1,686,870	42,731	1,729,601		8
	B. Health Care and Programs										
9	Medical Director			52,800	52,800		52,800		52,800		9
10	Nursing and Medical Records	4,149,209	208,780	17,710	4,375,699		4,375,699	12,365	4,388,064		10
10a	Therapy			821,563	821,563		821,563		821,563		10a
11	Activities	275,623	27,699	5,264	308,586		308,586		308,586		11
12	Social Services	117,258		8,435	125,693		125,693		125,693		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt. Alloc. Benefits							1,105	1,105		15
16	TOTAL Health Care and Programs	4,542,090	236,479	905,772	5,684,341		5,684,341	13,470	5,697,811		16
	C. General Administration										
17	Administrative	99,368		1,121,978	1,221,346		1,221,346	(1,019,526)	201,820		17
18	Directors Fees										18
19	Professional Services			97,648	97,648		97,648	6,585	104,233		19
20	Dues, Fees, Subscriptions & Promotions			22,346	22,346		22,346	1,320	23,666		20
21	Clerical & General Office Expenses	251,699	23,614	16,943	292,256		292,256	383,688	675,944		21
22	Employee Benefits & Payroll Taxes			900,625	900,625		900,625	14,637	915,262		22
23	Inservice Training & Education			3,187	3,187		3,187		3,187		23
24	Travel and Seminar			7,615	7,615		7,615	514	8,129		24
25	Other Admin. Staff Transportation			41	41		41	17,531	17,572		25
26	Insurance-Prop.Liab.Malpractice			265,699	265,699		265,699	3,829	269,528		26
27	Other (specify):* Mgmt. Alloc. Benefits							69,093	69,093		27
28	TOTAL General Administration	351,067	23,614	2,436,082	2,810,763		2,810,763	(522,329)	2,288,434		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,735,190	686,019	3,760,765	10,181,974		10,181,974	(466,128)	9,715,846		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.

Facility Name & ID Number Lexington Health Care Center-Lombard

#0028860

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
	D. Ownership											
30	Depreciation			169,554	169,554		169,554	159,331	328,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,367	17,367		17,367	60,687	78,054			32
33	Real Estate Taxes							151,555	151,555			33
34	Rent-Facility & Grounds			1,494,783	1,494,783		1,494,783	(1,490,796)	3,987			34
35	Rent-Equipment & Vehicles			62,415	62,415		62,415	4,579	66,994			35
36	Other (specify):*											36
37	TOTAL Ownership			1,744,119	1,744,119		1,744,119	(1,114,644)	629,475			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		385,388	9,509	394,897		394,897		394,897			39
40	Barber and Beauty Shops			34,335	34,335		34,335		34,335			40
41	Coffee and Gift Shops			4,843	4,843		4,843		4,843			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Non-allowable Cos			111,747	111,747		111,747	(111,747)				43
44	TOTAL Special Cost Centers		385,388	283,074	668,462		668,462	(111,747)	556,715			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,735,190	1,071,407	5,787,958	12,594,555		12,594,555	(1,692,519)	10,902,036			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

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	(1,257)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,245)	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	(247)	30		9
10	Interest and Other Investment Income	(27,872)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,413)	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	(3,241)	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	(45,297)	43		24
25	Fund Raising, Advertising and Promotional	(14,940)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(33,699)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(73,000)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (206,211)		\$	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)	(1,486,308)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,486,308)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,692,519)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center-Lombard

ID# 0028860

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salaries	\$ (38,466)	21	1
2	Misc. Income	(1,650)	21	2
3	Labs-Part A	(12,512)	43	3
4	X-Rays-Part A	(10,093)	43	4
5	Collections	(9,829)	19	5
6	Trust Fees	(450)	43	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
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(73,000)		49

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%	See Attached Schedule B	See Attached Schedule B	Lexington Health		
John Samatas	33.33%			Care Systems of		
Cynthia Thiem	33.34%			Lombard Ltd. Ptsp.	Lombard	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. 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	\$ 1,494,783	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	\$	\$ (1,494,783)	1
2	V	30 Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	107,648	107,648	2
3	V	32 Interest Expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	71,835	71,835	3
4	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	2,454	2,454	4
5	V	33 Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	147,783	147,783	5
6	V	43 State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	14,693	14,693	6
7	V	43 Trust fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	450	450	7
8	V							8
9	V							9
10	V							10
11	V			** - The owners of Lexington Health Care Center of Lombard, Inc. own				11
12	V			100% of Lexington Health Care Systems of Lombard Limited Partnership.				12
13	V							13
14	Total		\$ 1,494,783			\$ 344,863	\$ * (1,149,920)	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.	**	\$ 324	\$	324	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,961		4,961	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	123		123	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	889		889	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	42,515		42,515	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	3,798		3,798	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	186		186	21	
22	V	6 Security service		Royal Management Corp.	**	9		9	22	
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,820		5,820	23	
24	V	10 Medical consultant		Royal Management Corp.	**	4,293		4,293	24	
25	V	10 Management allocation - salaries		Royal Management Corp.	**	8,072		8,072	25	
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	1,105		1,105	26	
27	V	17 Management allocation - salaries		Royal Management Corp.	**	102,452		102,452	27	
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	12,688		12,688	28	
29	V	19 Professional fees		Royal Management Corp.	**	3,726		3,726	29	
30	V	20 Dues & subscriptions		Royal Management Corp.	**	536		536	30	
31	V	21 Communications		Royal Management Corp.	**	127		127	31	
32	V	20 Advertising - help wanted		Royal Management Corp.	**	784		784	32	
33	V	21 Management allocation - salaries		Royal Management Corp.	**	402,297		402,297	33	
34	V	21 Bank charges		Royal Management Corp.	**	1,140		1,140	34	
35	V	21 Office supplies & printing		Royal Management Corp.	**	10,131		10,131	35	
36	V	21 Postage		Royal Management Corp.	**	3,703		3,703	36	
37	V								37	
38	V	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 609,679	\$ *	609,679	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.	**	\$ 6,406	\$ 6,406	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	514	514	16	
17	V	25 Auto expense		Royal Management Corp.	**	17,531	17,531	17	
18	V	26 Insurance general		Royal Management Corp.	**	3,829	3,829	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	69,093	69,093	19	
20	V	30 Depreciation		Royal Management Corp.	**	51,930	51,930	20	
21	V	32 Interest		Royal Management Corp.	**	14,244	14,244	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	26	26	22	
23	V	33 Property taxes		Royal Management Corp.	**	3,772	3,772	23	
24	V	34 Rent expense		Royal Management Corp.	**	3,987	3,987	24	
25	V	35 Equipment rental		Royal Management Corp.	**	1,155	1,155	25	
26	V	17 Management fees	1,121,978	Royal Management Corp.	**		(1,121,978)	26	
27	V	35 Auto Lease expense		Royal Management Corp.	**	3,424	3,424	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	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.							37
38	V							38	
39	Total		\$ 1,121,978			\$ 175,911	\$ * (946,067)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660
1/1/07-12/31/07

Schedule 6B

VII. Related Parties
Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
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 Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 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	33.33	See Schedule 7A	3	6.00	Salary	\$ 34,541	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33	See Schedule 7A	2	4.00	Salary	24,672	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	3	6.00	Salary	24,672	L17, C7	3
4	Jason Samatas	VP of Operations	Administrative	0.00	See Schedule 7A	4	8.00	Salary	18,567	L17, C7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	3	6.00	Salary	3,955	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	\$ 106,407		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-Lombard

0028860

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	\$ 81,760	\$ 324	1
2	5	Utilities - gas & electric	Bed Days	748,545	10	45,421	81,760	4,961	2
3	5	Utilities - water & sewer	Bed Days	748,545	10	1,129	81,760	123	3
4	5	Utilities - maintenance office	Bed Days	748,545	10	8,141	81,760	889	4
5	6	Management allocation - salaries	Bed Days	748,545	10	389,246	389,246	42,515	5
6	6	Repairs & maintenance	Bed Days	748,545	10	34,773	81,760	3,798	6
7	6	Scavenger & exterminating	Bed Days	748,545	10	1,705	81,760	186	7
8	6	Security service	Bed Days	748,545	10	78	81,760	9	8
9	7	Management allocation - employee	Bed Days	748,545	10	53,283	81,760	5,820	9
10	10	Medical consultant	Bed Days	748,545	10	39,304	81,760	4,293	10
11	10	Management allocation - salaries	Bed Days	748,545	10	73,905	73,905	8,072	11
12	15	Management allocation - employee	Bed Days	748,545	10	10,117	81,760	1,105	12
13	17	Management allocation - salaries	Bed Days	748,545	10	937,986	937,986	102,452	13
14	19	Computer consultant & supplies	Bed Days	748,545	10	116,160	81,760	12,688	14
15	19	Professional fees	Bed Days	748,545	10	34,111	81,760	3,726	15
16	20	Dues & subscriptions	Bed Days	748,545	10	4,903	81,760	536	16
17	21	Communications	Bed Days	748,545	10	1,161	81,760	127	17
18	20	Advertising - help wanted	Bed Days	748,545	10	7,177	81,760	784	18
19	21	Management allocation - salaries	Bed Days	748,545	10	3,683,186	3,683,186	402,297	19
20	21	Bank charges	Bed Days	748,545	10	10,433	81,760	1,140	20
21	21	Office supplies & printing	Bed Days	748,545	10	92,754	81,760	10,131	21
22	21	Postage	Bed Days	748,545	10	33,908	81,760	3,704	22
23	21	Telephone	Bed Days	748,545	10	58,647	81,760	6,406	23
24	24	Travel and Seminar	Bed Days	748,545	10	4,702	81,760	514	24
25	TOTALS					\$ 5,645,200	\$ 5,084,323	\$ 616,600	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860

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	25	Auto expense	Bed Days	748,545	10	\$ 160,505	\$ 81,760	\$ 17,531	1
2	26	Insurance general	Bed Days	748,545	10	35,055	81,760	3,829	2
3	27	Management allocation - employee	Bed Days	748,545	10	632,578	81,760	69,093	3
4	30	Depreciation - leasehold improv.	Bed Days	748,545	10	475,433	81,760	51,929	4
5	32	Interest	Bed Days	748,545	10	130,405	81,760	14,244	5
6	32	Amortization of mortgage costs	Bed Days	748,545	10	242	81,760	26	6
7	33	Property taxes	Bed Days	748,545	10	34,533	81,760	3,772	7
8	34	Rent expense	Bed Days	748,545	10	36,507	81,760	3,987	8
9	35	Equipment rental	Bed Days	748,545	10	10,570	81,760	1,155	9
10		Auto Lease	Bed Days	748,545	10	31,346	81,760	3,424	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	\$	\$ 168,990	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	GMAC		X	Mortgage	\$39,766.00	4/11/94	\$ 3,978,766	\$ 633,631	4/11/09	0.0875	\$ 71,835	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	LaSalle Bank, N.A.		X	Line of Credit	Varies	4/6/02	750,000	320,000	5/31/08	Prime	17,367	6								
7												7								
8												8								
9	TOTAL Facility Related				\$39,766.00		\$ 4,728,766	\$ 953,631			\$ 89,202	9								
B. Non-Facility Related*																				
10							Interest income offset				(27,872)	10								
11							Amortization of mortgage costs				2,480	11								
12							Allocation of management company				14,244	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (11,148)	14								
15	TOTALS (line 9+line14)						\$ 4,728,766	\$ 953,631			\$ 78,054	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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-Lombard COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0028860

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>06-19-307-002</u>	<u>Building and Land</u>	\$ <u>138,583.42</u>	\$ <u>138,583.42</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ <u>132,281.84</u>	\$ <u>3,772.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>270,865.26</u>	\$ <u>142,355.42</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.

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,770 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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square feet

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>30,000</u>	<u>1984</u>	<u>\$ 616,761</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>17,683</u>	<u>2</u>
3	TOTALS	30,000		\$ 634,444	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860

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	215	1984	1984	\$ 3,661,473	\$ 104,614	35	\$ 104,614	\$	\$ 2,430,087	4
5	9	1995	1995	284,157	8,116	35	8,116		101,482	5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvements		1990	96,217		10			96,217	9
10	Leasehold Improvements Additions		1995	71,493		10			71,493	10
11	Building Improvements		1994	20,200		10			20,200	11
12	Building Improvements		1995	14,535	415	35	415		5,191	12
13	Building Improvements - dishwasher hood		1996	2,748		10			2,748	13
14	Building Improvements - outside painting		1996	11,308		10			11,308	14
15	Building Improvements - dining room		1996	3,752		10			3,752	15
16	Leasehold Improvements		1992	16,299	466	35	466		7,219	16
17	Leasehold Improvements		1994	21,836		10			21,836	17
18	Leasehold Improvements - 2nd floor		1996	19,319		10			18,353	18
19	Leasehold Improvements - bathroom rehab		1996	9,216		10			8,909	19
20	Leasehold Improvements - fan coil repairs		1996	6,669	191	35	191		2,160	20
21	Land Improvements		1993	2,985	199	15	199		2,886	21
22	Land Improvements		1995	4,596	306	15	306		3,830	22
23	Capitalized Repairs		1986	1,730		10			1,730	23
24	Building Improvements - basement		1996	18,993	475	10	475		18,993	24
25	Leasehold Improvements - Corner Guards		1997	520	26	10	26		520	25
26	Leasehold Improvements - Corridor flooring		1997	10,380	519	10	519		10,380	26
27	BI: Kitchen Rehab		1998	2,494	249	10	249		2,369	27
28	Wiring for MDS project		1998	3,365	337	10	337		3,197	28
29	Install Fire Sprinklers in Mechanical Rms		1998	4,600	131	35	131		1,249	29
30	Tile for Lobby		1998	20,530	2,053	10	2,053		19,504	30
31	Walk in Freezers/Coolers		1998	3,183	91	35	91		864	31
32	Fire Wall Repairs		1998	12,411	355	35	355		3,369	32
33	Underground storage tank		1998	2,613		10			2,613	33
34	Repave parking lot		1999	7,625	508	15	508		4,321	34
35	Lounge Floor Tile		1999	2,963	296	10	296		2,519	35
36										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 & ID Number Lexington Health Care Center-Lombard

0028860

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	Rewire Building	1999	\$ 9,083	\$ 260	35	\$ 260		\$ 2,206	37
38	Heat exchanger for water heater	1999	1,660		5			1,660	38
39	Compressor and tank for freezer	1999	2,924		5			2,924	39
40	Plumbing Improvements	2000	2,833	283	10	283		2,125	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		471	41
42	Water heater repairs	2000	3,831		5			3,831	42
43	Automatic door	2000	4,556	130	35	130		976	43
44	Install sprinklers	2001	6,082	608	10	608		4,004	44
45	Infrared curtains for elevator	2001	4,500	450	10	450		2,775	45
46	Elevator upgrade	2002	3,006	301	5	301		3,006	46
47	Condensor	2002	2,679	268	5	268		2,679	47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		6,777	48
49	Plumbing loop repairs	2003	6,125	613	10	613		2,501	49
50	Fire alarm panel/call system	2003	8,495	425	20	425		2,088	50
51	Facility Rehab - Painting	2003	6,872	687	10	687		2,909	51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		6,192	52
53	Nurse call system	2003	49,451	2,473	20	2,473		10,096	53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		1,293	54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		78,620	55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		69,082	56
57	Floor Tile	2003	58,720	2,936	20	2,936		14,680	57
58	Carpeting/cove base	2003	29,518	2,952	10	2,952		14,759	58
59	Water heater	2004	9,209	921	10	921		2,916	59
60	Kitchen sewer and dishroom	2004	31,233	1,562	20	1,562		4,815	60
61	Landscaping	2005	3,255	163	20	163		393	61
62	HVAC	2005	8,028	401	20	401		870	62
63	Kitchen sewer, dishroom and ceiling	2005	22,924	1,146	20	1,146		2,961	63
64	Lobby and reception redecorating - painting/wallpaper	2005	37,999	1,900	20	1,900		5,067	64
65	Rehab therapy room - electrical, carpet, tile	2005	66,393	3,320	20	3,320		8,852	65
66	Rehab 1st floor therapy room - electrical, carpet, tile	2005	39,341	1,967	20	1,967		5,245	66
67	Wallpaper, tile, electrical for transitional unit	2005	22,946	1,147	20	1,147		3,155	67
68	Window treatments	2005	8,053	403	20	403		1,040	68
69	Tile, flooring, and wallpaper	2005	57,699	2,885	20	2,885		7,453	69
70	TOTAL (lines 4 thru 69)		\$ 5,504,063	\$ 180,423		\$ 180,423		\$ 3,157,720	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington Health Care Center-Lombard

0028860

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	
1	Totals from Page 12A, Carried Forward		\$ 5,504,063	\$ 180,423		\$ 180,423	\$	\$ 3,157,720	1
2	Countertops	2005	845	169	5	169		451	2
3	Curtains and blinders	2005	4,672	935	5	935		2,206	3
4	Mini scroll	2005	527	105	5	105		237	4
5	Medical Records Storage/Office Room	2006	5,901	148	40	148		172	5
6	Office Remodel	2006	5,537	138	40	138		138	6
7	Piping	2006	4,510	301	15	301		401	7
8	HVAC	2006	7,985	200	40	200		200	8
9	Emergency A/C	2006	9,385	235	40	235		235	9
10	Adm Office-HVAC	2006	6,421	161	40	161		227	10
11	Sink installation	2006	2,561	64	40	64		112	11
12	Land Improvements Patio	2006	23,736	1,582	15	1,582		2,110	12
13	Brick Pavers	2007	8,500	378	15	378		378	13
14	Landscaping	2007	16,420	342	20	342		342	14
15	Parking Lot	2007	13,219	275	20	275		275	15
16	Roof	2007	9,800	368	20	368		368	16
17	HVAC	2007	8,197	205	20	205		205	17
18	LHI-Emergency A/C	2007	11,126	93	20	93		93	18
19	LHI-Plumbing & Sprinkler	2007	6,799	170	10	170		170	19
20	Automatic Doors in Common Areas	2007	20,874	435	20	435		435	20
21	Tike System & Foundation	2007	4,500	19	20	19		19	21
22	Exterior of Building Painting	2007	16,600	208	20	208		208	22
23									23
24									24
25	Land Improvements-management company	2002	27,870		15	552	552	10,993	25
26	Building-management company	2002	216,828		40	1,235	1,235	32,072	26
27	HVAC, electrical, security system-management company	2003	2,149		30	63	63	653	27
28	Key card system-management company	2004	338		20	9	9	58	28
29	VAV TX controls-management compnay	2005	103		20	4	4	15	29
30	Building Improvements-management company	2006	75		20	1	1	6	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,939,543	\$ 186,954		\$ 188,818	\$ 1,864	\$ 3,210,499	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	\$ 738,454	\$ 85,750	\$ 85,759	\$ 9		\$ 372,014	71
72	Current Year Purchases	88,388	4,242	4,242			4,242	72
73	Fully Depreciated Assets							73
74	Allocated from management company	267,831		45,052	45,052		136,072	74
75	TOTALS	\$ 1,094,673	\$ 89,992	\$ 135,053	\$ 45,061		\$ 512,328	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 management compnay			42,484		5,014	5,014		27,853	79
80	TOTALS			\$ 42,484	\$	\$ 5,014	\$ 5,014		\$ 27,853	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)	\$ 7,711,144	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 276,946	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 328,885	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 51,939	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,750,680	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	1st floor remodel	\$ 669,238	92
93			93
94			94
95		\$ 669,238	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: _____

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				3,987			6
7	TOTAL				\$ 3,987			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: \$ 63,570 Description: Copier- \$5,579; Fax Machine- \$550; Mailing Machine- \$190; Medical Equip.- \$56,096; Mgmt. Co.-\$1,155

(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	Allocation from Management Company			3,424	20
21	TOTAL		\$ _____	\$ 3,424	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?</p> <p><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. 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 CNA _____</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 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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	3,935	\$ 305,441	\$	3,935	\$ 305,441	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,174	95,489		1,174	95,489	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		5,530	420,633		5,530	420,633	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				385,388		385,388	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Dentist Dentist/Hearing Aids Other (specify): <u>Wound Mgmt</u>	L39, C3 L39, C3				1,317 8,192			8,192	13
14	TOTAL			\$	10,639	\$ 831,072	\$ 385,388	10,639	\$ 1,215,143	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-Lombard

0028860

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,491	\$ 45,485	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>515,853</u>)	2,214,728	2,214,728	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,233	99,233	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(85,423)	(85,423)	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,244,029	\$ 2,274,023	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		634,444	13
14	Buildings, at Historical Cost		3,858,310	14
15	Leasehold Improvements, at Historical Cost	1,814,377	2,081,233	15
16	Equipment, at Historical Cost	699,839	1,137,157	16
17	Accumulated Depreciation (book methods)	(855,615)	(3,750,680)	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 _____)	669,238	669,238	22
23	Other(specify): <u>Mortgage cost net</u>		3,275	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,327,839	\$ 4,632,977	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,571,868	\$ 6,907,000	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 424,376	\$ 424,376	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,056	1,056	28
29	Short-Term Notes Payable	320,000	320,000	29
30	Accrued Salaries Payable	379,328	379,328	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,279	10,279	31
32	Accrued Real Estate Taxes(Sch.IX-B)		153,600	32
33	Accrued Interest Payable		4,620	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached schedule 17A</u>	437,218	334,617	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,572,257	\$ 1,627,876	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		633,631	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)	\$	\$ 633,631	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,572,257	\$ 2,261,507	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,999,611	\$ 4,645,493	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,571,868	\$ 6,907,000	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Lombard, Inc.

Provider #0028660

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>
Notes Payable		65,000
Accrued 401K	25,430	25,430
Due to Royal	26,016	26,016
Accrued Expenses	250,804	250,804
Accrued Royal Gen Mgmt Fees	66,738	66,738
Accrued Rent	167,601	-
Accrued Wage Assignments	1,063	1,063
Advance Bi-Weekly Payments	(100,704)	(100,704)
Withholding Dental Insurance	270	270
	<u>437,218</u>	<u>334,617</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,940,881	1
2	Restatements (describe):		2
3		(246,651)	3
4	Post closing adjustments		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,694,230	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,274,381	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	(969,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 305,381	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,999,611	24 *

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,846,028	1
2	Discounts and Allowances for all Levels	(5,892,717)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,953,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,342,452	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,342,452	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,363	12
13	Barber and Beauty Care	40,221	13
14	Non-Patient Meals	1,257	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	645,532	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,313	19
20	Radiology and X-Ray	15,884	20
21	Other Medical Services	153,556	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 892,126	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,872	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,872	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Bed Hold Discharge</u>	651,525	28
28a	<u>Misc. Income</u>	1,650	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 653,175	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,868,936	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,686,870	31
32	Health Care	5,684,341	32
33	General Administration	2,810,763	33
	B. Capital Expense		
34	Ownership	1,744,119	34
	C. Ancillary Expense		
35	Special Cost Centers	545,822	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,594,555	40
41	Income before Income Taxes (line 30 minus line 40)**	1,274,381	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,274,381	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-Lombard

0028860

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	2,056	2,138	\$ 116,022	\$ 54.27	1
2	Assistant Director of Nursing	4,763	5,287	192,872	36.48	2
3	Registered Nurses	51,662	55,934	1,794,118	32.08	3
4	Licensed Practical Nurses	14,326	15,989	443,812	27.76	4
5	CNAs & Orderlies	105,122	111,982	1,344,712	12.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	15,559	16,898	232,031	13.73	8
9	Activity Director	2,039	2,185	33,860	15.50	9
10	Activity Assistants	20,654	22,240	241,763	10.87	10
11	Social Service Workers	5,094	5,584	117,258	21.00	11
12	Dietician	2,067	2,151	36,240	16.85	12
13	Food Service Supervisor	1,976	2,214	35,842	16.19	13
14	Head Cook	2,042	2,214	43,569	19.68	14
15	Cook Helpers/Assistants	13,433	14,263	124,078	8.70	15
16	Dishwashers	19,445	20,448	151,004	7.38	16
17	Maintenance Workers	2,295	2,405	35,963	14.95	17
18	Housekeepers	38,005	40,797	327,242	8.02	18
19	Laundry	10,469	11,441	88,095	7.70	19
20	Administrator	1,386	1,705	99,368	58.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,125	15,708	251,699	16.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,652	1,847	25,642	13.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	328,170	353,430	\$ 5,735,190 *	\$ 16.23	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	263	\$ 14,386	L1, C3	35
36	Medical Director	Monthly	52,800	L9, C3	36
37	Medical Records Consultant	17	1,045	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	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	112	5,264	L11, C3	44
45	Social Service Consultant	105	5,225	L12, C3	45
46	Other(specify) <u>Psychosocial</u>	54	3,210	L12, C3	46
47	<u>Rehabcare</u>		23	L10, C3	47
48	<u>See Schedule 20B</u>		5,493	L10, C3	48
49	TOTAL (lines 35 - 48)	551	\$ 89,846		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.

Provider # 0028660

1/1/07-12/31/07

Schedule 20B

20B

Consultant Services

<u>Type</u>	<u>Hours</u>	<u>Amount</u>	<u>Line</u>
Medical Consultant	Monthly	4293	L10, C3
PA Application Consultant	Monthly	1200	L10, C3
		<u>5493</u>	

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	
Nancy McDonald	Administrator	0%	\$ 93,064	Workers' Compensation Insurance	\$ 97,427	IDPH License Fee	\$	
Susan Polier	Administrator	0%	6,304	Unemployment Compensation Insurance	92,930	Advertising: Employee Recruitment	17,068	
				FICA Taxes	416,744	Health Care Worker Background Check (Indicate # of checks performed <u>75</u>)	750	
				Employee Health Insurance	228,322	Patient Background Checks <u>225</u>	2,250	
				Employee Meals	14,637	Miscellaneous Licenses and Fees	2,000	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	278	
				401K Contributions	25,430			
				Life Insurance	4,084			
				Other Employee Benefits	35,688			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,368			Allocated from management co.	1,320	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management fees(eliminated in Column 7)			\$ 1,121,978			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,121,978	TOTAL (agree to Schedule V, line 22, col.8)		\$ 915,262	TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
RSM McGladrey	Accounting		\$ 24,122			\$	Out-of-State Travel	\$
Cassidy, Shade & Gloor	Legal		19,934					
James Samatas	Legal		125					
Personnel Planners	U/C Consulting		2,410				In-State Travel	
Sachnoff & Weaver	Legal		9,100					
Serpico, Novelle, Petrosino LTD.	Legal		5,601					
Systematic Management Systems	Billing Services		3,887					
Grawboski Law center	Legal-Collection fees		9,829				Seminar Expense	7,615
ING	401K Audit		1,371					
							Allocation from management co.	514
See attached schedule 21C			21,269				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 97,648	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							TOTAL	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Lombard, Inc.
 Provider #0028660
 1/1/07-12/31/07

Schedule F

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
XO Communications	Computer Consulting	
National Data Care Corp	Computer Consulting	2,256
Information Data Care Corp	Computer Consulting	578
AAOD	Computer Consulting	512
Ehealth	Computer Consulting	2,400
Krakau	Computer Consulting	441
Action Computer Service	Computer Consulting	162
Microsoft	Computer Consulting	4,965
Visual Click	Computer Consulting	97
CDW	Computer Consulting	1,016
Lanac	Computer Consulting	4,117
Lintech	Computer Consulting	3,137
Alperian Technology	Computer Consulting	215
Royal Billout-Computer Service Web Site-March	Computer Consulting	125
Royal Billout-Computer Service Web Site-June	Computer Consulting	186
Action Computers	Computer Consulting	162
Krakau Business Computers	Computer Consulting	195
Campbell	Computer Consulting	55
Royal Billout-Advertising	Computer Consulting	650
		<u>21,269</u>
Total Legal		97,648
<u>Non-allowable Legal</u>		
Grawboski Law Center	Collections	(9,829)
<u>Allocated from Management Company</u>		
McGladrey & Pullen LLP	Accounting	376
RSM McGladrey	Accounting	550
Aronberg, Goldgenhn Davis	Accounting	311
Gilson Labus & Silverman	Accounting	505
ING Life & Annuity	Pension Consultation	6
Elizabeth Schwartz	Physician credentialing consultant	183
Pension Administrators, Inc.	401K Administration	512
Addison Search	Billing Consulting	51
Gene Whitehom	Medicaid Reimb Specialist	919
James Samatas	Legal	8
Sachnoff & Weaver	Legal	164
KMZ Rosenmann	Legal	-
Lintech	Computer consulting	4,441
Lanac Technology	Computer consulting	3,806
Lifecare software, Inc.	Computer consulting	2,538
CDW Direct	Computer consulting	1,903
		<u>16,273</u>
<u>Allocated from Samvest of Lombard II</u>		
Gilson, Labus & Silverman	Accounting	141

Total, Agrees to Schedule V, Line 19, Column 8

104,233

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard# 0028860Report 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? 6 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,713 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 122,640
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. \$ 14,637 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,257
- (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 have been 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 \$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