



Facility Name & ID Number Lexington of Orland Park

# 0041855 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 1/18/07

	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	270	Skilled (SNF)	278	101,334	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	270	TOTALS	278	101,334	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	6,327	488	12,315	19,130	8
9	SNF/PED					9
10	ICF	58,212	4,786	4,165	67,163	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,539	5,274	16,480	86,293	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.16%

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 07/08/96

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 278 and days of care provided 12,133

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	378,421	48,631	15,952	443,004		443,004		443,004		1
2	Food Purchase		393,193		393,193		393,193	(18,611)	374,582		2
3	Housekeeping	360,709	47,589		408,298		408,298	403	408,701		3
4	Laundry	65,766	21,579		87,345		87,345		87,345		4
5	Heat and Other Utilities			281,560	281,560		281,560	7,406	288,966		5
6	Maintenance	55,256		132,551	187,807		187,807	57,641	245,448		6
7	Other (specify):* <b>Allocated Benefits</b>							7,214	7,214		7
8	<b>TOTAL General Services</b>	860,152	510,992	430,063	1,801,207		1,801,207	54,053	1,855,260		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			71,200	71,200		71,200		71,200		9
10	Nursing and Medical Records	4,841,138	249,663	35,144	5,125,945		5,125,945	15,325	5,141,270		10
10a	Therapy			1,033,808	1,033,808		1,033,808		1,033,808		10a
11	Activities	307,026	34,441	5,910	347,377		347,377		347,377		11
12	Social Services	128,520		7,298	135,818		135,818		135,818		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Allocated Benefits</b>							1,373	1,373		15
16	<b>TOTAL Health Care and Programs</b>	5,276,684	284,104	1,153,360	6,714,148		6,714,148	16,698	6,730,846		16
	<b>C. General Administration</b>										
17	Administrative	125,308		1,337,908	1,463,216		1,463,216	(1,210,929)	252,287		17
18	Directors Fees										18
19	Professional Services			191,999	191,999		191,999	3,258	195,257		19
20	Dues, Fees, Subscriptions & Promotions			47,553	47,553		47,553	1,635	49,188		20
21	Clerical & General Office Expenses	348,757	29,230	27,093	405,080		405,080	488,620	893,700		21
22	Employee Benefits & Payroll Taxes			979,802	979,802		979,802	17,808	997,610		22
23	Inservice Training & Education			85	85		85		85		23
24	Travel and Seminar			13,542	13,542		13,542	638	14,180		24
25	Other Admin. Staff Transportation			4,540	4,540		4,540	21,726	26,266		25
26	Insurance-Prop.Liab.Malpractice			428,605	428,605		428,605	4,745	433,350		26
27	Other (specify):* <b>Allocated Benefits</b>							85,638	85,638		27
28	<b>TOTAL General Administration</b>	474,065	29,230	3,031,127	3,534,422		3,534,422	(586,861)	2,947,561		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,610,901	824,326	4,614,550	12,049,777		12,049,777	(516,110)	11,533,667		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 Orland Park

#0041855

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			105,697	105,697		105,697	279,366	385,063			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			101,242	101,242		101,242	387,604	488,846			32
33	Real Estate Taxes							474,589	474,589			33
34	Rent-Facility & Grounds			2,099,702	2,099,702		2,099,702	(2,094,759)	4,943			34
35	Rent-Equipment & Vehicles			76,862	76,862		76,862	5,673	82,535			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,383,503	2,383,503		2,383,503	(947,527)	1,435,976			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		487,882	14,423	502,305		502,305		502,305			39
40	Barber and Beauty Shops			29,467	29,467		29,467		29,467			40
41	Coffee and Gift Shops			6,422	6,422		6,422		6,422			41
42	Provider Participation Fee			151,998	151,998		151,998		151,998			42
43	Other (specify):* <b>Non-allowable Cos</b>			163,838	163,838		163,838	(163,838)				43
44	<b>TOTAL Special Cost Centers</b>		487,882	366,148	854,030		854,030	(163,838)	690,192			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,610,901	1,312,208	7,364,201	15,287,310		15,287,310	(1,627,475)	13,659,835			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	(803)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,067)	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				9
10	Interest and Other Investment Income	(97,092)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(921)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(107,905)	43		24
25	Fund Raising, Advertising and Promotional	(20,450)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,098)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(79,791)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (316,127)		\$	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)	(1,311,348)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,311,348)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,627,475)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Orland Park

ID# 0041855

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	X-Rays-Part A	\$ (18,393)	43	1
2	Labs-Part A	(7,592)	43	2
3	Misc. Income	(2,527)	21	3
4	Legal Collection Fees	(16,465)	19	4
5	Out of period legal	(622)	19	5
6	Trust Fees	(75)	43	6
7	Non-allowable marketing salaries	(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
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(79,791)		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 Discretionary Trust	30%			Lexington Health Care		
John Samatas Discretionary Trust	30%	See attached Schedule B		Systems of Orland		
Cynthia Thiem Discretionary Trust	30%			Park Ltd. Ptsp.	Orland Park	Real estate ptsp.
Dean Sweitzer	10%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 Depreciation	\$	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	\$ 215,005	\$ 215,005	1
2	V	32 Interest expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	460,457	460,457	2
3	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	6,553	6,553	3
4	V	33 Property taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	469,915	469,915	4
5	V	34 Rental Expense	2,099,701	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(2,099,701)	5
6	V	43 Trust fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	75	75	6
7	V	43 State Replacement Tax		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	588	588	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of Orland Park, Inc. own 100%				12
13	V			of Lexington Health Care Systems of Orland Park Ltd Ptsp.				13
14	Total		\$ 2,099,701			\$ 1,152,593	\$ * (947,108)	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.	**	\$ 403	\$	403	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,149		6,149	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	153		153	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,104		1,104	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	52,694		52,694	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,708		4,708	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	231		231	21
22	V	6 Security service		Royal Management Corp.	**	8		8	22
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	7,214		7,214	23
24	V	10 Medical consultant		Royal Management Corp.	**	5,320		5,320	24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	10,005		10,005	25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	1,373		1,373	26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	126,979		126,979	27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	15,725		15,725	28
29	V	19 Professional fees		Royal Management Corp.	**	4,620		4,620	29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	665		665	30
31	V	21 Communications		Royal Management Corp.	**	156		156	31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	970		970	32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	498,610		498,610	33
34	V	21 Bank charges		Royal Management Corp.	**	1,413		1,413	34
35	V	21 Office supplies & printing		Royal Management Corp.	**	12,557		12,557	35
36	V	21 Postage		Royal Management Corp.	**	4,590		4,590	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 755,647	\$ *	755,647	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.	**	\$ 7,938	\$ 7,938	
16	V	24 Travel & seminar		Royal Management Corp.	**	638	638	
17	V	25 Auto expense		Royal Management Corp.	**	21,726	21,726	
18	V	26 Insurance general		Royal Management Corp.	**	4,745	4,745	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	85,638	85,638	
20	V	30 Depreciation		Royal Management Corp.	**	64,361	64,361	
21	V	32 Interest		Royal Management Corp.	**	17,654	17,654	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	32	32	
23	V	33 Property taxes		Royal Management Corp.	**	4,674	4,674	
24	V	34 Rent expense		Royal Management Corp.	**	4,942	4,942	
25	V	35 Equipment rental		Royal Management Corp.	**	1,430	1,430	
26	V	17 Management fees	1,337,908	Royal Management Corp.	**		(1,337,908)	
27	V	35 Auto Lease		Royal Management Corp.	**	4,243	4,243	
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V	** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.						
39	Total		\$ 1,337,908			\$ 218,021	\$ * (1,119,887)	

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Orland Park, Inc.**  
**Provider # 0041855**  
**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 Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling

**See Accountants' Compilation Report**

Facility Name &amp; ID Number

Lexington of Orland Park

# 0041855

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	30.00	See Schedule 7A	5	10.00	Salary	\$ 42,811	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00	See Schedule 7A	2	4.00	Salary	30,578	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	30.00	See Schedule 7A	2	4.00	Salary	30,578	L17, C7	3
4	Jason Samatas	VP of operations	Administrative	0.00	See Schedule 7A	10	20.00	Salary	23,012	L17, C7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	2	4.00	Salary	4,903	L21, C7	5
6											6
7	Dean Sweitzer	Owner*	Administrative	10.00	104,021	5	10.00	Salary	15,902	L21, C7	7
8		All individuals work in excess of 40 hours per week.									8
9											9
10		* Dean Sweitzer is an owner only in Lexington Health Care Center of Orland Park, Inc. He is an employee									10
11		of Royal Management Corp. and provides administrative services to Royal Management Corp. His compensation									11
12		has been allocated to all 10 Lexington facilities.									12
13								TOTAL	\$ 147,784		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

# 0041855

Report Period Beginning:

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	\$ 101,334	\$ 402	1
2	5	Utilities - gas & electric	Bed Days	748,545	10	45,421	101,334	6,149	2
3	5	Utilities - water & sewer	Bed Days	748,545	10	1,129	101,334	153	3
4	5	Utilities - maintenance office	Bed Days	748,545	10	8,141	101,334	1,102	4
5	6	Management allocation - salaries	Bed Days	748,545	10	389,246	389,246	52,694	5
6	6	Repairs & maintenance	Bed Days	748,545	10	34,773	101,334	4,707	6
7	6	Scavenger & exterminating	Bed Days	748,545	10	1,705	101,334	231	7
8	6	Security service	Bed Days	748,545	10	78	101,334	11	8
9	7	Management allocation - employee	Bed Days	748,545	10	53,283	101,334	7,213	9
10	10	Medical consultant	Bed Days	748,545	10	39,304	101,334	5,321	10
11	10	Management allocation - salaries	Bed Days	748,545	10	73,905	73,905	10,005	11
12	15	Management allocation - employee	Bed Days	748,545	10	10,117	101,334	1,370	12
13	17	Management allocation - salaries	Bed Days	748,545	10	937,986	937,986	126,980	13
14	19	Computer consultant & supplies	Bed Days	748,545	10	116,160	101,334	15,725	14
15	19	Professional fees	Bed Days	748,545	10	34,111	101,334	4,618	15
16	20	Dues & subscriptions	Bed Days	748,545	10	4,903	101,334	664	16
17	21	Communications	Bed Days	748,545	10	1,161	101,334	157	17
18	20	Advertising - help wanted	Bed Days	748,545	10	7,177	101,334	972	18
19	21	Management allocation - salaries	Bed Days	748,545	10	3,683,186	3,683,186	498,610	19
20	21	Bank charges	Bed Days	748,545	10	10,433	101,334	1,412	20
21	21	Office supplies & printing	Bed Days	748,545	10	92,754	101,334	12,557	21
22	21	Postage	Bed Days	748,545	10	33,908	101,334	4,590	22
23	21	Telephone	Bed Days	748,545	10	58,647	101,334	7,939	23
24	24	Travel and Seminar	Bed Days	748,545	10	4,702	101,334	637	24
25	TOTALS					\$ 5,645,200	\$ 5,084,323	\$ 764,219	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

# 0041855

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	\$ 101,334	\$ 21,728	1
2	26	Insurance general	Bed Days	748,545	10	35,055	101,334	4,746	2
3	27	Management allocation - employee	Bed Days	748,545	10	632,578	101,334	85,635	3
4	30	Depreciation	Bed Days	748,545	10	475,433	101,334	64,362	4
5	32	Interest	Bed Days	748,545	10	130,405	101,334	17,654	5
6	32	Amortization of mortgage costs	Bed Days	748,545	10	242	101,334	33	6
7	33	Property taxes	Bed Days	748,545	10	34,533	101,334	4,675	7
8	34	Rent expense	Bed Days	748,545	10	36,507	101,334	4,942	8
9	35	Equipment rental	Bed Days	748,545	10	10,570	101,334	1,431	9
10	35	Auto Lease	Bed Days	748,545	10	31,346	101,334	4,243	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	\$	\$ 209,449	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Orland Park

# 0041855

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Lexington Financial Services	X		Mortgage	Varies	12/29/98	\$ 9,000,000	\$ 7,315,412	2/1/26	0.0650	\$ 460,457	1								
2	L.L.C.											2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	LaSalle Bank N.A.		X	Line of Credit	Varies	4/6/02	1,650,000	540,000	5/31/08	Prime	25,484	6								
7	Shareholder	X		Working Capital	None	Various		1,799,000	Demand	Prime +1	75,758	7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 10,650,000	\$ 9,654,412			\$ 561,699	9								
<b>B. Non-Facility Related*</b>																				
10										Amortization of Mortgage Cost	6,585	10								
11										Interest Income Offset	(21,334)	11								
12										Shareholder Interest	(75,758)	12								
13										Allocated from Management Co.	17,654	13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (72,853)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 10,650,000	\$ 9,654,412			\$ 488,846	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.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2006 report.		\$	<b>507,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	<b>484,891</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(22,110)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>499,200</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>12,950</b>	5
			<b>4,674</b>	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(20,125)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>474,589</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>435,909</b>	8
	2003	<b>448,025</b>	9
	2004	<b>486,436</b>	10
	2005	<b>491,839</b>	11
	2006	<b>484,891</b>	12
<b>2006 tax bill paid:</b>		<b>\$484,891</b>	
<b>Est. tax with 3% increase:</b>		<b>\$499,437</b>	
<b>Use:</b>		<b>\$499,200</b>	

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

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

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

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

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

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

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

FACILITY NAME Lexington of Orland Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

CONTACT PERSON REGARDING THIS REPORT Sue 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>27-10-100-099-0000</u>	<u>Land &amp; Building</u>	\$ <u>484,890.50</u>	\$ <u>484,890.50</u>
2. _____	_____	\$ _____	\$ _____
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>	_____	\$ <u>132,281.84</u>	\$ <u>4,674.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>617,172.34</u>	\$ <u>489,564.50</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 Orland Park

# 0041855

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block & 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).

N/A

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

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>152,460</u>	<u>1995</u>	<u>\$ 776,408</u>	<u>1</u>
2	<u>Allocated from Management Co.</u>		<u>2002</u>	<u>21,315</u>	<u>2</u>
3	<b>TOTALS</b>	<b>152,460</b>		<b>\$ 797,723</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Orland Park

# 0041855

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	250	1996	1996	\$ 8,569,286	\$		\$ 214,232	\$ 214,232	\$ 2,461,095	4
5	10	1998	1998	63,790	1,595	40	1,595		14,353	5
6	10	2001	2001							6
7										7
8										8
	<b>Improvement Type**</b>									
9	Electrical wiring		1996	2,304	58	40	58		643	9
10	Paving		1997	11,589		40	773	773	8,113	10
11	Wiring		1998	3,932	393	40	393		3,736	11
12	Additional building costs - 10 bed addition		1999	1,808	45	10	45		407	12
13	Seal/restrip parking lot		1999	3,450	230	40	230		1,955	13
14	Wiring		1999	1,798	45	15	45		382	14
15	Roof repairs		2000	23,201	1,547	40	1,547		11,600	15
16	Electrical wiring		2000	5,732	164	15	164		1,228	16
17	Ceiling mount curtain rod hardware		2000	6,952	199	35	199		1,490	17
18	Automatic door closer/sensors		2000	3,624	242	35	242		1,812	18
19	Seal and restripe parking lot		2001	2,277	228	15	228		1,480	19
20	HVAC control		2001	2,548	255	10	255		1,656	20
21	Infrared curtains for elevator doors		2001	4,500	450	10	450		2,925	21
22	Fire alarm panel		2002	5,120	512	10	512		2,816	22
23	Parking lot lights		2002	9,975	998	10	998		5,486	23
24	Chiller room compressor		2002	8,879	888	10	888		8,879	24
25	Carpeting		2002	7,038	704	5	704		7,038	25
26	Pave and seal parking lot		2005	4,180	209	5	209		488	26
27	HVAC		2005	6,143	307	20	307		640	27
28	Electrical wiring		2005	3,637	182	20	182		394	28
29	Kitchen rehab		2005	6,360	318	20	318		874	29
30	Elevator rehab		2005	8,948	447	20	447		1,193	30
31	Lounge, lobby, and reception area rehab		2005	27,662	1,383	20	1,383		2,997	31
32	Landscaping enhancements		2006	5,795	386	20	386		515	32
33	HVAC		2006	9,300	465	15	465		504	33
34	LHI-therapy room rehab LL TCU/main therapy		2006	33,184	1,659	20	1,659		2,212	34
35										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

XI. OWNERSHIP COSTS (continued)

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

1	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 Landscaping	2007	\$ 17,383	\$ 483	15	\$ 483	\$	\$ 483	37
38 Parking lot	2007	1,120	19	20	19		19	38
39 Plumbing-Fine Dining	2007	2,068	95	20	95		95	39
40 Laundry Room Rehab	2007	37,283	1,398	20	1,398		1,398	40
41 Employee lunch room	2007	2,865	107	20	107		107	41
42 Basement Renovation	2007	1,148	24	20	24		24	42
43 Patio Improvements	2007	7,000	88	20	88		88	43
44 1st floor remodel-carpentry, flooring, plumbing, electrical- fixtures, painting	2007	1,481,886	15,436	40	15,436		15,436	44
45								45
46 1st floor remodel-carpentry, flooring, plumbing, electrical-	2007	126,266		40				46
47 Basement Renovation	2007	20,192		20				47
48 Therapy Room Renovation	2007	978						48
49								49
50								50
51								51
52								52
53								53
54 Land improvements - management company	2002	33,594		15	691	691	13,251	54
55 Building - management company	2002	261,354		40	1,418	1,418	38,659	55
56 HVAC, electrical, security system - management company	2003	2,592		30	181	181	786	56
57 Key card system - management company	2004	407		20	11	11	68	57
58 VAV TX controls - management company	2005	124		20	3	3	19	58
59 Interior Signs - Management Company	2006	90		20	5	5	6	59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 10,839,363	\$ 31,559		\$ 248,873	\$ 217,314	\$ 2,617,350	70

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	\$ 299,963	\$ 38,781	\$ 38,782	\$ 1	5	\$ 174,576	71
72	Current Year Purchases	474,425	35,356	35,356		5	35,356	72
73	Fully Depreciated Assets	94,998				5	94,998	73
74	Allocated from management co.	322,834		55,838	55,838		164,016	74
75	TOTALS	\$ 1,192,220	\$ 74,137	\$ 129,976	\$ 55,839		\$ 468,946	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 co.			51,205		6,214	6,214		33,571	79
80	TOTALS			\$ 51,205	\$	\$ 6,214	\$ 6,214		\$ 33,571	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)	\$ 12,880,511	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,696	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 385,063	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 279,367	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,119,867	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

Facility Name & ID Number Lexington of Orland Park

# 0041855

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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			4,943			6
7	TOTAL			\$ 4,943			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: \$ 78,292 Description: Copier-\$9,854; Postage Meter-\$179; Med Equip Rental-\$66,829; Alloc Mgmt. Co. \$1,430

(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			4,243	20
21	TOTAL		\$ _____	\$ 4,243	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><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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	6,380	\$ 440,816	\$	6,380	\$ 440,816	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,585	85,146		1,585	85,146	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,135	507,846		8,135	507,846	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				487,882		487,882	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Wound Therapy Other (specify): <b>Dentist</b>	L39,C3 L39,C3				4,060 10,363			10,363	13
14	<b>TOTAL</b>			\$	16,099	\$ 1,048,231	\$ 487,882	16,099	\$ 1,532,053	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 of Orland Park  
 # 0041855  
 XV. BALANCE SHEET - Unrestricted Operating Fund.

Report Period Beginning: 01/01/2007  
 Ending: 12/31/2007  
 As of 12/31/2007 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 551,262	\$ 626,666	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>1,567,358</u> )	2,170,272	2,170,272	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,151	57,151	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,778,685	\$ 2,854,089	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	97,511	97,511	12
13	Land		797,723	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	1,834,060	2,270,077	15
16	Equipment, at Historical Cost	791,311	1,243,425	16
17	Accumulated Depreciation (book methods)	(322,221)	(3,119,867)	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): <u>See Schedule 17A</u>		106,647	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,400,661	\$ 9,964,802	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,179,346	\$ 12,818,891	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 355,978	\$ 355,978	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,339,000	2,339,000	29
30	Accrued Salaries Payable	418,376	418,376	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,063	11,063	31
32	Accrued Real Estate Taxes(Sch.IX-B)		499,200	32
33	Accrued Interest Payable		30,992	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See attached schedule 17A</u>	501,116	139,890	36
37	_____			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 3,625,533	\$ 3,794,499	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,315,412	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</b> (sum of lines 39 thru 44)	\$	\$ 7,315,412	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,625,533	\$ 11,109,911	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,553,813	\$ 1,708,980	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 5,179,346	\$ 12,818,891	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington Health Care Center of Orland Park, Inc.  
 Provider # 0041855  
 1/1/07/12/31/07

Schedule 17A

XV. Balance Sheet  
 B. Long Term Assets

23. Other Long Term Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Mortgage Cost	-	163,813
Accumulated Amort of Mortgage Cost	-	(57,166)
	-	106,647

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due from Royal	(25,966)	(25,966)
Due from LHCC Chicago Ridge	908	908
Due from Lexington Financial Services		(1,880)
Due from LHCC LaGrange	2,578	2,578
Prepaid Expense		7,786
Accrued 401K	(20,569)	(20,569)
Due to	(438)	(438)
401K Withholding	5	5
Due to Republic Construction	85,212	85,212
Accrued expenses	(289,042)	(289,042)
Accrued Royal General Mgmt. Fees	(3,161)	(3,161)
Accrued Rent	(418,653)	
Accrued Wage Assignments	1,326	1,326
Advance-Biweekly Part A Payments	166,684	166,684
Interest Rate Swap		(63,333)
	(501,116)	(139,890)

SEE ACCOUNTANTS' COMPILATION REPORT

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,469,896</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post closing adjustments</b>	<b>(1,094,667)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,375,229</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>178,584</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>178,584</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,553,813</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 20,509,700	1
2	Discounts and Allowances for all Levels	(7,659,959)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,849,741	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,838,759	6
7	Oxygen	(108)	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,838,651	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	7,632	12
13	Barber and Beauty Care	34,842	13
14	Non-Patient Meals	803	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	548,947	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,715	19
20	Radiology and X-Ray	21,275	20
21	Other Medical Services	112,000	21
22	Laundry	(176)	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 747,038	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	21,334	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 21,334	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous &amp; Investment Income</u>	9,130	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,130	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,465,894	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,801,207	31
32	Health Care	6,714,148	32
33	General Administration	3,534,422	33
	<b>B. Capital Expense</b>		
34	Ownership	2,383,503	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	702,032	35
36	Provider Participation Fee	151,998	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 15,287,310	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	178,584	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 178,584	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 Orland Park

# 0041855

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	1,511	1,649	\$ 76,279	\$ 46.26	1
2	Assistant Director of Nursing	7,844	8,397	286,148	34.08	2
3	Registered Nurses	35,985	38,977	1,231,049	31.58	3
4	Licensed Practical Nurses	44,955	49,156	1,333,594	27.13	4
5	CNAs & Orderlies	136,708	147,122	1,720,366	11.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,325	14,642	170,868	11.67	8
9	Activity Director	2,704	2,896	47,026	16.24	9
10	Activity Assistants	23,594	25,333	260,000	10.26	10
11	Social Service Workers	7,345	7,815	128,520	16.45	11
12	Dietician	1,945	2,126	33,383	15.70	12
13	Food Service Supervisor	2,000	2,126	36,419	17.13	13
14	Head Cook	1,984	2,126	27,957	13.15	14
15	Cook Helpers/Assistants	14,712	15,834	137,140	8.66	15
16	Dishwashers	18,152	19,627	143,522	7.31	16
17	Maintenance Workers	4,023	4,367	55,256	12.65	17
18	Housekeepers	42,242	45,694	360,709	7.89	18
19	Laundry	8,366	8,905	65,766	7.39	19
20	Administrator	2,239	2,311	125,308	54.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,823	21,349	348,757	16.34	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	1,527	1,639	22,834	13.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	390,984	422,091	\$ 6,610,901 *	\$ 15.66	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	288	\$ 15,952	L1, C3	35
36	Medical Director	Monthly	71,200	L9, C3	36
37	Medical Records Consultant	23	1,513	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	126	5,910	L11, C3	44
45	Social Service Consultant	96	4,800	L12, C3	45
46	Other(specify) <u>Psychosocial</u>	50	2,498	L12, C3	46
47	<u>MDS</u>	127	6,559	L10,C3	47
48	<u>See Schedule 20B</u>		14,735		48
49	TOTAL (lines 35 - 48)	709	\$ 125,567		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Orland Park, Inc.

Provider # 0041855

1/1/07-12/31/07

Schedule 20B

Consultant Services

<u>Type</u>	<u>Hours</u>	<u>Amount</u>	<u>Line</u>
RehabCare	1	191	L10, C3
PA Application	364	9,244	L10, C3
Medical Consultant Montly		5,320	L10, C3
		<u>14,755</u>	

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	
<u>Lawrence Putz</u>	<u>Administrator</u>	<u>0</u>	\$ <u>125,308</u>	<u>Workers' Compensation Insurance</u>	\$ <u>102,432</u>	<u>IDPH License Fee</u>	\$ <u>975</u>	
				<u>Unemployment Compensation Insurance</u>	<u>96,902</u>	<u>Advertising: Employee Recruitment</u>	<u>42,988</u>	
				<u>FICA Taxes</u>	<u>480,328</u>	<u>Health Care Worker Background Check</u>	<u>800</u>	
				<u>Employee Health Insurance</u>	<u>211,687</u>	(Indicate # of checks performed <u>80</u> )		
				<u>Employee Meals</u>	<u>17,808</u>	<u>Patient Background Checks</u>	<u>1,200</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Fees</u>	<u>1,257</u>	
				<u>401K Contributions</u>	<u>20,585</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>333</u>	
				<u>Life Insurance</u>	<u>6,295</u>			
				<u>Other Employee Benefits</u>	<u>61,573</u>			
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>125,308</u></b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>\$ <u>997,610</u></b>	
<b>(List each licensed administrator separately.)</b>				<b>G. Schedule of Travel and Seminar**</b>				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			Description	
Description			Amount	Description	Line #	Amount		
<u>Management Fees-Royal Operating</u>			\$ <u>883,028</u>				<u>Out-of-State Travel</u>	\$
<u>Management Fees-Royal General</u>			<u>454,880</u>					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ <u>1,337,908</u></b>	<b>TOTAL</b>			<b>\$</b>	
<b>(Attach a copy of any management service agreement)</b>				<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>			<b>\$ <u>191,999</u></b>	
C. Professional Services				G. Schedule of Travel and Seminar**			Description	
Vendor/Payee	Type			Amount				
<u>Grabowski Law Center, LCC</u>	<u>Collections</u>			\$ <u>16,308</u>				
<u>Cassiday Schade, LLP</u>	<u>Legal</u>			<u>60,866</u>				
<u>Freedman Anselmo Lindberg</u>	<u>Collections</u>			<u>156</u>				
<u>James Samatas</u>	<u>Legal</u>			<u>100</u>				
<u>McGladrey &amp; Pullen, LLP</u>	<u>Accounting</u>			<u>4,299</u>				
<u>McGladrey &amp; Pullen, LLP</u>	<u>Accounting</u>			<u>21,632</u>				
<u>Personnel Planners</u>	<u>U/C Consulting</u>			<u>1,740</u>				
<u>Reed Smith/Sachnoff &amp; Weaver</u>	<u>Legal</u>			<u>48,372</u>				
<u>RSM McGladrey, Inc.</u>	<u>Accounting</u>			<u>4,158</u>				
<u>Scott &amp; Krause</u>	<u>Legal</u>			<u>171</u>				
<u>Serpico Novelle Petrosino</u>	<u>Legal</u>			<u>2,338</u>				
<u>See attached schedule 21C</u>				<u>31,859</u>				
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>191,999</u></b>	<b>TOTAL</b>			<b>\$</b>	
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>				<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>			<b>\$ <u>14,180</u></b>	
							<u>Allocated from mgmt. Co.</u>	<u>638</u>
							<u>Seminar Expense</u>	<u>13,542</u>
							<u>Entertainment Expense</u>	( )
							<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	<b>\$ <u>14,180</u></b>

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

\*\*See instructions.

Lexington Health Care Center of Orland Park, Inc.

FYE: 12/31/07

Provider Number: 0041855

Schedule F

XIX. Support Schedules

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
ING	401K Audit	1,148
Systematic Mgmt Systems	Billing Services	5,118
National Data Care Corp	Computer Consulting	4,202
Information Controls	Computer Consulting	723
AAOD	Computer Consulting	512
Ehealth	Computer Consulting	2,400
Alperian Technology	Computer Consulting	215
Krakau	Computer Consulting	675
Action Computer Service	Computer Consulting	324
Microsoft	Computer Consulting	5,598
Visual Click	Computer Consulting	97
CDW	Computer Consulting	1,059
Lanac	Computer Consulting	5,635
Lintech	Computer Consulting	3,137
Royal/Computer Service	Computer Consulting	311
Royal/Internal Marketing	Computer Consulting	650
Royal/Andrew Campbell Photography	Computer Consulting	55
		<u>31,859</u>
Total Professional Services		<u>191,999</u>
Allocated from management co.		
James Samatas	Legal-filing fees	12
Sachnoff & Weaver	Legal	203
McGladrey & Pullen LLP	Accounting	467
RSM McGladrey	Accounting	679
Aronberg, Goldgehn Davis	Accounting	386
Gilson Labus & Silverman	Accounting	628
ING Life & Annuity	Pension Consultation	6
Elizabeth Schwarz	Physician Credentialing Consultant	226
Pension Administrators, Inc.	401K Administration	636
Addison Search	Billing Consulting	61
Gene Whitehorn	Medicaid Reimb. Specialist	1,141
Lintech	Computer Consulting	5,504
Lanac Technology	Computer Consulting	4,718
Lifecare software, Inc.	Computer Consulting	3,145
CDW Direct	Computer Consulting	2,359
		<u>20,170</u>
Allocated from Samvest of Lombard II		
Gilson, Labus & Silverman	Accounting	<u>175</u>
Allocated from building partnership		<u>-</u>
Non-Allowable Legal		
MCD 4 & 5	Grabowski Law Center (Collections)	(16,308)
	Freedman Anselmo Lindberg (Collections)	(156)
	Cassiday Shade	(551)
	Reed Smith	(72)
		<u>(17,087)</u>
Total, Agrees to Schedule V, Line 19, Column 8		<u>195,257</u>

**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	<b>TOTALS</b>		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park# 0041855Report 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? 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. \$ 78,931 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. \$ 151,998  
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. \$ 17,808 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 803
- (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