

Facility Name & ID Number Lexington of Streamwood

0037002 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	214	81,710	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	214	81,710	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,960	1,249	9,404	17,613	8
9	SNF/PED					9
10	ICF	35,723	4,105	1,654	41,482	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,683	5,354	11,058	59,095	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.32%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/08/91

J. Was the facility purchased or leased after January 1, 1978?

YES Date New Construction NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 214 and days of care provided 9,202

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 Streamwood, Inc.
Provider # 0037002
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>59,095</u>
Percent Occupancy				<u><u>72.32%</u></u>

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 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	351,817	30,326	18,902	401,045		401,045		401,045		1
2	Food Purchase		265,779		265,779		265,779	(13,444)	252,335		2
3	Housekeeping	336,737	40,315		377,052		377,052	324	377,376		3
4	Laundry	69,637	16,155		85,792		85,792		85,792		4
5	Heat and Other Utilities			232,448	232,448		232,448	5,970	238,418		5
6	Maintenance	27,929		144,801	172,730		172,730	46,480	219,210		6
7	Other (specify):* Mgmt Co - Allocated							5,816	5,816		7
8	TOTAL General Services	786,120	352,575	396,151	1,534,846		1,534,846	45,146	1,579,992		8
	B. Health Care and Programs										
9	Medical Director			63,000	63,000		63,000		63,000		9
10	Nursing and Medical Records	3,661,848	262,843	193,647	4,118,338		4,118,338	12,357	4,130,695		10
10a	Therapy			718,839	718,839		718,839		718,839		10a
11	Activities	221,959	27,580	6,358	255,897		255,897		255,897		11
12	Social Services	126,723		7,525	134,248		134,248		134,248		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co - Allocated							1,104	1,104		15
16	TOTAL Health Care and Programs	4,010,530	290,423	989,369	5,290,322		5,290,322	13,461	5,303,783		16
	C. General Administration										
17	Administrative	106,142		1,041,301	1,147,443		1,147,443	(938,912)	208,531		17
18	Directors Fees										18
19	Professional Services			117,281	117,281		117,281	7,690	124,971		19
20	Dues, Fees, Subscriptions & Promotions			134,429	134,429		134,429	718	135,147		20
21	Clerical & General Office Expenses	242,871	36,239	19,931	299,041		299,041	375,041	674,082		21
22	Employee Benefits & Payroll Taxes			786,238	786,238		786,238	13,196	799,434		22
23	Inservice Training & Education			876	876		876		876		23
24	Travel and Seminar			9,457	9,457		9,457	513	9,970		24
25	Other Admin. Staff Transportation			272	272		272	17,520	17,792		25
26	Insurance-Prop.Liab.Malpractice			253,330	253,330		253,330	3,827	257,157		26
27	Other (specify):* Mgmt Co - Allocated							69,051	69,051		27
28	TOTAL General Administration	349,013	36,239	2,363,115	2,748,367		2,748,367	(451,356)	2,297,011		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,145,663	679,237	3,748,635	9,573,535		9,573,535	(392,749)	9,180,786		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 Streamwood

#0037002

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			119,284	119,284		119,284	205,070	324,354			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214,384	214,384		214,384	83,601	297,985			32
33	Real Estate Taxes							534,169	534,169			33
34	Rent-Facility & Grounds			1,877,399	1,877,399		1,877,399	(1,873,414)	3,985			34
35	Rent-Equipment & Vehicles			101,031	101,031		101,031	4,576	105,607			35
36	Other (specify):*											36
37	TOTAL Ownership			2,312,098	2,312,098		2,312,098	(1,045,998)	1,266,100			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		401,341	22,398	423,739		423,739		423,739			39
40	Barber and Beauty Shops			15,966	15,966		15,966		15,966			40
41	Coffee and Gift Shops			2,680	2,680		2,680		2,680			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Non-allowable Cos			113,744	113,744		113,744	(113,744)				43
44	TOTAL Special Cost Centers		401,341	277,428	678,769		678,769	(113,744)	565,025			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,145,663	1,080,578	6,338,161	12,564,402		12,564,402	(1,552,491)	11,011,911			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 Streamwood

0037002

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	(248)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,942)	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	5	30		9
10	Interest and Other Investment Income	(14,019)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(746)	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	(10,490)	43		18
19	Entertainment				19
20	Contributions	(475)	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	(48,275)	43		24
25	Fund Raising, Advertising and Promotional	(19,663)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(129)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(269,287)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (368,269)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	(1,184,222)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,184,222)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,552,491)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Streamwood

ID# 0037002

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	X-Rays-Part A	\$ (12,521)	43	1
2	Labs-Part A	(16,503)	43	2
3	Miscellaneous Income	(4,325)	10	3
4	Legal Collections Fees	(8,771)	19	4
5	Chamber of commerce dues	(600)	20	5
6	Trust Fees	(100)	43	6
7	Marketing Salaries	(44,180)	21	7
8	Shareholder Interest	(182,244)	32	8
9	Nonallowable Legal Expenses	(43)	19	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
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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	Total	(269,287)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(248)	0	0	0	0	0	0	0	0	0	0	(248)	2
3	Housekeeping	0	0	324	0	0	0	0	0	0	0	0	324	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	5,970	0	0	0	0	0	0	0	0	5,970	5
6	Maintenance	0	0	46,480	0	0	0	0	0	0	0	0	46,480	6
7	Other (specify):*	0	0	5,816	0	0	0	0	0	0	0	0	5,816	7
8	TOTAL General Services	(248)	0	58,590	0	0	0	0	0	0	0	0	58,342	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,325)	0	12,357	0	0	0	0	0	0	0	0	8,032	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	1,104	0	0	0	0	0	0	0	0	1,104	15
16	TOTAL Health Care and Programs	(4,325)	0	13,461	0	0	0	0	0	0	0	0	9,136	16
	C. General Administration													
17	Administrative	0	0	102,389	(1,041,301)	0	0	0	0	0	0	0	(938,912)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,814)	100	16,404	0	0	0	0	0	0	0	0	7,690	19
20	Fees, Subscriptions & Promotions	(600)	0	1,318	0	0	0	0	0	0	0	0	718	20
21	Clerical & General Office Expenses	(44,180)	0	417,144	6,402	0	0	0	0	0	0	0	379,366	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	513	0	0	0	0	0	0	0	513	24
25	Other Admin. Staff Transportation	0	0	0	17,520	0	0	0	0	0	0	0	17,520	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,827	0	0	0	0	0	0	0	3,827	26
27	Other (specify):*	0	0	0	69,051	0	0	0	0	0	0	0	69,051	27
28	TOTAL General Administration	(53,594)	100	537,255	(943,988)	0	(460,227)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,167)	100	609,306	(943,988)	0	(392,749)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Streamwood# 0037002

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	5	153,168	0	51,897	0	0	0	0	0	0	0	205,070	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(196,263)	265,603	0	14,261	0	0	0	0	0	0	0	83,601	32
33	Real Estate Taxes	0	530,399	0	3,770	0	0	0	0	0	0	0	534,169	33
34	Rent-Facility & Grounds	0	(1,877,399)	0	3,985	0	0	0	0	0	0	0	(1,873,414)	34
35	Rent-Equipment & Vehicles	0	0	0	4,576	0	0	0	0	0	0	0	4,576	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(196,258)	(928,229)	0	78,489	0	(1,045,998)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(113,844)	100	0	0	0	0	0	0	0	0	0	(113,744)	43
44	TOTAL Special Cost Centers	(113,844)	100	0	0	0	0	0	0	0	0	0	(113,744)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(368,269)	(928,029)	609,306	(865,499)	0	(1,552,491)	45						

Facility Name & ID Number Lexington of Streamwood

0037002

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

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 Streamwood	Streamwood	Real estate ptsp.
				Limited Partnership	Lombard	Mgmt. Co.
				Royal Mgmt. Corp.		
				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	19 Professional fees	\$	Sambell of Streamwood Limited Partnership	**	\$ 100	\$	100	1	
2	V	30 Depreciation		Sambell of Streamwood Limited Partnership	**	153,168		153,168	2	
3	V	32 Interest expense		Sambell of Streamwood Limited Partnership	**	260,635		260,635	3	
4	V	32 Amortization of mortgage costs		Sambell of Streamwood Limited Partnership	**	4,968		4,968	4	
5	V	33 Property taxes		Sambell of Streamwood Limited Partnership	**	530,399		530,399	5	
6	V	34 Rental expense	1,877,399	Sambell of Streamwood Limited Partnership	**			(1,877,399)	6	
7	V	43 Trust fees		Sambell of Streamwood Limited Partnership	**	100		100	7	
8	V								8	
9	V								9	
10	V								10	
11	V								11	
12	V	** The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Sambell of Streamwood Limited Partnership								12
13	V								13	
14	Total		\$ 1,877,399			\$ 949,370	\$ *	(928,029)	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 324	\$	324	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,958		4,958	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	123		123	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	889		889	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	42,489		42,489	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	3,796		3,796	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	186		186	21
22	V	6 Security service		Royal Management Corp.	**	9		9	22
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,816		5,816	23
24	V	10 Medical consultant		Royal Management Corp.	**	4,290		4,290	24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	8,067		8,067	25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	1,104		1,104	26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	102,389		102,389	27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	12,680		12,680	28
29	V	19 Professional fees		Royal Management Corp.	**	3,724		3,724	29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	535		535	30
31	V	21 Communications		Royal Management Corp.	**	127		127	31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	783		783	32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	402,050		402,050	33
34	V	21 Bank charges		Royal Management Corp.	**	1,139		1,139	34
35	V	21 Office supplies & printing		Royal Management Corp.	**	10,125		10,125	35
36	V	21 Postage		Royal Management Corp.	**	3,703		3,703	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% or Royal Management Corp.							38
39	Total		\$			\$ 609,306	\$ *	609,306	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	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	
16	V	24 Travel & seminar		Royal Management Corp.	**	513	513	
17	V	25 Auto expense		Royal Management Corp.	**	17,520	17,520	
18	V	26 Insurance general		Royal Management Corp.	**	3,827	3,827	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	69,051	69,051	
20	V	30 Depreciation		Royal Management Corp.	**	51,897	51,897	
21	V	32 Interest		Royal Management Corp.	**	14,235	14,235	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	26	26	
23	V	33 Property taxes		Royal Management Corp.	**	3,770	3,770	
24	V	34 Rent expense		Royal Management Corp.	**	3,985	3,985	
25	V	35 Equipment rental		Royal Management Corp.	**	1,154	1,154	
26	V	17 Management fees	1,041,301	Royal Management Corp.	**		(1,041,301)	
27	V	35 Auto Lease Expense		Royal Management Corp.	**	3,422	3,422	
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 Streamwood, Inc. own 100% of Royal Management Corp.						
39	Total		\$ 1,041,301			\$ 175,802	\$ * (865,499)	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
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 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 Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number

Lexington of Streamwood

0037002

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	23.33	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 Streamwood

0037002

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	748,545	10	\$ 2,970	\$ 81,710	\$ 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 - employee	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 - employee	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 Streamwood

0037002

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	748,545	10	\$ 160,505	\$ 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 - employee	Bed Days	748,545	10	632,578	81,710	69,051	3
4	30	Depreciation - leasehold improv.	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 Streamwood

0037002

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	Name of Lender	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, L.L.C	X		Mortgage	Varies	02/01/96	5,985,000	4,160,003	2/1/26	Variable	260,635	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Shareholders	X		Working Capital	None	Various	1,154,048	4,681,829	Demand	Prime + 1	182,244	6						
7	LaSalle Bank N.A.		X	Working Capital	None	4/4/04	900,000	305,000	5/31/08	Prime/Libor	32,140	7						
8												8						
9	TOTAL Facility Related						\$ 8,039,048	\$ 9,146,832			\$ 475,019	9						
B. Non-Facility Related*																		
10										Amortization of mortgage costs	4,994	10						
11										Interest income offset	(14,019)	11						
12										Allocated from management compnay	14,235	12						
13										Less: Shareholder interest	(182,244)	13						
14	TOTAL Non-Facility Related						\$	\$			\$ (177,034)	14						
15	TOTALS (line 9+line14)						\$ 8,039,048	\$ 9,146,832			\$ 297,985	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.		\$	416,000	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	\$	443,467	2
3. Under or (over) accrual (line 2 minus line 1).		\$	27,467	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	502,800	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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	Allocated from Management Company		3,770	
		\$	132	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	534,169	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	444,124	8
	2003	453,831	9
	2004	441,442	10
	2005	449,212	11
	2006	443,467	12

FOR BHF USE ONLY			
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

Accrual Computation
See Attached Schedule
Use: **\$502,800**

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 Streamwood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4796

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-25-300-006-0000</u>	<u>Land & Building</u>	\$ <u>443,467.07</u>	\$ <u>443,467.07</u>
2. <u>Royal Management Corp(Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>132,282.00</u>	\$ <u>3,770.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>575,749.07</u>	\$ <u>447,237.07</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 Streamwood

0037002

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>30,000</u>	<u>1991</u>	<u>\$ 211,400</u>	<u>1</u>
2	<u>Allocated from Management Compnay</u>		<u>2002</u>	<u>17,683</u>	<u>2</u>
3	TOTALS	30,000		\$ 229,083	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002

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	200	1991	1991	\$ 5,248,322	\$		\$ 149,952	\$ 149,952	\$ 2,474,209	4
5	10	1993	1993	105,236			3,007	3,007	43,597	5
6	14	1995	1995	82,650	2,357		2,361	4	29,518	6
7										7
8										8
	Improvement Type**									
9	Building Improvement		1993	7,336			210	210	3,039	9
10	Land Improvements		1995	7,000	467	15	467		5,833	10
11	Kitchen & Nurses Station		1996	12,316	352	35	352		4,047	11
12	Piping		1996	3,139	90	35	90		1,031	12
13	Basement remodeling		1997	20,204	1,347	10	1,347		20,204	13
14	Floor repairs		1997	555	51	10	51		555	14
15	Corner Guards		1997	998	91	10	91		998	15
16	Corner Guards		1998	3,563	356	10	356		3,385	16
17	Wiring		1998	2,050	205	10	205		1,948	17
18	Tile		1998	11,697	1,170	10	1,170		10,527	18
19	Patio		1999	12,012	801	15	801		6,473	19
20	Parking lot		2000	1,773	177	10	177		1,330	20
21	110-ton A/C unit		2000	6,923	692	10	692		5,192	21
22	Rods for bedside curtains		2000	5,872	587	10	587		4,404	22
23	Automatic doors		2000	1,300	130	10	130		975	23
24	Rehab project: carpeting, wallcovering, handrails, painting		2000	85,195	8,519	10	8,519		63,896	24
25	Compressor/tube bundles-cooling system		2001	12,921	1,292	10	1,292		8,399	25
26	Rehab project: resident rooms, corridors, dining room		2001	212,217	10,611	20	10,611		68,971	26
27	Parking lot		2002	29,288	2,929	10	2,929		16,108	27
28	Office area rehab		2002	26,991	1,350	20	1,350		7,423	28
29	Elevator interior upgrade		2002	1,120	112	10	112		626	29
30	Gazebo		2002	3,393	339	10	339		1,866	30
31	Elevator electronic curtains		2002	4,500	450	10	450		2,663	31
32	Door frame protector		2003	5,276	528	10	528		2,594	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring		2003	9,392	939	10	939		4,148	33
34	Roof		2003	29,950	1,498	20	1,498		6,115	34
35	Kitchen Sewer/Dishroom		2004	6,224	622	10	622		2,075	35
36	Compressor/tube bundles-cooling system		2004	14,737	737	20	737		2,456	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 Streamwood

0037002

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	Kitchen fire protection upgrade	2004	\$ 1,427	\$ 143	10	\$ 143	\$	\$ 535	37
38	Landscaping	2005	8,495	425	20	425		956	38
39	Kitchen renovation	2005	12,034	602	20	602		1,203	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		3,744	40
41	Therapy room renovation	2005	11,628	581	20	581		1,357	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		6,717	42
43	Dialysis units	2005	66,426	3,783	20	3,783		8,342	43
44	Create transitional unit	2005	14,490	725	20	725		1,449	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		887	45
46	Basement renovation	2005	46,561	2,328	20	2,328		5,044	46
47	Landscaping enhancement	2006	3,414	228	15	228		341	47
48	HVAC	2006	17,125	856	20	856		928	48
49	Door closer	2006	4,446	222	20	222		389	49
50	Blinds	2006	1,566	313	5	313		339	50
51	Employee lunch room rehab	2006	2,883	144	20	144		240	51
52	Storeroom door lock	2006	2,843	142	20	142		213	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		4,974	53
54	Fine dining	2006	7,650	382	20	382		606	54
55	Automatic door	2006	2,259	113	20	113		141	55
56	Landscaping	2007	10,606	44	20	44		44	56
57	Parking lot	2007	2,777	35	20	35		35	57
58	HVAC	2007	1,501	56	20	56		56	58
59	Painting Building	2007	16,150	336	20	336		336	59
60									60
61	Land Improvements-management company	2002	27,870		15	1,684	1,684	10,993	61
62	Building-management company	2002	216,828		40	40,788	40,788	32,072	62
63	HVAC, electrical, security system-management company	2003	2,149		30	150	150	653	63
64	Key card system-management company	2004	338		20	17	17	58	64
65	VAC TX controls-management company	2005	103		20	6	6	15	65
66	Build Imp-management company	2006	75		5	5	5	6	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,606,756	\$ 57,806		\$ 253,629	\$ 195,823	\$ 2,887,278	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 Streamwood

0037002

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 368,038	\$ 56,891	\$ 56,891	\$	5	\$ 163,613	71
72	Current Year Purchases	61,546	4,587	4,587		5	4,587	72
73	Fully Depreciated Assets	3,024					3,024	73
74	Allocated from Management Company	267,831		4,237	4,237		136,072	74
75	TOTALS	\$ 700,439	\$ 61,478	\$ 65,715	\$ 4,237		\$ 307,296	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)	\$ 7,578,762	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,284	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 324,354	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 205,070	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,222,427	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	Remodel (Carpentry,	\$ 773,680	92
93	Flooring, Paint, Electrical)		93
94			94
95		\$ 773,680	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: \$ 102,185 Description: Copier-\$5,717; Medical Equip-\$70,341; Oxygen-\$24,973; Mgmt. Co. Allocation-\$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	<u>Allocated from management co.</u>			<u>3,422</u>	18
19					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	L10A, C3	hrs	\$	3,911	\$ 230,292	\$	3,911	\$ 230,292	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,110	76,043		1,110	76,043	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		7,143	412,504		7,143	412,504	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 prescrpts				401,341		401,341	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Attached Sch D</u>	L39,C3				22,398			22,398	13
14	TOTAL			\$	12,164	\$ 741,237	\$ 401,341	12,164	\$ 1,142,578	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

Lexington Health Care Center of Streamwood, Inc.

Provider # 0037002

1/1/07-12/31/07

Schedule D

XIV. Special Services

Outside Practitioner
(other than consultant)

Service	Schedule & Line Reference	Units	Cost	Total Units	Total Cost
Wound Therapy	L39, C3		20,506		20,506
Dentist	L39, C3		1,892		1,892
			-	-	22,398

Facility Name & ID Number Lexington of Streamwood
 # 0037002
 XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

Report Period Beginning: 01/01/2007
 (last day of reporting year)

Ending: 12/31/2007

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	\$ (62,189)	\$ (50,632)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>551,056</u>)	1,558,632	1,558,632	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,491	42,491	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)	\$ 1,538,934	\$ 1,550,491	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	69,739	69,739	12
13	Land		229,083	13
14	Buildings, at Historical Cost		5,436,208	14
15	Leasehold Improvements, at Historical Cost	998,497	1,170,548	15
16	Equipment, at Historical Cost	432,476	742,923	16
17	Accumulated Depreciation (book methods)	(493,302)	(3,222,427)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Construction in Progr</u>)	773,680	773,680	22
23	Other(specify): <u>Mortgage Cost, net</u>		68,127	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,781,090	\$ 5,267,881	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,320,024	\$ 6,818,372	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 244,288	\$ 244,288	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,986,829	4,986,829	29
30	Accrued Salaries Payable	246,610	246,610	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,758	9,758	31
32	Accrued Real Estate Taxes(Sch.IX-B)		502,800	32
33	Accrued Interest Payable		17,531	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See attached schedule 17A</u>	5,134,328	667,760	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,621,813	\$ 6,675,576	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,160,003	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Interest rate swap</u>		35,877	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,195,880	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,621,813	\$ 10,871,456	46
47	TOTAL EQUITY (page 18, line 24)	\$ (7,301,789)	\$ (4,053,084)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,320,024	\$ 6,818,372	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Streamwood, Inc.

Provider #0037002

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	(46,496)	(46,496)
Due to Schaumburg	1,130	1,130
Due to Lexington Financial Svc	-	(1,154)
Due from Lake Zurich	(603)	(603)
Due from Bloomingdale	994	994
Escrow - Insurance	(408,839)	(408,839)
Bond Withholding	(657)	(657)
401K Withholding	(1,666)	(1,666)
Accrued 401K	(17,518)	(17,518)
Due to Lexington Financial Svc	(269)	(269)
Due to Republic Construction	(14,604)	(14,604)
Accrued Expenses	(270,172)	(270,172)
Accrued Royal Gen Mgmt Fees	3,541	3,541
Accrued Rent	(4,467,722)	-
Accrued Wage Assignments	342	342
Advance Bi-Weekly Payments	88,211	88,211
	<u>(5,134,328)</u>	<u>(667,760)</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,036,408)	1
2	Restatements (describe):		2
3	Post Closing Adjustment	(53,650)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,090,058)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,211,731)	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	()	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)	\$ (2,211,731)	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)	\$ (7,301,789)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,441,611	1
2	Discounts and Allowances for all Levels	(6,715,657)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,725,954	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,540,915	6
7	Oxygen	989	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,541,904	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	3,228	12
13	Barber and Beauty Care	17,908	13
14	Non-Patient Meals	248	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	836,253	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,119	19
20	Radiology and X-Ray	18,044	20
21	Other Medical Services	140,987	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,061,787	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,019	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,019	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Investment Income</u>	4,722	28
28a	<u>Miscellaneous Income</u>	4,285	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,007	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,352,671	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,534,846	31
32	Health Care	5,290,322	32
33	General Administration	2,748,367	33
	B. Capital Expense		
34	Ownership	2,312,098	34
	C. Ancillary Expense		
35	Special Cost Centers	556,129	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,564,402	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,211,731)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,211,731)	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 Streamwood

0037002

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	1,359	1,554	\$ 75,780	\$ 48.76	1
2	Assistant Director of Nursing	5,917	6,327	206,495	32.64	2
3	Registered Nurses	51,554	56,204	1,746,583	31.08	3
4	Licensed Practical Nurses	11,242	12,299	329,251	26.77	4
5	CNAs & Orderlies	86,693	93,195	1,090,164	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,791	13,590	184,719	13.59	8
9	Activity Director	2,032	2,138	32,735	15.31	9
10	Activity Assistants	16,434	17,685	189,224	10.70	10
11	Social Service Workers	5,730	6,147	126,723	20.62	11
12	Dietician	709	820	12,100	14.76	12
13	Food Service Supervisor	1,853	1,974	34,690	17.57	13
14	Head Cook	1,906	2,175	32,672	15.02	14
15	Cook Helpers/Assistants	11,429	12,336	108,029	8.76	15
16	Dishwashers	20,464	21,923	164,326	7.50	16
17	Maintenance Workers	1,937	2,163	27,929	12.91	17
18	Housekeepers	38,895	42,365	336,737	7.95	18
19	Laundry	8,518	9,261	69,637	7.52	19
20	Administrator	1,377	1,871	106,142	56.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,577	17,944	242,871	13.53	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	1,904	2,071	28,856	13.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	299,321	324,042	\$ 5,145,663 *	\$ 15.88	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	358	\$ 18,902	L1, C3	35
36	Medical Director	Monthly	63,000	L9, C3	36
37	Medical Records Consultant	19	1,141	L10,C3	37
38	Nurse Consultant	5	500	L10,C3	38
39	Pharmacist Consultant	11	2,200	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	108	5,064	L11,C3	44
45	Social Service Consultant	101	5,038	L12,C3	45
46	Other(specify) <u>Psychosocial</u>	50	2,487	L12,C3	46
47	<u>Medical Biller</u>		1,258	L10,C3	47
48	<u>See Attached Schedule 20A</u>		7,763	L10,C3	48
49	TOTAL (lines 35 - 48)	651	\$ 107,354		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	887	\$ 48,241	L10,C3	50
51	Licensed Practical Nurses	2,432	102,226	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,319	\$ 150,467		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.

Provider # 0037002

1/1/07-12/31/07

Schedule 20A

XVIII. B. Consultant Services

Service	Schedule & Line Reference	Number of Hrs. Paid & Accrued	Cost
PA Application	L39, C3	63	3,473
Medical Consultant	L39, C3	Monthly	4,290
		63	7,763

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Theodore O'Brien	Administrator		\$ 54,388	Workers' Compensation Insurance	\$ 80,559	IDPH License Fee	\$	
Patrick Scales	Administrator		51,754	Unemployment Compensation Insurance	80,225	Advertising: Employee Recruitment	13,715	
				FICA Taxes	377,227	Health Care Worker Background Check (Indicate # of checks performed 160)	1,600	
				Employee Health Insurance	191,947	Patient Background Checks	2,400	
				Employee Meals	13,196	Miscellaneous Licenses & Fees	4,302	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	1,862	
				401K Contributions	17,518	Employment Fees	110,550	
				Life Insurance	4,071	Allocated from Management Co.	1,318	
				Other Employee Benefits	34,691	Less: Chamber of commerce dues	(600)	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,142	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 799,434		\$ 135,147		
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (eliminated in Col. 7)			\$ 1,041,301			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,041,301	TOTAL			Seminar Expense	
							9,457	
							Allocated from management co.	
							513	
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 117,281				TOTAL	
							\$ 9,970	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Streamwood, Inc.
 Provider # 0037002
 1/1/07-12/31/07

XIX. Support Schedules
 C. Professional Services

Schedule 21C

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
National Data Care Corp	Computer Consulting	2,155
Information Controls	Computer Consulting	578
AAOD	Computer Consulting	512
Ehealth	Computer Consulting	2,400
Alperian Technology	Computer Consulting	215
Krakau	Computer Consulting	598
Action Computer Service	Computer Consulting	324
Microsoft	Computer Consulting	8,294
Visual Click	Computer Consulting	97
CDW	Computer Consulting	1,016
Lanac	Computer Consulting	4,487
Lintech	Computer Consulting	3,137
Royal/Computer Service Website	Computer Consulting	125
Royal/Computer Service Website	Computer Consulting	186
Royal/Internet Mktg	Computer Consulting	650
Royal/Adrew Campbell Photography	Computer Consulting	55
	To Page 21C	<u>24,830</u>

Total, Agrees to Schedule V, Line 19, Column 3 117,281

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 Schwartz	Physician Credentialing Consultant	183
Pension Administrators, Inc.	401(k) Administration	512
Addison Search	Recruitment Consulting	51
Gene Whitehorn	Medicaid Reimb. Specialist	918
Lintech	Computer Consulting	4,438
Lanac Technology	Computer Consulting	3,804
Lifecare Software, Inc.	Computer Consulting	2,536
CDW Direct	Computer Consulting	1,902

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

Allocated from building partnership		
James Samatas	Filing and recording fees	100

Nonallowable Legal Fees		
Reed Smith	Legal	(43)
Grabowski Law Center	Collections	(8,771)

Total, Agrees to Schedule V, Line 19, Column 8 124,971

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 Streamwood# 0037002Report 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. \$ 44,298 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. \$ 13,196 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 248
- (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? N/A 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