

Facility Name & ID Number Lexington of Schaumburg

0036095 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>224</u>	Skilled (SNF)	<u>214</u>	<u>81,710</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>224</u>	TOTALS	<u>214</u>	<u>81,710</u>	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	<u>7,871</u>	<u>1,350</u>	<u>10,081</u>	<u>19,302</u>	8
9	SNF/PED					9
10	ICF	<u>43,486</u>	<u>5,768</u>	<u>3,422</u>	<u>52,676</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>51,357</u>	<u>7,118</u>	<u>13,503</u>	<u>71,978</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.09%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES NO Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
 Date started 04/01/90

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 9,363

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07
 * All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Schaumburg, Inc.
Provider # 0036095
1/1/07-12/31/07

Schedule 2A

Licensed Bed Days

<u>Start Date</u>	<u>End Date</u>	<u># of Days</u>	<u># of Beds</u>	<u>Licensed Bed Days</u>
1/1/2007	12/27/2007	360	224	80,640
12/27/2007	12/31/2007	5	214	1,070
Total Licensed Bed Days				<u>81,710</u>
Total Census				<u>71,978</u>
Percent Occupancy				<u><u>88.09%</u></u>

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	363,359	37,106	18,833	419,298		419,298		419,298	1	
2	Food Purchase		325,033		325,033		325,033	(14,921)	310,112	2	
3	Housekeeping	347,436	44,755		392,191		392,191	324	392,515	3	
4	Laundry	83,992	20,476		104,468		104,468		104,468	4	
5	Heat and Other Utilities			243,858	243,858		243,858	5,970	249,828	5	
6	Maintenance	34,444		151,665	186,109		186,109	46,480	232,589	6	
7	Other (specify):* Mgmt Co Alloc Benef							5,816	5,816	7	
8	TOTAL General Services	829,231	427,370	414,356	1,670,957		1,670,957	43,669	1,714,626	8	
	B. Health Care and Programs										
9	Medical Director			40,100	40,100		40,100		40,100	9	
10	Nursing and Medical Records	4,305,268	219,502	154,940	4,679,710		4,679,710	12,357	4,692,067	10	
10a	Therapy			855,244	855,244		855,244		855,244	10a	
11	Activities	250,492	29,988	6,849	287,329		287,329		287,329	11	
12	Social Services	88,685		8,559	97,244		97,244		97,244	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* Mgmt Co Alloc Benef							1,104	1,104	15	
16	TOTAL Health Care and Programs	4,644,445	249,490	1,065,692	5,959,627		5,959,627	13,461	5,973,088	16	
	C. General Administration										
17	Administrative	111,410		1,113,482	1,224,892		1,224,892	(1,011,093)	213,799	17	
18	Directors Fees									18	
19	Professional Services			80,391	80,391		80,391	7,760	88,151	19	
20	Dues, Fees, Subscriptions & Promotions			43,258	43,258		43,258	1,318	44,576	20	
21	Clerical & General Office Expenses	264,553	20,823	27,545	312,921		312,921	377,512	690,433	21	
22	Employee Benefits & Payroll Taxes			857,507	857,507		857,507	14,693	872,200	22	
23	Inservice Training & Education			1,193	1,193		1,193		1,193	23	
24	Travel and Seminar			6,935	6,935		6,935	513	7,448	24	
25	Other Admin. Staff Transportation			1,123	1,123		1,123	17,520	18,643	25	
26	Insurance-Prop.Liab.Malpractice			227,334	227,334		227,334	3,827	231,161	26	
27	Other (specify):* Mgmt Co Alloc Benef							69,051	69,051	27	
28	TOTAL General Administration	375,963	20,823	2,358,768	2,755,554		2,755,554	(518,899)	2,236,655	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,849,639	697,683	3,838,816	10,386,138		10,386,138	(461,769)	9,924,369	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Lexington of Schaumburg

#0036095

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			136,188	136,188		136,188	226,468	362,656			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,916	43,916		43,916	311,669	355,585			32
33	Real Estate Taxes							482,826	482,826			33
34	Rent-Facility & Grounds			1,826,056	1,826,056		1,826,056	(1,822,071)	3,985			34
35	Rent-Equipment & Vehicles			44,669	44,669		44,669	4,576	49,245			35
36	Other (specify):*											36
37	TOTAL Ownership			2,050,829	2,050,829		2,050,829	(796,532)	1,254,297			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		399,227	6,226	405,453		405,453		405,453			39
40	Barber and Beauty Shops			27,326	27,326		27,326		27,326			40
41	Coffee and Gift Shops			7,951	7,951		7,951		7,951			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Non-allowable Cos			103,733	103,733		103,733	(103,733)				43
44	TOTAL Special Cost Centers		399,227	267,876	667,103		667,103	(103,733)	563,370			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,849,639	1,096,910	6,157,521	13,104,070		13,104,070	(1,362,034)	11,742,036			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095

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	(228)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,921)	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	(18,149)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,117)	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	(325)	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	(56,747)	43		24
25	Fund Raising, Advertising and Promotional	(20,453)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(110)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(98,438)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (200,488)		\$	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)	(1,161,546)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,161,546)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,362,034)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Schaumburg

ID# 0036095

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (5,510)	43	1
2	X-Rays - Part A	(14,580)	43	2
3	Non-Allowable Collection Fees	(8,250)	19	3
4	Non-Allowable out of period legal fees	(494)	19	4
5	Marketing Salary	(44,180)	21	5
6	Shareholder Interest	(23,521)	32	6
7	Trust Fees	(50)	43	7
8	Miscellaneous Income	(1,853)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(98,438)		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
See attached Schedule B		See attached Schedule B		Sambell of Schaumburg		
				Ltd. Ptsp.	Schaumburg	Real estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization				
1	V	19 Professional Fees	\$	Sambell of Schaumburg Limited Partnership	**	\$ 100	\$	100	1	
2	V	30 Depreciation		Sambell of Schaumburg Limited Partnership	**	174,570		174,570	2	
3	V	32 Amortization of mortgage costs		Sambell of Schaumburg Limited Partnership	**	6,902		6,902	3	
4	V	32 Interest expense		Sambell of Schaumburg Limited Partnership	**	332,176		332,176	4	
5	V	33 Property taxes		Sambell of Schaumburg Limited Partnership	**	479,056		479,056	5	
6	V	34 Rental expense	1,826,056	Sambell of Schaumburg Limited Partnership	**			(1,826,056)	6	
7	V	43 State replacement tax		Sambell of Schaumburg Limited Partnership	**	30		30	7	
8	V	43 Trust fees		Sambell of Schaumburg Limited Partnership	**	50		50	8	
9	V								9	
10	V								10	
11	V								11	
12	V								12	
13	V	** The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Sambell of Schaumburg Limited Partnership.								13
14	Total		\$ 1,826,056			\$ 992,884	\$ *	(833,172)	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg# 0036095Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 324	\$	324	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,958		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.	**	402,051		402,051	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.	**	3,701		3,701	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% or Royal Management Corp.							38
39	Total		\$			\$ 609,305	\$ *	609,305	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg# 0036095Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 6,402	\$	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.	**	51,898		51,898	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	1,113,482	Royal Management Corp.	**			(1,113,482)	26	
27	V	35 Auto Lease Expense		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 Streamwood, Inc. own 100% of Royal Management Corp.								38
39	Total		\$ 1,113,482			\$ 175,803	\$ *	(937,679)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Schaumburg, Inc.

Provider # 0036095

1/1/07 - 12/31/07

Schedule B

VII. Related Parties

Owners

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

Related Nursing Homes

City

Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number

Lexington of Schaumburg

#

0036095

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	3	6.00	Salary	3,952	L21, C7	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 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 Schaumburg # 0036095 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	3	Housekeeping supplies	Bed Days	748,545	10	\$ 2,970	\$ 81,710	\$ 324	1
2	5	Utilities - gas & electric	Bed Days	748,545	10	45,421	81,710	4,958	2
3	5	Utilities - water & sewer	Bed Days	748,545	10	1,129	81,710	123	3
4	5	Utilities - maintenance office	Bed Days	748,545	10	8,141	81,710	889	4
5	6	Management allocation - salaries	Bed Days	748,545	10	389,246	389,246	42,489	5
6	6	Repairs & maintenance	Bed Days	748,545	10	34,773	81,710	3,796	6
7	6	Scavenger & exterminating	Bed Days	748,545	10	1,705	81,710	186	7
8	6	Security service	Bed Days	748,545	10	78	81,710	9	8
9	7	Management allocation - employe	Bed Days	748,545	10	53,283	81,710	5,816	9
10	10	Medical consultant	Bed Days	748,545	10	39,304	81,710	4,290	10
11	10	Management allocation - salaries	Bed Days	748,545	10	73,905	73,905	8,067	11
12	15	Management allocation - employe	Bed Days	748,545	10	10,117	81,710	1,104	12
13	17	Management allocation - salaries	Bed Days	748,545	10	937,986	937,986	102,389	13
14	19	Computer consultant & supplies	Bed Days	748,545	10	116,160	81,710	12,680	14
15	19	Professional fees	Bed Days	748,545	10	34,111	81,710	3,724	15
16	20	Dues & subscriptions	Bed Days	748,545	10	4,903	81,710	535	16
17	21	Communications	Bed Days	748,545	10	1,161	81,710	127	17
18	20	Advertising - help wanted	Bed Days	748,545	10	7,177	81,710	783	18
19	21	Management allocation - salaries	Bed Days	748,545	10	3,683,186	3,683,186	402,051	19
20	21	Bank charges	Bed Days	748,545	10	10,433	81,710	1,139	20
21	21	Office supplies & printing	Bed Days	748,545	10	92,754	81,710	10,125	21
22	21	Postage	Bed Days	748,545	10	33,908	81,710	3,701	22
23	21	Telephone	Bed Days	748,545	10	58,647	81,710	6,402	23
24	24	Travel and Seminar	Bed Days	748,545	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 Schaumburg

0036095 Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	748,545	10	\$ 160,505	\$ 81,710	\$ 17,520	1
2	26	Insurance general	Bed Days	748,545	10	35,055	81,710	3,827	2
3	27	Management allocation - employe	Bed Days	748,545	10	632,578	81,710	69,051	3
4	30	Depreciation	Bed Days	748,545	10	475,433	81,710	51,898	4
5	32	Interest	Bed Days	748,545	10	130,405	81,710	14,235	5
6	32	Amortization of mortgage costs	Bed Days	748,545	10	242	81,710	26	6
7	33	Property taxes	Bed Days	748,545	10	34,533	81,710	3,770	7
8	34	Rent expense	Bed Days	748,545	10	36,507	81,710	3,985	8
9	35	Equipment rental	Bed Days	748,545	10	10,570	81,710	1,154	9
10	35	Auto lease	Bed Days	748,545	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 Schaumburg

0036095

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Lexington Financial					\$		\$		1									
2	Services, LLC	X		Mortgage	Varies	4/25/01	6,200,000	5,293,334	2/1/26	Variable	332,176	2							
3												3							
4												4							
5												5							
Working Capital																			
6	LaSalle Bank, N.A.		X	Working Capital	Varies	4/6/02	1,350,000	415,000	5/31/08	Prime	20,395	6							
7	Shareholder Loan	X		Working Capital	None	Varies	830,000	830,000	Demand	Various	23,521	7							
8												8							
9	TOTAL Facility Related						\$ 8,380,000	\$ 6,538,334			\$ 376,092	9							
B. Non-Facility Related*																			
10									Amortization of loan costs		6,902	10							
11									Disallow Shareholder interest expense		(23,521)	11							
12									Offset interest income		(18,149)	12							
13									Allocated from Home Office		14,261	13							
14	TOTAL Non-Facility Related						\$	\$			\$ (20,507)	14							
15	TOTALS (line 9+line14)						\$ 8,380,000	\$ 6,538,334			\$ 355,585	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 Schaumburg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036095

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>07-27-201-039-000</u>	<u>Land & Building</u>	\$ <u>390,988.93</u>	\$ <u>390,988.93</u>
2. <u>Royal Management Corp. (Samvest of</u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u>Schaumburg II)</u>	<u>Land & Building</u>	\$ <u>132,282.00</u>	\$ <u>3,770.00</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>523,270.93</u>	\$ <u>394,758.93</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 Schaumburg# 0036095

Report Period Beginning:

01/01/2007 Ending:12/31/2007**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 85,541 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3C. 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/AF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: _____ 4. Dates Incurred: N/ANature of Costs: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>230,000</u>	<u>1988</u>	<u>\$ 211,532</u>	<u>1</u>
2	<u>Allocated from Management Company</u>		<u>2002</u>	<u>17,683</u>	<u>2</u>
3	TOTALS	230,000		\$ 229,215	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095

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	1990	1990	\$ 6,091,126	\$	35	\$ 174,032	\$ 174,032	\$ 3,086,247	4
5	9	1995	1995	146,217	4,178	35	4,178		52,220	5
6										6
7										7
8										8
Improvement Type**										
9	Building improvements		1991	3,521		10			3,491	9
10	Building improvements		1992	859	25	35	25		381	10
11	Land improvements		1992	5,764		20	288	288	4,466	11
12	Land improvements		1992	5,000		20	250	250	3,625	12
13	Fan coil units in offices		1996	5,149	147	35	147		1,692	13
14	Basement rehab		1997	14,697	245	10	245		14,697	14
15	Brick		1997	1,500	43	35	43		446	15
16	Dining room rehab		1997	6,422	428	10	428		6,422	16
17	Parking lot repave and restripe		1998	2,777	278	10	278		2,638	17
18	Wiring		1998	3,667	367	10	367		3,484	18
19	Retile 2nd and 3rd floor corridors		1998	10,100	1,010	10	1,010		9,595	19
20	Plumbing for HVAC		1998	2,263		5			2,263	20
21	Lobby-floor tile		1999	7,478	748	10	748		6,605	21
22	Wallpaper-labor		1999	9,705	970	10	970		8,492	22
23	New patio		1999	19,039	1,269	15	1,269		10,471	23
24	New pay phone/wiring		1999	2,975	298	10	298		2,455	24
25	Roof repairs		2000	9,625	963	10	963		7,219	25
26	Water heater		2000	6,688	669	10	669		5,016	26
27	Automatic door		2000	1,300	130	10	130		975	27
28	Rehab project - paint resident rooms, carpet hallways, and tile		2000	52,760	5,276	10	5,276		39,570	28
29	Water heater and storage tanks		2001	12,102	1,210	10	1,210		8,472	29
30	Garbage area		2001	4,788	479	20	479		3,112	30
31										31
32										32
33										33
34										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

Facility Name & ID Number Lexington of Schaumburg

0036095

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Roof	2002	\$ 25,600	\$ 2,560	10	\$ 2,560	\$	\$ 13,653	37
38	Facility rehab - paint resident rooms, carpet hallways, and tile	2002	327,253	16,363	20	16,363		104,549	38
39	Elevator electronic curtain	2002	4,500	450	10	450		2,475	39
40	Elevator upgrade	2002	5,471	547	10	547		3,009	40
41	Painting and decorating	2003	13,477	1,348	10	1,348		5,391	41
42	Electrical improvements	2003	844	42	20	42		172	42
43	Repave parking lot	2004	28,840	721	40	721		2,463	43
44	Dining room remodel - paint	2004	11,387	569	20	569		2,088	44
45	Landscaping	2005	593	30	20	30		72	45
46	HVAC upgrade	2005	17,734	887	20	887		1,847	46
47	Generator upgrade	2005	19,650	983	20	983		2,948	47
48	Window replacement	2005	3,899	195	20	195		455	48
49	Flooring replacement	2005	1,483	74	20	74		173	49
50	Lobby, lounge and reception rehab	2005	27,180	1,359	20	1,359		2,718	50
51	Therapy room rehab	2005	35,135	1,757	20	1,757		3,806	51
52	Create first floor therapy room	2005	32,045	1,602	20	1,602		4,540	52
53	Create transitional care unit	2005	29,170	1,458	20	1,458		3,039	53
54	Basement renovation	2005	5,996	300	20	300		600	54
55	Countertops	2005	845	169	5	169		451	55
56	Interior signs	2005	4,412	882	5	882		1,912	56
57	Window treatments	2005	912	182	5	182		441	57
58	Wall covering	2005	439	88	5	88		198	58
59	Panel Brick Replacement	2006	17,387	869	20	869		1,014	59
60	Landscaping Enhancement	2006	7,608	507	15	507		634	60
61	HVAC	2006	12,232	612	20	612		663	61
62	Sink	2006	2,331	117	20	117		194	62
63	TCU Units	2006	16,379	819	20	819		1,024	63
64	Employee lunch room rehab	2006	8,127	406	20	406		610	64
65	Dining room rehab	2006	2,357	118	20	118		177	65
66	Basement renovation	2006	9,465	473	20	473		631	66
67	Oxygen room rehab	2006	2,662	133	20	133		178	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,100,935	\$ 55,353		\$ 229,923	\$ 174,570	\$ 3,446,179	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Schaumburg

0036095

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,100,935	\$ 55,353		\$ 229,923	\$ 174,570	\$ 3,446,179	1
2	Replace Sidewalk	2007	14,625	305	20	305		305	2
3	Landscaping	2007	15,700	196	20	196		196	3
4	Emergency A/C	2007	15,545	453	20	453		453	4
5	1st Floor Remodel - Carpentry, Flooring, Plumbing, Paint	2007	676,072	5,634	40	5,634		5,634	5
6	Bathroom Faucets	2007	12,358	51	20	51		51	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17	Land improvements - management company	2002	27,870		15	464	464	10,993	17
18	Building - management company	2002	216,828		40	1,355	1,355	32,072	18
19	HVAC, electrical, security system - management company	2003	2,149		30	37	37	653	19
20	Key card system - management company	2004	338		20	5	5	58	20
21	VAV TX controls - management company	2005	103		20	1	1	15	21
22	Interior Signs - management company	2006	75		5			6	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)		\$ 8,082,598	\$ 61,992		\$ 238,424	\$ 176,432	\$ 3,496,615	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 444,984	\$ 59,757	\$ 59,757	\$	5-10	\$ 210,311	71
72	Current Year Purchases	230,955	14,440	14,440		5	14,440	72
73	Fully Depreciated Assets	7,095				5-10	7,095	73
74	Allocated from management company	267,831		45,025	45,025		136,072	74
75	TOTALS	\$ 950,865	\$ 74,197	\$ 119,222	\$ 45,025		\$ 367,918	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 company			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 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)	\$ 9,305,162	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 136,189	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 362,656	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 226,467	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,892,386	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A

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

If NO, see instructions.

YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	<u>Allocated from management company</u>			<u>3,985</u>			6
7	TOTAL			\$ <u>3,985</u>			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: \$ 45,823 Description: Copier-\$4,905; Postage-\$194; Copier-\$4,679; Oxygen-\$15,642; Med Equip-\$19,249; Alloc Mgmt 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	<u>Allocation from Management Co</u>			<u>3,422</u>	19
20					20
21	TOTAL		\$	\$ <u>3,422</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2008 \$ _____

13. /2009 \$ _____

14. /2010 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,278	\$ 285,933	\$	5,278	\$ 285,933	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,082	81,803		1,082	81,803	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,493	487,508		6,493	487,508	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				399,227		399,227	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Wound Therapy	39(3)				6,226			6,226	13
14	TOTAL			\$	12,853	\$ 861,470	\$ 399,227	12,853	\$ 1,260,697	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

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Schaumburg # 0036095 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 219,518	\$ 287,810	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>900,470</u>)	1,723,435	1,723,435	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,316	48,316	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,991,269	\$ 2,059,561	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	40,257	40,257	12
13	Land		229,215	13
14	Buildings, at Historical Cost		6,091,126	14
15	Leasehold Improvements, at Historical Cost	1,733,327	1,991,472	15
16	Equipment, at Historical Cost	683,035	993,349	16
17	Accumulated Depreciation (book methods)	(590,326)	(3,892,386)	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>Mortgage Cost, net</u>		127,109	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,866,293	\$ 5,580,142	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,857,562	\$ 7,639,703	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 292,497	\$ 292,497	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,245,000	1,245,000	29
30	Accrued Salaries Payable	266,444	266,444	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,534	6,534	31
32	Accrued Real Estate Taxes(Sch.IX-B)		505,200	32
33	Accrued Interest Payable		22,360	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	1,091,300	535,595	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,901,775	\$ 2,873,630	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,293,334	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Interest rate swap liability</u>		45,683	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,339,017	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,901,775	\$ 8,212,647	46
47	TOTAL EQUITY(page 18, line 24)	\$ 955,787	\$ (572,944)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,857,562	\$ 7,639,703	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Schaumburg, Inc.
Provider #0036095
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	(43,495)	(43,495)
Due from Lombard	(497)	(497)
Due from Lexington Financial Service	-	(1,356)
Due from Bloomingdale	(678)	(678)
Due from Lake Zurich	(516)	(516)
Due from Streamwood	(1,130)	(1,130)
Escrow-Insurance	(54,701)	(54,701)
Bond Withholding	(529)	(529)
401k Withholding	(3,161)	(3,161)
Accrued 401K	(22,008)	(22,008)
Due to Lexington Financial Service	(312)	(312)
Due to Republic Construction	(19,483)	(19,483)
Accrued Expenses	(296,472)	(296,472)
Accrued Royal Gen Mgmt Fees	(67,299)	(67,299)
Accrued Rent	(557,061)	-
Accrued Wage Assignments	(135)	(135)
Advance Bi-Weekly Payments	(24,091)	(24,091)
Withholding - Dental Insurance	290	290
Withholding - EP/CI/WL	254	254
Withholding - Short-term Disability	159	159
Due from Ins Carrier	(435)	(435)
	<u>(1,091,300)</u>	<u>(535,595)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,326,895	1
2	Restatements (describe):		2
3	Post Closing Adjustment	460,081	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,786,976	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(237,189)	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	(594,000)	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)	\$ (831,189)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 955,787	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.

	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 17,307,223	1
2	Discounts and Allowances for all Levels	(7,010,374)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,296,849	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,711,679	6
7	Oxygen	1,200	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,712,879	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	10,184	12
13	Barber and Beauty Care	31,514	13
14	Non-Patient Meals	228	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	657,341	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,799	19
20	Radiology and X-Ray	20,593	20
21	Other Medical Services	82,864	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 834,523	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	20,777	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,777	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	1,853	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,853	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,866,881	30

	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,670,957	31
32	Health Care	5,959,627	32
33	General Administration	2,755,554	33
B. Capital Expense			
34	Ownership	2,050,829	34
C. Ancillary Expense			
35	Special Cost Centers	544,463	35
36	Provider Participation Fee	122,640	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,104,070	40
41	Income before Income Taxes (line 30 minus line 40)**	(237,189)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (237,189)	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 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 Schaumburg**

0036095

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	1,495	1,765	\$ 90,640	\$ 51.35	1
2	Assistant Director of Nursing	4,194	4,493	151,841	33.80	2
3	Registered Nurses	52,749	58,017	1,934,354	33.34	3
4	Licensed Practical Nurses	11,114	12,889	348,947	27.07	4
5	CNAs & Orderlies	109,579	118,686	1,474,632	12.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17,366	18,645	274,135	14.70	8
9	Activity Director	1,777	1,926	30,985	16.09	9
10	Activity Assistants	19,692	21,222	219,507	10.34	10
11	Social Service Workers	4,585	5,080	88,685	17.46	11
12	Dietician	2,019	2,154	38,800	18.01	12
13	Food Service Supervisor	1,891	2,114	36,882	17.45	13
14	Head Cook	1,939	2,074	25,702	12.39	14
15	Cook Helpers/Assistants	11,144	11,997	114,384	9.53	15
16	Dishwashers	18,540	19,593	147,591	7.53	16
17	Maintenance Workers	1,841	2,105	34,444	16.36	17
18	Housekeepers	40,218	43,289	347,436	8.03	18
19	Laundry	10,212	11,000	83,992	7.64	19
20	Administrator	2,018	2,265	111,410	49.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,403	17,025	264,553	15.54	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	2,029	2,166	30,719	14.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	329,805	358,505	\$ 5,849,639 *	\$ 16.32	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	389	\$ 18,833	1(3)	35
36	Medical Director	Monthly	40,100	9(3)	36
37	Medical Records Consultant	29	1,122	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	122	5,734	11(3)	44
45	Social Service Consultant	50	5,063	12(3)	45
46	Other(specify) <u>MDS Consultant</u>	143	7,417	10(3)	46
47	<u>Psychosocial Consultant</u>	61	3,496	12(3)	47
48	<u>See Attached Schedule 20A</u>		11,299	10(3)	48
49	TOTAL (lines 35 - 48)	794	\$ 95,464		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,603	\$ 82,620	10(3)	50
51	Licensed Practical Nurses	988	38,385	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,591	\$ 121,005		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Schaumburg, Inc.

Provider # 0036095

1/1/07-12/31/07

Schedule 20A

XVIII. B. Consultant Services

Service	Schedule & Line Reference	Number of Hrs. Paid & Accrued	Cost
PA Application	L10, C3	267	7,009
Medical Consultant	L10, C3	Monthly	4,290
		<u>267</u>	<u>11,299</u>

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Schaumburg

0036095

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	
Delnez Vazifdar	Administrator	0	\$ 32,730	Workers' Compensation Insurance	\$ 91,772	IDPH License Fee	\$	
Theresa Bowen	Administrator	0	78,680	Unemployment Compensation Insurance	52,082	Advertising: Employee Recruitment	30,231	
				FICA Taxes	425,330	Health Care Worker Background Check		
				Employee Health Insurance	216,214	(Indicate # of checks performed <u>75</u>)	748	
				Employee Meals	14,693	Patient Background Checks <u>112.2</u>	1,122	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	7,890	
				401(k) Contribution	22,790	Miscellaneous Dues & Subscriptions	3,267	
				Other Employee Benefits	44,497			
				Employee Life Insurance	4,822			
TOTAL (agree to Schedule V, line 17, col. 1)						Management Company Allocation	1,318	
(List each licensed administrator separately.)			\$ 111,410			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-Royal Operating			\$ 732,582					
Management Fees-Royal General			380,900					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,113,482					
(Attach a copy of any management service agreement)								
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
McGladrey & Pullen, LLP	Accounting		\$ 22,083	N/A			Out-of-State Travel	\$
RSM McGladrey, Inc.	Accounting		4,689					
ING	401 (k)		48					
Cassiday Schade	Legal		7,980				In-State Travel	
Grabowski Law Center, LLC	Collections		8,250					
James Samatas	Legal		100					
LaSalle Bank	Financial Services		156					
Moody's	Financial Services		644					
Personnel Planners	U/C Consultants		1,110					
Reed Smith/Sachnoff & Weaver	Legal		6,075					
Scott & Krause	Financial Services		171					
See Schedule 21C			29,085					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 80,391					
				TOTAL		\$ 872,200		
				TOTAL (agree to Schedule V, line 22, col.8)				
				TOTAL (agree to Sch. V, line 20, col. 8)				\$ 44,576
				TOTAL (agree to Sch. V, line 24, col. 8)				\$ 7,448

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Schaumburg, Inc.
 Provider #0036095
 1/1/07 - 12/31/07

Schedule 21C

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Systematic Management Systems	Billing Services	5,858
ING	401k Consulting	1,606
National Datacare Corporation	Computer Consulting	1,799
Information Controls, Inc.	Computer Consulting	578
AAOD	Computer Consulting	512
eHealth Solutions	Computer Consulting	2,400
Alperian Technology	Computer Consulting	215
Krakau Business	Computer Consulting	656
Action Computer Service	Computer Consulting	324
Microsoft	Computer Consulting	5,386
Visual Click	Computer Consulting	97
CDW	Computer Consulting	1,016
Lanac	Computer Consulting	4,485
Lintech	Computer Consulting	3,137
Computer Service Website	Computer Consulting	311
Internet Marketing	Computer Consulting	650
Andrew Campbell Photography	Computer Consulting	55
		<u>29,085</u>

Total, Agrees to Schedule V, Line 19, Column 3 80,391

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 Consulting	6
Elizabeth Schwarz	Physician Credentialing Consultant	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 Consulting	Computer Consulting	3,804
Lifecare Software, Inc.	Computer Consulting	2,536
CDW Direct	Computer Consulting	1,902
		<u>16,263</u>

Real estate entity
 James Samtas Legal-filing fees 100

Allocated from Samvest of Lombard II
 Gilson, Labus & Silverman Accounting 141

Nonallowable legal fees
 Cassidy Schade Legal (444)
 Grabowski Law Center, LLC Collections (8,250)
 Lexington Financial Services Legal (50)
(8,744)

Total, Agrees to Schedule V, Line 19, Column 8 88,151

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 65,259 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 benefits on Schedule V. \$ 14,693 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? 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? N/A
- 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