

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0035188</u></p> <p>Facility Name: <u>Lexington Health Care Center-Bloomingtondale</u></p> <p>Address: <u>165 South Bloomingtondale Road</u> <u>Bloomingtondale</u> <u>60108</u> <small>Number City Zip Code</small></p> <p>County: <u>Dupage</u></p> <p>Telephone Number: <u>(630)980-8700</u> Fax # <u>(630)980-6170</u></p> <p>HFS ID Number: <u>363635151001</u></p> <p>Date of Initial License for Current Owners: <u>5/1/89</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 789-7700</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>15 S. Old State Capitol Plz, Ste. 200, Springfield, IL 62701</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u></td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>15 S. Old State Capitol Plz, Ste. 200, Springfield, IL 62701</u> (Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	166	Skilled (SNF)	166	60,756	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	166	TOTALS	166	60,756	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF	5,497	1,160	6,573	13,230	8
9	SNF/PED					9
10	ICF	31,695	5,766	1,567	39,028	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,192	6,926	8,140	52,258	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.01%

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 05/01/89

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 166 and days of care provided 6,253

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale # 0035188 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	325,171	28,687	14,768	368,626		368,626		368,626		1
2	Food Purchase		237,830		237,830		237,830	(11,519)	226,311		2
3	Housekeeping	277,576	27,287		304,863		304,863	379	305,242		3
4	Laundry	60,145	14,383		74,528		74,528		74,528		4
5	Heat and Other Utilities			225,070	225,070		225,070	5,601	230,671		5
6	Maintenance	30,909		155,585	186,494		186,494	38,414	224,908		6
7	Other (specify):* Mgmt Co - Allocated							4,172	4,172		7
8	TOTAL General Services	693,801	308,187	395,423	1,397,411		1,397,411	37,047	1,434,458		8
	B. Health Care and Programs										
9	Medical Director			53,800	53,800		53,800		53,800		9
10	Nursing and Medical Records	2,938,703	206,682	8,336	3,153,721		3,153,721	14,788	3,168,509		10
10a	Therapy			751,314	751,314		751,314		751,314		10a
11	Activities	271,356	24,878	10,609	306,843		306,843		306,843		11
12	Social Services	106,582		7,126	113,708		113,708		113,708		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co - Allocated							2,490	2,490		15
16	TOTAL Health Care and Programs	3,316,641	231,560	831,185	4,379,386		4,379,386	17,278	4,396,664		16
	C. General Administration										
17	Administrative	96,586		914,263	1,010,849		1,010,849	(868,002)	142,847		17
18	Directors Fees										18
19	Professional Services			110,933	110,933		110,933	11,222	122,155		19
20	Dues, Fees, Subscriptions & Promotions			31,799	31,799		31,799	3,913	35,712		20
21	Clerical & General Office Expenses	297,864	25,205	21,244	344,313		344,313	330,772	675,085		21
22	Employee Benefits & Payroll Taxes			641,285	641,285		641,285	11,519	652,804		22
23	Inservice Training & Education			776	776		776		776		23
24	Travel and Seminar			5,799	5,799		5,799	484	6,283		24
25	Other Admin. Staff Transportation			141	141		141	16,521	16,662		25
26	Insurance-Prop.Liab.Malpractice			178,726	178,726		178,726	2,544	181,270		26
27	Other (specify):* Mgmt Co - Allocated							50,029	50,029		27
28	TOTAL General Administration	394,450	25,205	1,904,966	2,324,621		2,324,621	(440,998)	1,883,623		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,404,892	564,952	3,131,574	8,101,418		8,101,418	(386,673)	7,714,745		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington Health Care Center-Bloomington

#0035188

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			129,129	129,129		129,129	252,317	381,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,341	10,341		10,341	314,970	325,311			32
33	Real Estate Taxes							116,805	116,805			33
34	Rent-Facility & Grounds			1,194,167	1,194,167		1,194,167	(1,191,057)	3,110			34
35	Rent-Equipment & Vehicles			56,312	56,312		56,312	3,476	59,788			35
36	Other (specify):*											36
37	TOTAL Ownership			1,389,949	1,389,949		1,389,949	(503,489)	886,460			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		230,781	446	231,227		231,227		231,227			39
40	Barber and Beauty Shops			17,807	17,807		17,807		17,807			40
41	Coffee and Gift Shops			3,016	3,016		3,016		3,016			41
42	Provider Participation Fee			91,134	91,134		91,134		91,134			42
43	Other (specify):* Non-allowable cost			84,770	84,770		84,770	(84,770)				43
44	TOTAL Special Cost Centers		230,781	197,173	427,954		427,954	(84,770)	343,184			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,404,892	795,733	4,718,696	9,919,321		9,919,321	(974,932)	8,944,389			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,025)	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	52	30		9
10	Interest and Other Investment Income	(57,385)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,495)	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	(875)	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	(30,470)	43		24
25	Fund Raising, Advertising and Promotional	(13,454)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,499)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(169,425)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (284,576)		\$	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)	(690,356)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (690,356)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (974,932)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center-Bloomingtondale

ID# 0035188

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Shareholder Interest	\$ (9,418)	32	1
2	Radiology	(23,138)	43	2
3	Laboratory	(5,853)	43	3
4	Personal Item Replacement	(1,940)	43	4
5	Trust Fees	(135)	43	5
6	Collection Fees	(7,895)	19	6
7	Loss on Mortgage Cost	(63,510)	43	7
8	Nonallowable Legal Expenses	(2,041)	19	8
9	Nonallowable Marketing Salaries	(45,255)	21	9
10	Nonallowable Marketing Expenses	(9,238)	10	10
11	Nonallowable Accounting Fees	(1,002)	19	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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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	(169,425)		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				Sambell of Bloomingtondale		
				Limited Partnership Bloomingtondale		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:		
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 Bloomingtondale Limited Partnership	**	\$ 300	\$	300	1
2	V	21 Office Supplies		Sambell of Bloomingtondale Limited Partnership	**	(2,798)		(2,798)	2
3	V	30 Depreciation Expense		Sambell of Bloomingtondale Limited Partnership	**	211,165		211,165	3
4	V	32 Interest		Sambell of Bloomingtondale Limited Partnership	**	365,131		365,131	4
5	V	32 Amortization of Mortgage Cost		Sambell of Bloomingtondale Limited Partnership	**	1,332		1,332	5
6	V	33 Property Tax		Sambell of Bloomingtondale Limited Partnership	**	114,167		114,167	6
7	V	34 Rent	1,194,167	Sambell of Bloomingtondale Limited Partnership	**			(1,194,167)	7
8	V	43 Trust Fees		Sambell of Bloomingtondale Limited Partnership	**	135		135	8
9	V	43 State Replacement Tax		Sambell of Bloomingtondale Limited Partnership	**	3,979		3,979	9
10	V	43 Loss on Mortgage Cost		Sambell of Bloomingtondale Limited Partnership	**	63,510		63,510	10
11	V								11
12	V			** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc.					12
13	V			own 100% of Sambell of Bloomingtondale Limited Partnership					13
14	Total		\$ 1,194,167			\$ 756,921	\$ *	(437,246)	14

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

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.	**	\$ 379	\$	379	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,660		4,660	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	118		118	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	823		823	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	34,154		34,154	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,052		4,052	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	208		208	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	4,172		4,172	22
23	V	10 Medical consultant		Royal Management Corp.	**	3,639		3,639	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	20,387		20,387	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	2,490		2,490	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	46,261		46,261	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	17,449		17,449	27
28	V	19 Professional fees		Royal Management Corp.	**	4,411		4,411	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	2,981		2,981	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	932		932	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	358,011		358,011	31
32	V	21 Bank charges		Royal Management Corp.	**	4,219		4,219	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	7,972		7,972	33
34	V	21 Postage		Royal Management Corp.	**	2,541		2,541	34
35	V								35
36	V								36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 519,859	\$ *	519,859	39

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

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.	**	\$ 6,082	\$	6,082	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	484		484	16	
17	V	25 Auto expense		Royal Management Corp.	**	16,521		16,521	17	
18	V	26 Insurance general		Royal Management Corp.	**	2,544		2,544	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	50,029		50,029	19	
20	V	30 Depreciation		Royal Management Corp.	**	41,100		41,100	20	
21	V	32 Interest		Royal Management Corp.	**	15,286		15,286	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	24		24	22	
23	V	33 Property taxes		Royal Management Corp.	**	2,638		2,638	23	
24	V	34 Rent expense		Royal Management Corp.	**	3,110		3,110	24	
25	V	35 Equipment rental		Royal Management Corp.	**	749		749	25	
26	V	17 Management fees	914,263	Royal Management Corp.	**			(914,263)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	2,727		2,727	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 Bloomington, Inc. own 100% of Royal Management Corp.								38
39	Total		\$ 914,263			\$ 141,294	\$ *	(772,969)	39	

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

Lexington Health Care Center of Bloomingdale, Inc.

Provider # 0035188

1/1/08-12/31/08

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%

VII. Related Parties

Related Nursing Homes

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	2.91	5.80	Salary	\$ 15,420	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	2.91	5.80	Salary	15,420	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	2.91	5.80	Salary	15,420	L17, C7	3
4	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	0.52	1.04	Salary	1,072	L21, C7	4
5	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	4.15	8.00	Salary	15,178	L17/21, C7	5
6											6
7											7
8											8
9											9
10						All individuals work in excess of 40 hours per week.					10
11											11
12											12
13								TOTAL	\$ 62,510		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

Royal Management Corp.
Related Party Compensation
Period: 01/01/08 - 12/31/08

Schedule 7A

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives and Member of the Board of Directors.

Compensation Received From Other Nursing Homes

<u>Facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>Daniel Thiem</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Lombard, Inc.	20,808	20,808	20,808	1,447	20,481	84,352
Lexington Health Care Center of Bloomingdale, Inc.	15,420	15,420	15,420	1,072	15,178	62,510
Lexington Health Care Center of Schaumburg, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Chicago Ridge, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Streamwood, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Elmhurst, Inc.	13,469	13,469	13,469	936	13,257	54,600
Lexington Health Care Center of Lake Zurich, Inc.	19,415	19,415	19,415	1,350	19,109	78,704
Lexington Health Care Center of Orland Park, Inc.	25,825	25,825	25,825	1,795	25,418	104,688
Lexington Health Care Center of Wheeling, Inc.	19,972	19,972	19,972	1,389	19,658	80,963
Lexington Health Care Center of LaGrange, Inc.	11,054	11,054	11,054	769	10,880	44,811
Total	185,600	185,600	185,600	12,904	182,679	752,383

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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	731,268	10	\$ 4,564	\$ 60,756	\$ 379	1
2	5	Utilities - gas & electric	Bed Days	731,268	10	56,094	60,756	4,660	2
3	5	Utilities - water & sewer	Bed Days	731,268	10	1,425	60,756	118	3
4	5	Utilities - maintenance office	Bed Days	731,268	10	9,903	60,756	823	4
5	6	Management allocation - salaries	Bed Days	731,268	10	411,084	411,084	34,154	5
6	6	Repairs & maintenance	Bed Days	731,268	10	48,773	60,756	4,052	6
7	6	Scavenger & exterminating	Bed Days	731,268	10	2,504	60,756	208	7
8	7	Management allocation - employee	Bed Days	731,268	10	50,217	60,756	4,172	8
9	10	Medical consultant	Bed Days	731,268	10	43,800	60,756	3,639	9
10	10	Management allocation - salaries	Bed Days	731,268	10	245,385	245,385	20,387	10
11	15	Management allocation - employee	Bed Days	731,268	10	29,975	60,756	2,490	11
12	17	Management allocation - salaries	Bed Days	731,268	10	556,800	556,807	46,261	12
13	19	Computer consultant & supplies	Bed Days	731,268	10	210,020	60,756	17,449	13
14	19	Professional fees	Bed Days	731,268	10	53,093	60,756	4,411	14
15	20	Dues & subscriptions	Bed Days	731,268	10	35,880	60,756	2,981	15
16	20	Advertising - help wanted	Bed Days	731,268	10	11,214	60,756	932	16
17	21	Management allocation - salaries	Bed Days	731,268	10	4,309,068	4,039,070	358,011	17
18	21	Bank charges	Bed Days	731,268	10	50,778	60,756	4,219	18
19	21	Office supplies & printing	Bed Days	731,268	10	95,951	60,756	7,972	19
20	21	Postage	Bed Days	731,268	10	30,589	60,756	2,541	20
21	21	Telephone	Bed Days	731,268	10	73,204	60,756	6,082	21
22	24	Travel and Seminar	Bed Days	731,268	10	5,826	60,756	484	22
23									23
24									24
25	TOTALS					\$ 6,336,147	\$ 5,252,346	\$ 526,425	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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	731,268	10	\$ 198,854	\$ 60,756	\$ 16,521	1
2	26	Insurance general	Bed Days	731,268	10	30,619	60,756	2,544	2
3	27	Management allocation - employee	Bed Days	731,268	10	602,157	60,756	50,029	3
4	30	Depreciation	Bed Days	731,268	10	494,680	60,756	41,100	4
5	32	Interest	Bed Days	731,268	10	183,980	60,756	15,286	5
6	32	Amortization of mortgage costs	Bed Days	731,268	10	283	60,756	24	6
7	33	Property taxes	Bed Days	731,268	10	31,746	60,756	2,638	7
8	34	Rent expense	Bed Days	731,268	10	37,431	60,756	3,110	8
9	35	Equipment rental	Bed Days	731,268	10	9,010	60,756	749	9
10	35	Auto Lease	Bed Days	731,268	10	32,828	60,756	2,727	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					\$ 1,621,588	\$	\$ 134,728	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	X		Mortgage	Varies	2/1/96	\$ 5,575,000			Variable	\$ 80,143	1						
2	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,375,000	6,305,669	1/1/2033	Variable	275,570	2						
3												3						
4												4						
5							Interest on financing insurance premium				1,994	5						
Working Capital																		
6	Bank of America		X	Working Capital	Varies	4/6/02	1,300,000	250,000	06/30/09	Prime/Libor	8,346	6						
7	Shareholder	X		Working Capital	None	Various	160,000		Demand	Varies	9,419	7						
8												8						
9	TOTAL Facility Related						\$ 13,410,000	\$ 6,555,669			\$ 375,472	9						
B. Non-Facility Related*																		
10										Amortization of mortgage costs	1,332	10						
11										Interest Income offset	(57,385)	11						
12										Management company allocation	15,310	12						
13										Non-Allowable Shareholder Interest	(9,418)	13						
14	TOTAL Non-Facility Related						\$	\$			\$ (50,161)	14						
15	TOTALS (line 9+line14)						\$ 13,410,000	\$ 6,555,669			\$ 325,311	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Bloomingtondale COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>02-15-401-003</u>	<u>Land & Building</u>	\$ <u>126,166.78</u>	\$ <u>126,166.78</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>174,993.86</u>	\$ <u>2,638.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>301,160.64</u>	\$ <u>128,804.78</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? X YES _____ 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>13,519</u>	<u>2</u>
3	TOTALS	43,000		\$ 416,067	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	82	1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 1,675,443	4
5	9	1992	1992	178,974		35	5,114	5,114	86,932	5
6	75	1994	1994	2,022,894		35	57,797	57,797	838,055	6
7										7
8										8
	Improvement Type**									
9	Capitalized repairs		1989	9,080		10			9,080	9
10	Building Improvements		1990	3,674		10			3,674	10
11	Building Improvements		1991	2,586		10			2,586	11
12	Building Improvements		1992	3,154		10			2,997	12
13	Building Improvements		1993	1,582		10			1,503	13
14	Building Improvements		1994	15,734		10			15,734	14
15	Land Improvements		1994	1,381		10			1,381	15
16	Land Improvements		1995	1,074		15	72	72	967	16
17	Building Improvements		1995	1,288		35	37	37	514	17
18	Building Improvements		1995	9,433	270	35	270		3,645	18
19	Building Improvements		1995	43,839	1,252	35	1,252		16,903	19
20	Concrete flooring, fire doors, tile, sprinkler heads,									20
21	and basement renovation		1996	8,706	207	10-35	260	53	3,606	21
22	Land improvements		1996	7,858		15	524	524	6,549	22
23										23
24	Resident room heaters		1997	3,563	102	35	102		1,222	24
25	Automatic doors		1997	12,950	370	35	370		4,101	25
26	Basement renovation		1997	58,806		10			58,806	26
27	Land Improvement - outdoor flagpoles		1997	1,574	105	15	105		1,206	27
28	1st Floor Remodel (Nurses Station/Lounge)		1998	76,487	3,824	10	3,824		76,487	28
29	Wiring for MDS		1998	4,506	225	10	225		4,506	29
30	Flag Pole		1998	787	39	10	39		787	30
31	Resurface/Stripe Parking Lot		1998	9,777	489	10	489		9,777	31
32	Kitchen tile/paint		1999	718	72	10	72		682	32
33	1st Floor Remodel		1999	3,296	330	10	330		3,296	33
34	Roof repairs		2000	5,748	383	15	383		3,257	34
35	Sump pump		2000	2,534	253	10	253		2,154	35
36	Sump pump basin repair		2000	6,307	631	10	631		5,361	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	Automatic door closers	2000	\$ 1,300	\$ 87	15	\$ 87		\$ 737	37
38	Infrared curtains for elevator doors	2001	3,000	300	10	300		2,250	38
39	Ejector pump	2002	3,050		5			3,050	39
40	Lift station pump	2002	3,359		5			3,359	40
41	New asphalt parking lot	2003	16,450	1,645	10	1,645		8,499	41
42	Roof repairs	2003	2,900	290	10	290		1,474	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		1,085	43
44	Kitchen remodel	2003	7,188	359	20	359		1,947	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		17,854	45
46	Floor tile	2003	16,305	815	20	815		4,892	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		19,259	47
48	Rehab-floor tile	2003	8,117	406	20	406		2,063	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		10,853	49
50	Foundation repair	2003	4,800	240	20	240		1,300	50
51	Parking lot	2004	24,550	2,455	10	2,455		10,843	51
52	Kitchen walk-in cooler floor	2004	7,161	716	10	716		3,103	52
53	Old Towne rehab	2004	13,967	698	20	698		2,968	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		42,658	54
55	Create first floor therapy room	2004	185	9	20	9		18	55
56	Transitional unit	2005	213	11	20	11		21	56
57	Landscaping	2005	8,814	441	20	441		1,396	57
58	Roof repairs	2005	3,250	163	20	163		515	58
59	HVAC upgrade	2005	7,048	352	20	352		1,175	59
60	Kitchen repair	2005	1,631	82	20	82		285	60
61	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		2,985	61
62	Window treatments	2005	3,606	721	5	721		2,406	62
63	Lower level therapy rehabilitation	2005	7,167	358	20	358		1,433	63
64	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		6,322	64
65	Alzheimers remodel	2005	35,986	1,799	20	1,799		5,698	65
66	Basement renovation	2005	14,176	709	20	709		2,126	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,126,369	\$ 43,857		\$ 192,646	\$ 148,789	\$ 3,003,785	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,126,369	\$ 43,857		\$ 192,646	\$ 148,789	\$ 3,003,785	1
2	Landscaping Enhancement	2006	7,084	472	15	472		1,102	2
3	Install Kitchen Sink	2006	2,915	146	20	146		401	3
4	Common area rehab	2006	2,382	119	20	119		318	4
5	Paint Building Exterior	2006	19,500	3,900	5	3,900		9,425	5
6	Patio	2006	53,305	3,554	15	3,554		7,403	6
7	Retaining Wall	2007	2,950	197	15	197		328	7
8	Roof Repair	2007	17,050	853	20	853		1,492	8
9	Air Conditioning units	2007	4,338	217	20	217		416	9
10	Paver walk and stairway	2007	10,500	525	20	525		875	10
11	Fire exit stairways	2007	9,379	469	20	469		547	11
12	Landscaping	2008	35,147	195	15	195		195	12
13	Parking Lot - Seal & Striping	2008	6,460	162	20	162		162	13
14	Roof	2008	15,300	510	20	510		510	14
15	HVAC - Spot Coolers	2008	5,589		40				15
16	Electrical - Storage Room	2008	4,768	99	20	99		99	16
17	Electrical - Fire Alarm Panel	2008	118,395	493	20	493		493	17
18	1st floor remodel-Carpentry,Flooring,Electrical,Parking fixtures	2008	557,202		27	13,508	13,508	13,508	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Land improvements - management company	2002	21,308		15	4,660	4,660	9,843	26
27	Building - management company	2002	165,774		40	28,665	28,665	28,665	27
28	HVAC, electrical, security system - management company	2003	1,643		30	293	293	614	28
29	Key card system - management company	2004	258		20	46	46	57	29
30	VAV TX controls - management company	2005	79		20	14	14	15	30
31	Interior Signs - management company	2006	57		5	8	8	8	31
32	Building improvements - management company	2008	35		5	7	7	7	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,187,787	\$ 55,768		\$ 251,758	\$ 195,990	\$ 3,080,268	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	\$ 534,624	\$ 70,773	\$ 70,773	\$	5-10	\$ 330,500	71
72	Current Year Purchases	445,748	2,588	51,509	48,921	5-10	51,509	72
73	Fully Depreciated Assets	9,962				3-5	9,962	73
74	Allocated from Mgmt. Co.	212,277		3,461	3,461		104,484	74
75	TOTALS	\$ 1,202,611	\$ 73,361	\$ 125,743	\$ 52,382		\$ 496,455	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 Mgmt. Co.			30,341		3,945	3,945		19,892	79
80	TOTALS			\$ 30,341	\$	\$ 3,945	\$ 3,945		\$ 19,892	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)	\$ 8,836,806	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 129,129	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 381,446	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 252,317	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,596,615	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$ N/A	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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>3,110</u>			6
7	TOTAL				\$ <u>3,110</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: \$ 57,061 Description: Copier-\$6,257; Mailing-\$185; Medical Equip-\$29,000; Oxygen Equip-\$20,870; Alloc from Mgmt Co-\$749

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocation from Management Co</u>			<u>2,727</u>	20
21	TOTAL		\$	\$ <u>2,727</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. /2009 \$ _____

13. /2010 \$ _____

14. /2011 \$ _____

* 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.

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	\$	6,130	\$ 425,448	\$	6,130	\$ 425,448	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,972	257,155		3,972	257,155	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,121	68,711		1,121	68,711	4
5	Physician Care		visits							5
6	Dental Care	39(3)	visits			275			275	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				230,781		230,781	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Wound Care</u>	39(3)				171			171	13
14	TOTAL			\$	11,223	\$ 751,760	\$ 230,781	11,223	\$ 982,541	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 343,064	\$ 358,305	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 279,780)	1,451,016	1,451,016	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,212	30,212	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	12,270	1,864,077	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,836,562	\$ 3,703,610	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	64,206	64,206	12
13	Land		416,067	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	1,238,485	2,005,056	15
16	Equipment, at Historical Cost	604,523	1,232,952	16
17	Accumulated Depreciation (book methods)	(745,491)	(3,596,615)	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>	(866)	52,075	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,160,857	\$ 5,356,472	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,997,419	\$ 9,060,082	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 359,787	\$ 359,787	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,644	25,644	28
29	Short-Term Notes Payable	250,000	250,000	29
30	Accrued Salaries Payable	211,422	211,422	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,615	2,615	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,400	32
33	Accrued Interest Payable		39,384	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	651,621	915,339	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,501,089	\$ 1,932,591	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,305,669	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,305,669	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,501,089	\$ 8,238,260	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,496,330	\$ 821,822	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,997,419	\$ 9,060,082	48

Lexington Health Care Center of Bloomingdale, Inc.

Provider #0035188

1/1/08-12/31/08

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 - Remodeling	-	(233,559)
Due to Royal	(29,323)	(29,323)
Accrued PTO	(127,270)	(127,270)
Accrued 401K	(22,566)	(22,566)
Due to Lexington Financial Service	(2,302)	(2,302)
Accrued Expenses	(62,857)	(62,857)
Accrued Royal Gen Mgmt Fees	(44,566)	(44,566)
Accrued Rent	(98,835)	-
Accrued Wage Assignments	653	653
Deferred Income	(125,012)	(125,012)
Advance Bi-Weekly Payments	(122,484)	(122,484)
Uncollectible Part A Co Pmts	128	128
Interest Rate Swap	-	(128,994)
	<u>(634,434)</u>	<u>(898,152)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,577,711	1
2	Restatements (describe):		2
3	Post Closing Adjustment	(189,309)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,388,402	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	107,928	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)	\$ 107,928	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)	\$ 1,496,330	24 *

* 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	\$ 13,166,307	1
2	Discounts and Allowances for all Levels	(5,088,198)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,078,109	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,472,894	6
7	Oxygen	7,282	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,480,176	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	3,178	12
13	Barber and Beauty Care	20,447	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	251,373	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,933	19
20	Radiology and X-Ray	10,670	20
21	Other Medical Services	143,301	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 461,902	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,242	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,242	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	364	28
28a	<u>Investment Income</u>	456	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 820	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,027,249	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,397,411	31
32	Health Care	4,379,386	32
33	General Administration	2,324,621	33
	B. Capital Expense		
34	Ownership	1,389,949	34
	C. Ancillary Expense		
35	Special Cost Centers	336,820	35
36	Provider Participation Fee	91,134	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,919,321	40
41	Income before Income Taxes (line 30 minus line 40)**	107,928	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 107,928	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.
The entity is a cash basis taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	1,891	1,943	\$ 89,259	\$ 45.94	1
2	Assistant Director of Nursing	3,575	3,857	132,790	34.43	2
3	Registered Nurses	41,805	46,174	1,463,907	31.70	3
4	Licensed Practical Nurses	3,248	3,486	81,466	23.37	4
5	CNAs & Orderlies	80,671	86,546	1,045,517	12.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,199	8,915	125,764	14.11	8
9	Activity Director	2,098	2,187	33,593	15.36	9
10	Activity Assistants	20,100	21,744	237,763	10.93	10
11	Social Service Workers	4,936	5,301	106,582	20.11	11
12	Dietician					12
13	Food Service Supervisor	1,837	2,049	40,725	19.88	13
14	Head Cook	1,973	2,049	29,511	14.40	14
15	Cook Helpers/Assistants	11,617	12,546	134,631	10.73	15
16	Dishwashers	13,447	14,366	120,304	8.37	16
17	Maintenance Workers	2,075	2,193	30,909	14.09	17
18	Housekeepers	29,808	32,367	277,576	8.58	18
19	Laundry	6,281	6,790	60,145	8.86	19
20	Administrator	1,763	1,983	96,586	48.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,471	18,876	297,864	15.78	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	252,795	273,372	\$ 4,404,892 *	\$ 16.11	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	239	\$ 14,768	1(3)	35
36	Medical Director	Monthly	53,800	9(3)	36
37	Medical Records Consultant	Monthly	172	10(3)	37
38	Nurse Consultant	18	1,015	10(3)	38
39	Pharmacist Consultant	615	4,050	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	99	4,738	11(3)	44
45	Social Service Consultant	96	4,822	12(3)	45
46	Other(specify) Psych	48	2,304	12(3)	46
47	Medical Consultant	Monthly	3,639	10(7)	47
48					48
49	TOTAL (lines 35 - 48)	1,115	\$ 89,308		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Jeffrey Baker	Administrator	0	\$ 96,586	Workers' Compensation Insurance	\$ 65,931	IDPH License Fee	\$			
				Unemployment Compensation Insurance	28,068	Advertising: Employee Recruitment	28,315			
				FICA Taxes	326,757	Health Care Worker Background Check				
				Employee Health Insurance	163,399	(Indicate # of checks performed <u>15</u>)	177			
				Employee Meals	11,519	Patient Background Checks	823			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,403			
				401(k) Contributions	22,749	Miscellaneous Dues & Subscriptions	1,081			
				Other Employee Benefits	34,381					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,586	TOTAL (agree to Schedule V, line 22, col.8)			\$ 652,804	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 35,712
B. Administrative - Other				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 Column 7)			\$ 914,263				Out-of-State Travel	\$		
							In-State Travel	5,799		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 914,263				Seminar Expense			
C. Professional Services										
Vendor/Payee	Type		Amount							
Action Computer Service	Computer Consulting		\$ 315				Management Company Allocation	484		
Converged Comm	Computer Consulting		140				Entertainment Expense	()		
Lintech LLC	Computer Consulting		5,468				(agree to Sch. V, line 24, col. 8)			
National Datacare	Computer Consulting		1,756	N/A			TOTAL	\$ 6,283		
E-Health Data Solutions	Computer Consulting		2,400							
C.D.W. Direct	Computer Consulting		323							
Krakau Business	Computer Consulting		157							
Healthware Consulting	Computer Consulting		2,060							
Alperian Technology	Computer Consulting		215							
Information Control	Computer Consulting		1,044							
See attached Schedule 21C			97,055							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 110,933	TOTAL			\$			

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Bloomingdale, Inc.

Provider # 0035188

1/1/08 - 12/31/08

Schedule 21C

XIX. Support Schedules

C. Professional Services

Vendor/Payee

Silverchair Learning Systems	Computer Consulting	4,300
Microsoft License	Computer Consulting	4,102
Vision Share	Computer Consulting	580
B2B Computer Products	Computer Consulting	1,665
Micro Center	Computer Consulting	91
Lanac/GP	Computer Consulting	2,131
Grabowski Law Center	Collections	7,895
Cassidy Schade LLP	Legal	19,418
Duane Morris	Legal	396
ING Life Insurance & Annuity	401k Consulting	915
James Samatas, Atty. At Law	Legal	237
Moody's	Bond Consulting	515
McGladrey & Pullen	Accounting	23,618
Personnel Planners	U/C Consulting	940
Reed Smith/Sachnoff & Weaver	Legal	19,647
ING Life Insurance & Annuity	401k Consulting	737
RSM McGladrey	Accounting	8,828
Gene Whitehorn	Medicaid Reimb. Specialist	1,040
		<u>97,055</u>

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

110,933

Allocated from management co.

James Samatas	Legal-filing fees	22
Sachnoff & Weaver	Legal	1,173
Duane Morris	Legal	10
McGladrey & Pullen LLP	Accounting	319
RSM McGladrey	Accounting	338
Gilson Labus & Silverman	Accounting	1,259
Pension Administrators, Inc.	401(k) Administration	354
Personnel Planners, Inc.	Unemployment Consultant	25
Beth Schwarz	Operations Consultant	14
Gene Whitehorn	Medicaid Reimb. Specialist	650
See Schedule 21D for Vendor List	Computer Consulting	17,447

Allocated from Samvest of Lombard II

Gilson, Labus & Silverman	Accounting	249
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Allocated from Sambell

James Samatas	Legal	300
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Nonallowable legal fees (2,041)

Nonallowable collection fees (7,895)

Nonallowable accounting fees (1,002)

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

122,155

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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington# 0035188Report Period Beginning: 01/01/2008Ending: 12/31/2008**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. \$ 22,872 Line 10(2)
- (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. \$ 91,134
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 11,519 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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees