



Facility Name & ID Number Lexington of Chicago Ridge

# 0042739 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	224	Skilled (SNF)	214	81,710	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	214	81,710	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		Other	Total	
		Private Pay				
8	SNF	5,908	836	11,770	18,514	8
9	SNF/PED					9
10	ICF	47,487	5,112	1,874	54,473	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,395	5,948	13,644	72,987	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.32%

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 06/04/91

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 214 and days of care provided 11,677

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.

Facility Name &amp; ID Number

Lexington of Chicago Ridge

# 0042739

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				Reclassification 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	346,424	42,140	17,858	406,422		406,422		406,422		1
2	Food Purchase		324,685		324,685		324,685	(9,895)	314,790		2
3	Housekeeping	358,252	42,990		401,242		401,242	324	401,566		3
4	Laundry	59,282	19,840		79,122		79,122		79,122		4
5	Heat and Other Utilities			236,040	236,040		236,040	5,970	242,010		5
6	Maintenance	27,882		152,929	180,811		180,811	46,480	227,291		6
7	Other (specify):* <b>Mgmt. Alloc. Emp Be</b>							5,816	5,816		7
8	<b>TOTAL General Services</b>	791,840	429,655	406,827	1,628,322		1,628,322	48,695	1,677,017		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			45,600	45,600		45,600		45,600		9
10	Nursing and Medical Records	4,029,616	246,040	38,604	4,314,260		4,314,260	12,357	4,326,617		10
10a	Therapy			814,595	814,595		814,595		814,595		10a
11	Activities	277,512	26,048	5,053	308,613		308,613		308,613		11
12	Social Services	108,285		6,772	115,057		115,057		115,057		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Mgmt. Alloc. Emp Be</b>							1,104	1,104		15
16	<b>TOTAL Health Care and Programs</b>	4,415,413	272,088	910,624	5,598,125		5,598,125	13,461	5,611,586		16
	<b>C. General Administration</b>										
17	Administrative	117,683		1,123,248	1,240,931		1,240,931	(1,020,859)	220,072		17
18	Directors Fees										18
19	Professional Services			86,207	86,207		86,207	12,793	99,000		19
20	Dues, Fees, Subscriptions & Promotions			35,151	35,151		35,151	1,318	36,469		20
21	Clerical & General Office Expenses	277,737	28,338	22,727	328,802		328,802	389,134	717,936		21
22	Employee Benefits & Payroll Taxes			819,737	819,737		819,737	9,895	829,632		22
23	Inservice Training & Education			1,094	1,094		1,094		1,094		23
24	Travel and Seminar			7,208	7,208		7,208	513	7,721		24
25	Other Admin. Staff Transportation			1,973	1,973		1,973	17,520	19,493		25
26	Insurance-Prop.Liab.Malpractice			238,549	238,549		238,549	3,827	242,376		26
27	Other (specify):* <b>Mgmt. Alloc. Emp Be</b>							69,051	69,051		27
28	<b>TOTAL General Administration</b>	395,420	28,338	2,335,894	2,759,652		2,759,652	(516,808)	2,242,844		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,602,673	730,081	3,653,345	9,986,099		9,986,099	(454,652)	9,531,447		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 &amp; ID Number

Lexington of Chicago Ridge

#0042739

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	
	<b>D. Ownership</b>											
30	Depreciation			109,221	109,221		109,221	198,760	307,981			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,211	56,211		56,211	262,109	318,320			32
33	Real Estate Taxes							572,980	572,980			33
34	Rent-Facility & Grounds			1,916,210	1,916,210		1,916,210	(1,912,225)	3,985			34
35	Rent-Equipment & Vehicles			89,566	89,566		89,566	4,576	94,142			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,171,208	2,171,208		2,171,208	(873,800)	1,297,408			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		456,305	13,879	470,184		470,184		470,184			39
40	Barber and Beauty Shops			21,981	21,981		21,981		21,981			40
41	Coffee and Gift Shops			5,178	5,178		5,178		5,178			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* <b>Non-allowable Cos</b>			101,132	101,132		101,132	(101,132)				43
44	<b>TOTAL Special Cost Centers</b>		456,305	264,810	721,115		721,115	(101,132)	619,983			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,602,673	1,186,386	6,089,363	12,878,422		12,878,422	(1,429,584)	11,448,838			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

# 0042739

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	(4,932)	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	(90)	30		9
10	Interest and Other Investment Income	(75,053)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(771)	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	(500)	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	(36,293)	43		24
25	Fund Raising, Advertising and Promotional	(21,419)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,607)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(235,887)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (377,552)</b>		<b>\$</b>	<b>30</b>

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)	(1,052,032)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (1,052,032)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,429,584)</b>		<b>37</b>

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

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

(See instructions.)

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

BHF USE ONLY						
48		49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Chicago Ridge

ID# 0042739

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	X-Rays-Part A	\$ (11,041)	43	1
2	Labs-Part A	(23,609)	43	2
3	Misc. Income	(295)	21	3
4	Trust Fees	(205)	43	4
5	Loss from extinguishment of debt	(163,009)	43	5
6	Legal Collection fees	(3,611)	19	6
7	Non-allowable marketing salary	(34,117)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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27				27
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29				29
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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>	(235,887)		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	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Chicago Ridge	
				Limited Partnership Chicago Rdige	Real estate ptsp.
				Royal Mgmt. Corp. Lombard	Mgmt. Co.
				Lexington Financial	
				Services II, 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	30 Depreciation	\$	Sambell of Chicago Ridge Limited Partnership	**	\$ 146,953	\$ 146,953 1
2	V	32 Interest expense		Sambell of Chicago Ridge Limited Partnership	**	322,230	322,230 2
3	V	32 Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	671	671 3
4	V	33 Real estate tax		Sambell of Chicago Ridge Limited Partnership	**	569,210	569,210 4
5	V	34 Rental expense	1,916,210	Sambell of Chicago Ridge Limited Partnership	**		(1,916,210) 5
6	V	43 State Replacement tax		Sambell of Chicago Ridge Limited Partnership	**	40	40 6
7	V	43 Trust fees		Sambell of Chicago Ridge Limited Partnership	**	205	205 7
8	V	43 Loss from extinguishment of debt		Sambell of Chicago Ridge Limited Partnership	**	163,009	163,009 8
9	V						9
10	V						10
11	V			** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%			11
12	V			of Sambell of Chicago Ridge Limited Partnership			12
13	V						13
14	Total		\$ 1,916,210			\$ 1,202,318	\$ * (713,892) 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.	**	4,958	4,958	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.	**	42,489	42,489	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	3,796	3,796	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.	**	5,816	5,816	23	
24	V	10 Medical consultant		Royal Management Corp.	**	4,290	4,290	24	
25	V	10 Management allocation - salaries		Royal Management Corp.	**	8,067	8,067	25	
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	1,104	1,104	26	
27	V	17 Management allocation - salaries		Royal Management Corp.	**	102,389	102,389	27	
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	12,680	12,680	28	
29	V	19 Professional fees		Royal Management Corp.	**	3,724	3,724	29	
30	V	20 Dues & subscriptions		Royal Management Corp.	**	535	535	30	
31	V	21 Communications		Royal Management Corp.	**	127	127	31	
32	V	20 Advertising - help wanted		Royal Management Corp.	**	783	783	32	
33	V	21 Management allocation - salaries		Royal Management Corp.	**	402,050	402,050	33	
34	V	21 Bank charges		Royal Management Corp.	**	1,139	1,139	34	
35	V	21 Office supplies & printing		Royal Management Corp.	**	10,125	10,125	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 Chicago Ridge, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 609,306	\$ * 609,306	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 6,402	\$ 6,402	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	513	513	16	
17	V	25 Auto expense		Royal Management Corp.	**	17,520	17,520	17	
18	V	26 Insurance general		Royal Management Corp.	**	3,827	3,827	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	69,051	69,051	19	
20	V	30 Depreciation		Royal Management Corp.	**	51,897	51,897	20	
21	V	32 Interest		Royal Management Corp.	**	14,235	14,235	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	26	26	22	
23	V	33 Property taxes		Royal Management Corp.	**	3,770	3,770	23	
24	V	34 Rent expense		Royal Management Corp.	**	3,985	3,985	24	
25	V	35 Equipment rental		Royal Management Corp.	**	1,154	1,154	25	
26	V	17 Management fees	1,123,248	Royal Management Corp.	**		(1,123,248)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	3,422	3,422	27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.							38
39	Total		\$ 1,123,248			\$ 175,802	\$ * (947,446)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Chicago Ridge, Inc.**

**Provider # 0040923**

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

**Schedule 6B**

VII. Related Parties

Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Lombard, Inc.	Lombard
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 Wheeling, Inc.	Wheeling
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 of Chicago Ridge      #      0042739      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	4	8.00	Salary	\$ 34,519	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33	See Schedule 7A	3	6.00	Salary	24,657	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34	See Schedule 7A	3	6.00	Salary	24,657	L17, C7	3
4	Jason Samatas	VP of Operations	Administrative	0.00	See Schedule 7A	5	10.00	Salary	18,556	L17, C7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	4	8.00	Salary	3,952	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	\$ 106,341		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739 Report Period Beginning: 01/01/2007Ending: 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 6148

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	3	Housekeeping supplies	Bed Days	10	\$ 2,970	\$	81,710	\$ 324	1
2	5	Utilities - gas & electric	Bed Days	10	45,421		81,710	4,958	2
3	5	Utilities - water & sewer	Bed Days	10	1,129		81,710	123	3
4	5	Utilities - maintenance office	Bed Days	10	8,141		81,710	889	4
5	6	Management allocation - salaries	Bed Days	10	389,246	389,246	81,710	42,489	5
6	6	Repairs & maintenance	Bed Days	10	34,773		81,710	3,796	6
7	6	Scavenger & exterminating	Bed Days	10	1,705		81,710	186	7
8	6	Security service	Bed Days	10	78		81,710	9	8
9	7	Management allocation - employee	Bed Days	10	53,283		81,710	5,816	9
10	10	Medical consultant	Bed Days	10	39,304		81,710	4,290	10
11	10	Management allocation - salaries	Bed Days	10	73,905	73,905	81,710	8,067	11
12	15	Management allocation - employee	Bed Days	10	10,117		81,710	1,104	12
13	17	Management allocation - salaries	Bed Days	10	937,986	937,986	81,710	102,389	13
14	19	Computer consultant & supplies	Bed Days	10	116,160		81,710	12,680	14
15	19	Professional fees	Bed Days	10	34,111		81,710	3,724	15
16	20	Dues & subscriptions	Bed Days	10	4,903		81,710	535	16
17	21	Communications	Bed Days	10	1,161		81,710	127	17
18	20	Advertising - help wanted	Bed Days	10	7,177		81,710	783	18
19	21	Management allocation - salaries	Bed Days	10	3,683,186	3,683,186	81,710	402,051	19
20	21	Bank charges	Bed Days	10	10,433		81,710	1,139	20
21	21	Office supplies & printing	Bed Days	10	92,754		81,710	10,125	21
22	21	Postage	Bed Days	10	33,908		81,710	3,701	22
23	21	Telephone	Bed Days	10	58,647		81,710	6,402	23
24	24	Travel and Seminar	Bed Days	10	4,702		81,710	513	24
25	TOTALS				\$ 5,645,200	\$ 5,084,323		\$ 616,220	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

# 0042739 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	10	\$ 160,505	\$	81,710	\$ 17,520	1
2	26	Insurance general	Bed Days	10	35,055		81,710	3,827	2
3	27	Management allocation - employee	Bed Days	10	632,578		81,710	69,051	3
4	30	Depreciation	Bed Days	10	475,433		81,710	51,898	4
5	32	Interest	Bed Days	10	130,405		81,710	14,235	5
6	32	Amortization of mortgage costs	Bed Days	10	242		81,710	26	6
7	33	Property taxes	Bed Days	10	34,533		81,710	3,770	7
8	34	Rent expense	Bed Days	10	36,507		81,710	3,985	8
9	35	Equipment rental	Bed Days	10	10,570		81,710	1,154	9
10	35	Auto Lease	Bed Days	10	31,346		81,710	3,422	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	\$		\$ 168,888	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

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** YES NO
	<b>A. Directly Facility Related</b>												
	<b>Long-Term</b>												
1	Lexington Financial	X		Mortgage	\$42,300.00	12/29/98	\$ 5,563,000	\$	1/2008	0.0675	\$ 93,880	1	
2	Services II, L.L.C	X		Mortgage	Varies	4/30/07	6,178,000	6,122,398	5/1/2017	0.0625	265,829	2	
3												3	
4												4	
5												5	
	<b>Working Capital</b>												
6	LaSalle Bank N.A.		X	Line of Credit	Varies	4/6/02	1,000,000		5/31/07	Prime/Libor	9,998	6	
7	JP Morgan Chase		X	Line of Credit	Varies	4/30/07	1,400,000	370,000	5/1/2010	Libor	8,734	7	
8												8	
9	TOTAL Facility Related				\$42,300.00		\$ 14,141,000	\$ 6,492,398			\$ 378,441	9	
	<b>B. Non-Facility Related*</b>												
10											Amortization of mortgage costs	697	10
11											Interest Income offset	(75,053)	11
12											Allocated from management co.	14,235	12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ (60,121)	14	
15	TOTALS (line 9+line14)						\$ 14,141,000	\$ 6,492,398			\$ 318,320	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 of Chicago Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042739

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>24-18-200-030-0000</u>	<u>Land &amp; Building</u>	\$ <u>518,952.70</u>	\$ <u>518,952.70</u>
2. <u>24-07-311-012-0000</u>	<u>Land &amp; Building</u>	\$ <u>16,451.66</u>	\$ <u>16,451.66</u>
3. <u>Royal Management Corp(Samvest of Lombard II)</u>		\$ <u>132,281.84</u>	\$ <u>3,770.00</u>
4. <u>05-01-202-019</u>	<u>Land &amp; Building</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>667,686.20</u>	\$ <u>539,174.36</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.

Facility Name & ID Number Lexington of Chicago Ridge

# 0042739

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 85,551 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 ground (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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	31,000	1989	\$ 505,000	1
2	Allocation from management company			17,683	2
3	TOTALS	31,000		\$ 522,683	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Chicago Ridge

# 0042739

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	1991	1991	\$ 5,143,342	\$	35	\$ 146,953	\$ 146,953	\$ 2,436,966	4
5	9	1995	1995	97,352	2,781	35	2,781		34,769	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Leasehold Improvements	1993	1993	2,693	77	35	77		1,117	9
10	Leasehold Improvements	1994	1994	6,581	188	35	188		2,539	10
11	Dishwasher hood	1996	1996	2,480		10			2,480	11
12	Lobby repairs	1996	1996	8,698		10			8,698	12
13	Basement rehab	1997	1997	24,477	408	10	408		24,477	13
14	Wiring	1998	1998	3,429	343	10	343		3,257	14
15	Handrails	1998	1998	895	60	15	60		567	15
16	Resurface & restripe parking lot	1998	1998	4,450	445	10	445		4,228	16
17	Fire wall	1998	1998	2,169	62	35	62		589	17
18	Foyer floor tile	1999	1999	32,379	3,238	10	3,238		28,601	18
19	Wallpapering / painting / decorating	1999	1999	8,833	883	10	883		7,287	19
20	Rebuild garage area	1999	1999	1,762	50	35	50		411	20
21	Roof repairs	2000	2000	6,240	624	10	624		4,680	21
22	Electrical wiring	2000	2000	3,986	114	35	114		854	22
23	Electrical wiring	2000	2000	2,536	72	35	72		544	23
24	Kitchen rehab	2000	2000	6,623	221	35	221		1,656	24
25	Automatic doors	2000	2000	1,300	130	10	130		975	25
26	Elevator eye sensors	2000	2000	4,500	300	15	300		2,250	26
27	Resurface & restripe parking lot	2001	2001	3,319	332	10	332		2,157	27
28	Door releases	2001	2001	5,200	520	10	520		3,380	28
29	Carpeting	2001	2001	10,022	1,002	10	1,002		6,515	29
30	Roof repairs	2002	2002	25,600	1,280	20	1,280		7,467	30
31	Elevator upgrade	2002	2002	9,865	986	10	986		5,508	31
32	Painting/decorating/carpet/wallpaper	2003	2003	38,165	1,908	20	1,908		9,541	32
33	Rehab/new office	2003	2003	26,733	1,337	20	1,337		6,683	33
34	Facility rehab - construction costs, painting & decorating	2003	2003	257,174	12,859	20	12,859		57,864	34
35	Facility rehab - electrical	2003	2003	12,840	642	20	642		2,889	35
36	Facility rehab - carpeting	2003	2003	7,800	780	10	780		3,510	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

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	Facility rehab - floor tile	2003	\$ 3,548	\$ 177	20	\$ 177	\$	\$ 798	37
38									38
39	Kickplates/Door protectors	2004	4,095	410	10	410		1,502	39
40	Kitchen Fire Protection Upgrade	2004	1,427	143	10	143		523	40
41	Parking Lot - Paving and Sealcoating	2005	4,375	219	20	219		510	41
42	Kitchen Rehab	2005	19,228	961	20	961		2,083	42
43	Lobby/Lounge Reception Area	2005	36,503	1,825	20	1,825		4,715	43
44	Sidewalk - Raise and Support	2005	1,330	67	20	67		150	44
45	Lower Level Therapy Rehab	2005	52,525	2,626	20	2,626		6,128	45
46	Transitional Unit	2005	1,020	51	20	51		106	46
47	Basement Renovation	2005	3,754	188	20	188		407	47
48	Landscaping Enhancement	2006	6,463	431	15	431		539	48
49	Lhi-Hvac	2006	4,333	217	20	217		235	49
50	Rehab Common Areas	2006	7,661	383	20	383		575	50
51	Modular Units attached to wall	2006	10,316	516	20	516		688	51
52	Cubical Curtains	2006	1,578	316	5	316		578	52
53	Landscaping	2007	5,000	139	15	139		139	53
54	Parking lot	2007	35,969		20				54
55	HVAC	2007	4,580	153	20	153		153	55
56	Emergency A/C	2007	30,293	505	20	505		505	56
57	Portable A/C	2007	3,768	79	20	79		79	57
58	Employee Lunch Room	2007	3,671	31	20	31		31	58
59	Painting	2007	16,150	269	20	269		269	59
60	1st floor remodel-carpentry, flooring, plumbing, electrical fixtures	2007	641,616		40				60
61	painting,								61
62	Create first floor therapy	2007	185	9	20	9		9	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,660,830	\$ 41,357		\$ 188,310	\$ 146,953	\$ 2,693,181	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	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 6,660,830	\$ 41,357		\$ 188,310	\$ 146,953	\$ 2,693,181		1
2									2
3									3
4	Land improvements - management company	2002 27,870			532	532	10,993		4
5	Building - management company	2002 216,828			1,205	1,205	32,072		5
6	HVAC, electrical, security system - management company	2003 2,149			112	112	653		6
7	Key card system - management company	2004 338			6	6	58		7
8	VAV TX controls - management company	2005 103			5	5	15		8
9	Interior Signs- management company	2006 75			2	2	6		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	TOTAL (lines 1 thru 33)	\$ 6,908,193	\$ 41,357		\$ 190,172	\$ 148,815	\$ 2,736,978		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 388,965	\$ 57,206	\$ 57,206	\$	5	\$ 192,677	71
72	Current Year Purchases	360,102	10,568	10,568		5	10,657	72
73	Fully Depreciated Assets	154,617				5	151,567	73
74	Allocation from management co.	222,192		45,025	45,025		136,072	74
75	TOTALS	\$ 1,125,876	\$ 67,774	\$ 112,799	\$ 45,025		\$ 490,973	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	Allocation from Mgmt. Co.			42,484		5,010	5,010		27,853	79
80	TOTALS			\$ 42,484	\$	\$ 5,010	\$ 5,010		\$ 27,853	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 8,599,237	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 109,131	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 307,981	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 198,850	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,255,804	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					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	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	Allocation from management co.			3,985			6
7	<b>TOTAL</b>			\$ 3,985			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: \$ 90,720 Description: Copier-\$8,045; Fax Machine-\$550; Med Equip Rental-\$80,971; Alloc. Managt. Co. \$ 1,154  
(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			3,422	20
21	<b>TOTAL</b>		\$	\$ 3,422	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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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>	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	5,704	\$	344,051				5,704	\$	344,051	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		965		68,702				965		68,702	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	L10A, C3	hrs		5,651		401,842				5,651		401,842	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							456,305			456,305	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Dentist Other (specify): <b>Wound Therapy</b>	L39, C3 L39, C3					1,620 12,259						12,259	13
14	<b>TOTAL</b>			\$	12,320	\$	828,474	\$	456,305		12,320	\$	1,283,159	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 &amp; ID Number Lexington of Chicago Ridge

# 0042739

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	\$ 411,549	\$ 448,873	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 601,132 )	2,060,461	2,060,461	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	129,292	129,292	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,069,325)	903,281	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,531,977	\$ 3,541,907	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,730	6,730	12
13	Land		522,683	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	1,517,488	1,764,851	15
16	Equipment, at Historical Cost	762,630	1,168,360	16
17	Accumulated Depreciation (book methods)	(473,109)	(3,255,804)	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 (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,813,739	\$ 5,350,162	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,345,716	\$ 8,892,069	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 277,553	\$ 277,553	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	370,000	370,000	29
30	Accrued Salaries Payable	379,757	379,757	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,079	5,079	31
32	Accrued Real Estate Taxes(Sch.IX-B)		552,200	32
33	Accrued Interest Payable		40,137	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Schedule 17A	926,128	289,963	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,958,517	\$ 1,914,689	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,122,398	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,122,398	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,958,517	\$ 8,037,087	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,387,199	\$ 854,982	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,345,716	\$ 8,892,069	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington Health Care Center of Chicago Ridge, Inc.

Provider #0036996

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	28,940	28,940
Due to/from Orland Park	908	908
Accrued 401K	31,844	31,844
Due to-republic construction	45,842	45,842
Accrued expenses	230,941	230,941
Accrued Royal General Mgmt Fees	1,681	1,681
Accrued Rent	636,165	
Advance Bi-weekly part a payments	(50,193)	(50,193)
	<u>926,128</u>	<u>289,963</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,208,116	1
2	Restatements (describe):		2
3			3
4	Post closing AJE's	(193,432)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,014,684	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	282,515	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	90,000	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)	\$ 372,515	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,387,199	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 17,788,369	1
2	Discounts and Allowances for all Levels	(7,364,119)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,424,250	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,707,629	6
7	Oxygen	2,663	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,710,292	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	6,112	12
13	Barber and Beauty Care	25,487	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	701,853	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,579	19
20	Radiology and X-Ray	10,436	20
21	Other Medical Services	209,176	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 995,643	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	30,284	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 30,284	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc/Investment Income</b>	468	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 468	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,160,937	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,628,322	31
32	Health Care	5,598,125	32
33	General Administration	2,759,652	33
<b>B. Capital Expense</b>			
34	Ownership	2,171,208	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	598,475	35
36	Provider Participation Fee	122,640	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,878,422	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	282,515	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 282,515	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 of Chicago Ridge**

# **0042739**

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	1,505	1,843	\$ 95,135	\$ 51.62	1
2	Assistant Director of Nursing	3,661	4,043	144,408	35.72	2
3	Registered Nurses	54,651	59,929	2,087,655	34.84	3
4	Licensed Practical Nurses	4,687	5,382	129,902	24.14	4
5	CNAs & Orderlies	104,673	113,219	1,331,580	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,964	14,157	211,488	14.94	8
9	Activity Director	2,055	2,185	38,671	17.70	9
10	Activity Assistants	20,909	22,423	238,841	10.65	10
11	Social Service Workers	5,493	5,652	108,285	19.16	11
12	Dietician	690	779	10,823	13.89	12
13	Food Service Supervisor	2,069	2,183	31,348	14.36	13
14	Head Cook	1,859	2,166	28,110	12.98	14
15	Cook Helpers/Assistants	11,207	12,383	110,210	8.90	15
16	Dishwashers	20,862	22,189	165,933	7.48	16
17	Maintenance Workers	1,852	1,945	27,882	14.34	17
18	Housekeepers	41,201	44,845	358,252	7.99	18
19	Laundry	6,523	7,157	59,282	8.28	19
20	Administrator	1,546	1,970	117,683	59.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,030	17,136	277,737	16.21	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	1,906	2,114	29,448	13.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	316,343	343,700	\$ 5,602,673 *	\$ 16.30	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	\$ 17,858	L1, C3	35
36	Medical Director	Monthly	45,600	L9,C3	36
37	Medical Records Consultant	23	1,348	L10, C3	37
38	Nurse Consultant		415	L10,C3	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	108	5,053	L11,C3	44
45	Social Service Consultant	96	4,788	L12,C3	45
46	Other(specify) <u>Psychosocial</u>	40	1,984	L12,C3	46
47	MDS	97	5,323	L10,C3	47
48	Medical Consultant	Monthly	4,290	L10, C3	48
49	TOTAL (lines 35 - 48)	603	\$ 89,057		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	
Marichu Bueno	Administrator	0	\$ 62,372	Workers' Compensation Insurance	\$ 87,652	IDPH License Fee	\$ 1,990	
Nancy McDonald	Administrator	0	55,311	Unemployment Compensation Insurance	62,005	Advertising: Employee Recruitment	26,442	
				FICA Taxes	416,046	Health Care Worker Background Check (Indicate # of checks performed 180 )	1,800	
				Employee Health Insurance	181,428	Patient Background Checks 270	2,700	
				Employee Meals	9,895	Miscellaneous Licenses & Fees	1,655	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	564	
				401K Contributions	31,844			
				Life Insurance	4,564			
				Other Employee Benefits	36,198			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,683			Allocated from management co.	1,318	
B. Administrative - Other						Less: Public Relations Expense ( )		
Description			Amount			Non-allowable advertising ( )		
Management Fees (eliminated in column 7)			\$ 1,123,248			Yellow page advertising ( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,123,248					
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
Grabowski Law Center, LLC	Collections		\$ 3,611				Out-of-State Travel	\$
Cassiday Shade, LLP	Legal		20,518					
Freedman, Anselmo, Lindberg	Legal		162				In-State Travel	
James Samatas. Atty.at law	Legal		100					
McGladrey & Pullen	Accounting		18,486				Seminar Expense	7,208
Personnel Planners	U/C Consulting		1,470					
Reed Smith/Sachnoff & Weaver	Legal		3,220				Allocation from management co.	513
RSM McGladrey	Accounting		4,482				Entertainment Expense ( )	
Serpico, Novelle, Petrosino	Legal		248				(agree to Sch. V, line 24, col. 8)	
Systematic Management Systems	Billing Services		7,329				TOTAL	\$ 7,721
ING	401K Services		1,752					
See attached Schedule 21C			24,830					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 86,207	TOTAL		\$		

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

\*\*See instructions.

Lexington Health Care Center of Chicago Ridge, Inc.  
 Provider # 0036996  
 1/1/07-12/31/07

XIX. Support Schedules  
 C. Professional Services

Schedule 21C

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
National Data Care Corp	Computer Consulting	3,441
Information Controls	Computer Consulting	289
AAOD	Computer Consulting	512
Ehealth	Computer Consulting	2,400
Krakau	Computer Consulting	441
Action Computer Service	Computer Consulting	162
Microsoft	Computer Consulting	6,657
Visual Click	Computer Consulting	97
CDW	Computer Consulting	798
Lanac	Computer Consulting	4,325
Lintech	Computer Consulting	3,369
Alperian Technology	Computer Consulting	215
Infiniti	Computer Consulting	189
Andrew Campbell	Computer Consulting	55
Royal/Shaker Advertising	Computer Consulting	650
Computer Service Website	Computer Consulting	311
Information Controls	Computer Consulting	289
CDW	Computer Consulting	218
Action Computer	Computer Consulting	162
Krakau Business Computer	Computer Consulting	195
Campbell Photography	Computer Consulting	55
		<u>24,830</u>

Total, Agrees to Schedule V, Line 19, Column 3 86,207

Allocated from management co.

James Samatas	Legal-filing fees	8
Sachnoff & Weaver	Legal	164
McGladrey & Pullen LLP	Accounting	376
RSM McGladrey	Accounting	550
Aronberg, Goldgehn Davis	Accounting	310
Gilson Labus Silverman	Accounting	505
ING Life & Annuity	Pension Consultation	6
Elizabeth Schwarz	Physician Credentialing Consultation	183
Pension Administrators, Inc.	401(K) Administration	512
Addison Search	Billing Consulting	51
Gene Whitehorn	Medicaid Reimb. Specialist	918
Lintech	Computer Consulting	4,438
Lanac Technology	Computer Consulting	3,804
Lifecare Software, Inc.	Computer Consulting	2,536
CDW Direct	Computer Consulting	1,902
		<u>16,263</u>

Allocated from Samvest of Lombard II

Gilson, Labus & Silverman	Accounting	141
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Allocated from Building partnership

-

Less Legal Collection Fees

(3,611)

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

99,000

**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	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739Report 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 organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 52,577 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.
- (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 benefit: on Schedule V. \$ 9,895 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? N/A  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

RECONCILIATION REPORT

Lexington of Chicago Ric

08:21 AM 4/22/2008

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,429,584	equal to	-1,429,584	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	318,320	equal to	318,320	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	572,980	equal to	572,980	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	307,981	equal to	307,981	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	3,985	equal to	3,985	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	94,142	equal to	94,142	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	814,595	equal to	814,595	0	FAILED	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	456,305	equal to	456,305	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,628,322	equal to	1,628,322	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	5,598,125	equal to	5,598,125	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	2,759,652	equal to	2,759,652	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	2,171,208	equal to	2,171,208	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	598,475	equal to	598,475	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+	N/A	38to41+43	4
Income Stat. Prov. Partic.	122,640	equal to	122,640	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,818,128	equal to	4,029,616	-211,488	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	277,512	equal to	277,512	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	108,285	equal to	108,285	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	346,424	equal to	346,424	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	27,882	equal to	27,882	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	358,252	equal to	358,252	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	59,282	equal to	59,282	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	117,683	equal to	117,683	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	277,737	equal to	277,737	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,602,673	equal to	5,602,673	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	17,858	< or = to	17,858	-1	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	45,600	< or = to	45,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,163	< or = to	38,604	-34,441	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to51	2	Pg3 G19	N/A	10	3
Activity Consultant	5,053	< or = to	5,053	-1	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	4,788	< or = to	6,772	-1,985	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	117,683	equal to	117,683	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	1,123,248	equal to	1,123,248	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	86,207	equal to	86,207	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	829,632	equal to	829,632	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	36,469	equal to	36,469	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	7,721	equal to	7,721	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	122,640	equal to	122,640	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	9,895	< or = to	9,895	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	9,895	equal to	9,895	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	11,677	equal to	11,770	-93	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-1,052,032	equal to	-1,052,032	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4c	B.	14	8
Total loan balance	6,492,398	equal to	6,492,398	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	552,200	equal to	552,200	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	522,683	equal to	522,683	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,908,193	equal to	6,908,193	0	FAILED	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,168,360	equal to	1,168,360	0	FAILED	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	3,255,804	equal to	3,255,804	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,387,199	equal to	1,387,199	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	282,515	equal to	282,515	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..E	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,345,716	equal to	3,345,716	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1



