



Facility Name & ID Number Lexington Health Care Center-Lombard

# 0028860 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	<u>224</u>	Skilled (SNF)	<u>224</u>	<u>81,984</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>224</u>	TOTALS	<u>224</u>	<u>81,984</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,821</u>	<u>1,262</u>	<u>12,421</u>	<u>17,504</u>	8
9	SNF/PED					9
10	ICF	<u>34,854</u>	<u>15,255</u>	<u>1,325</u>	<u>51,434</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>38,675</u>	<u>16,517</u>	<u>13,746</u>	<u>68,938</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.09%

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 10/9/84

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 224 and days of care provided 12,157

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

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

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 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
	<b>A. General Services</b>										
1	Dietary	429,758	39,186	15,448	484,392		484,392		484,392		1
2	Food Purchase		326,299		326,299		326,299	(16,037)	310,262		2
3	Housekeeping	361,579	40,046		401,625		401,625	512	402,137		3
4	Laundry	94,563	20,380		114,943		114,943		114,943		4
5	Heat and Other Utilities			297,647	297,647		297,647	7,559	305,206		5
6	Maintenance	34,217		169,832	204,049		204,049	51,836	255,885		6
7	Other (specify):* <b>Mgmt. Alloc. Benefits</b>							5,630	5,630		7
8	<b>TOTAL General Services</b>	920,117	425,911	482,927	1,828,955		1,828,955	49,500	1,878,455		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			52,800	52,800		52,800		52,800		9
10	Nursing and Medical Records	4,126,057	240,254	17,440	4,383,751		4,383,751	19,957	4,403,708		10
10a	Therapy			1,013,081	1,013,081		1,013,081		1,013,081		10a
11	Activities	290,375	32,600	21,159	344,134		344,134		344,134		11
12	Social Services	88,145		7,526	95,671		95,671		95,671		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Mgmt. Alloc. Benefits</b>							3,361	3,361		15
16	<b>TOTAL Health Care and Programs</b>	4,504,577	272,854	1,112,006	5,889,437		5,889,437	23,318	5,912,755		16
	<b>C. General Administration</b>										
17	Administrative	103,173		1,247,060	1,350,233		1,350,233	(1,184,636)	165,597		17
18	Directors Fees										18
19	Professional Services			84,227	84,227		84,227	23,517	107,744		19
20	Dues, Fees, Subscriptions & Promotions			15,272	15,272		15,272	5,280	20,552		20
21	Clerical & General Office Expenses	335,835	37,573	17,704	391,112		391,112	457,309	848,421		21
22	Employee Benefits & Payroll Taxes			901,995	901,995		901,995	15,131	917,126		22
23	Inservice Training & Education			1,151	1,151		1,151		1,151		23
24	Travel and Seminar			8,709	8,709		8,709	653	9,362		24
25	Other Admin. Staff Transportation			840	840		840	22,294	23,134		25
26	Insurance-Prop.Liab.Malpractice			218,567	218,567		218,567	3,433	222,000		26
27	Other (specify):* <b>Mgmt. Alloc. Benefits</b>							67,509	67,509		27
28	<b>TOTAL General Administration</b>	439,008	37,573	2,495,525	2,972,106		2,972,106	(589,510)	2,382,596		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,863,702	736,338	4,090,458	10,690,498		10,690,498	(516,692)	10,173,806		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-Lombard

#0028860

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	
	<b>D. Ownership</b>											
30	Depreciation			188,480	188,480		188,480	233,122	421,602			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,848	48,848		48,848	39,932	88,780			32
33	Real Estate Taxes							147,398	147,398			33
34	Rent-Facility & Grounds			1,595,840	1,595,840		1,595,840	(1,591,644)	4,196			34
35	Rent-Equipment & Vehicles			60,577	60,577		60,577	4,690	65,267			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,893,745	1,893,745		1,893,745	(1,166,502)	727,243			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		438,159		438,159		438,159		438,159			39
40	Barber and Beauty Shops			29,509	29,509		29,509		29,509			40
41	Coffee and Gift Shops			3,297	3,297		3,297		3,297			41
42	Provider Participation Fee			122,976	122,976		122,976		122,976			42
43	Other (specify):* <b>Non-allowable cost</b>			90,439	90,439		90,439	(90,439)				43
44	<b>TOTAL Special Cost Centers</b>		438,159	246,221	684,380		684,380	(90,439)	593,941			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,863,702	1,174,497	6,230,424	13,268,623		13,268,623	(1,773,633)	11,494,990			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	(906)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,508)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,696)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,779)	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	(38,304)	43		24
25	Fund Raising, Advertising and Promotional	(12,148)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,839)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Sch 5A</u>	(103,195)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (191,250)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,582,383)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,582,383)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,773,633)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

## Lexington Health Care Center-Lombard

ID# 0028860

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs Part A	\$ (12,480)	43	1
2	X-Rays Part A	(17,537)	43	2
3	Miscellaneous Income	(60)	21	3
4	Marketing Salary	(53,922)	21	4
5	Trust Fees	(450)	43	5
6	Out of period legal-Sambell	(100)	19	6
7	Additional Marketing Salary	(12,465)	10	7
8	Non-allowable accounting	(1,352)	19	8
9	Collections	(4,404)	19	9
10	Out of period legal	(425)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(103,195)		49

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%	See Attached Schedule B	See Attached Schedule B	Lexington Health		
John Samatas	33.33%			Care Systems of		
Cynthia Thiem	33.34%			Lombard Ltd. Ptsp.	Lombard	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. 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	34 Rental Expense	\$ 1,595,840	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	\$	\$ (1,595,840)	1
2	V	30 Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	177,662	177,662	2
3	V	32 Interest Expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	28,516	28,516	3
4	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	2,454	2,454	4
5	V	33 Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	143,840	143,840	5
6	V	43 State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	15,031	15,031	6
7	V	43 Trust fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	450	450	7
8	V	19 Professional Fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	300	300	8
9	V	21 Office Supplies		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	105	105	9
10	V							10
11	V			**-The owners of Lexington Health Care Center of Lombard, Inc. own				11
12	V			100% of Lexington Health Care Systems of Lombard Limited Partnership.				12
13	V							13
14	Total		\$ 1,595,840			\$ 368,358	\$ * (1,227,482)	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.	**	\$ 512	\$	512	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,289		6,289	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	160		160	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,110		1,110	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	46,087		46,087	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,468		5,468	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	281		281	21	
22	V	6 Security service		Royal Management Corp.	**				22	
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,630		5,630	23	
24	V	10 Medical consultant		Royal Management Corp.	**	4,911		4,911	24	
25	V	10 Management allocation - salaries		Royal Management Corp.	**	27,511		27,511	25	
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,361		3,361	26	
27	V	17 Management allocation - salaries		Royal Management Corp.	**	62,424		62,424	27	
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	23,546		23,546	28	
29	V	19 Professional fees		Royal Management Corp.	**	5,952		5,952	29	
30	V	20 Dues & subscriptions		Royal Management Corp.	**	4,023		4,023	30	
31	V	21 Communications		Royal Management Corp.	**				31	
32	V	20 Advertising - help wanted		Royal Management Corp.	**	1,257		1,257	32	
33	V	21 Management allocation - salaries		Royal Management Corp.	**	483,099		483,099	33	
34	V	21 Bank charges		Royal Management Corp.	**	5,693		5,693	34	
35	V	21 Office supplies & printing		Royal Management Corp.	**	10,757		10,757	35	
36	V	21 Postage		Royal Management Corp.	**	3,430		3,430	36	
37	V								37	
38	V	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 701,501	\$ *	701,501	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.	**	\$ 8,207	\$ 8,207	
16	V	24 Travel & seminar		Royal Management Corp.	**	653	653	
17	V	25 Auto expense		Royal Management Corp.	**	22,294	22,294	
18	V	26 Insurance general		Royal Management Corp.	**	3,433	3,433	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	67,509	67,509	
20	V	30 Depreciation		Royal Management Corp.	**	55,460	55,460	
21	V	32 Interest		Royal Management Corp.	**	20,626	20,626	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	32	32	
23	V	33 Property taxes		Royal Management Corp.	**	3,558	3,558	
24	V	34 Rent expense		Royal Management Corp.	**	4,196	4,196	
25	V	35 Equipment rental		Royal Management Corp.	**	1,010	1,010	
26	V	17 Management fees	1,247,060	Royal Management Corp.	**		(1,247,060)	
27	V	35 Auto Lease expense		Royal Management Corp.	**	3,680	3,680	
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						
38	V							
39	Total		\$ 1,247,060			\$ 190,658	\$ * (1,056,402)	

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

**Lexington Health Care Center of Lombard, Inc.**

**Provider # 0028660**

**1/1/08-12/31/08**

**Schedule 6B**

VII. Related Parties

Related Nursing Homes

Name of facility

City

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

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 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	33.33	See Schedule 7A	3.92	7.80	Salary	\$ 20,808	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33	See Schedule 7A	3.92	7.80	Salary	20,808	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	3.92	7.80	Salary	20,808	L17, C7	3
4	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	0.7	1.40	Salary	1,447	L21, C7	4
5	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	5.61	11.00	Salary	20,481	L17,21,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	\$ 84,352		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
<b>Total</b>	<b>185,600</b>	<b>185,600</b>	<b>185,600</b>	<b>12,904</b>	<b>182,679</b>	<b>752,383</b>

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard

# 0028860

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

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	731,268	10	\$ 4,564	\$ 81,984	\$ 512	1	
2	5	Utilities - gas & electric	Bed Days	731,268	10	56,094	81,984	6,289	2	
3	5	Utilities - water & sewer	Bed Days	731,268	10	1,425	81,984	160	3	
4	5	Utilities - maintenance office	Bed Days	731,268	10	9,903	81,984	1,110	4	
5	6	Management allocation - salaries	Bed Days	731,268	10	411,084	411,084	81,984	46,087	5
6	6	Repairs & maintenance	Bed Days	731,268	10	48,773	81,984	5,468	6	
7	6	Scavenger & exterminating	Bed Days	731,268	10	2,504	81,984	281	7	
8	6	Security service	Bed Days	731,268	10		81,984	0	8	
9	7	Management allocation - employee	Bed Days	731,268	10	50,217	81,984	5,630	9	
10	10	Medical consultant	Bed Days	731,268	10	43,800	81,984	4,911	10	
11	10	Management allocation - salaries	Bed Days	731,268	10	245,385	245,385	81,984	27,511	11
12	15	Management allocation - employee	Bed Days	731,268	10	29,975	81,984	3,361	12	
13	17	Management allocation - salaries	Bed Days	731,268	10	556,800	556,800	81,984	62,424	13
14	19	Computer consultant & supplies	Bed Days	731,268	10	210,020	81,984	23,546	14	
15	19	Professional fees	Bed Days	731,268	10	53,093	81,984	5,952	15	
16	20	Dues & subscriptions	Bed Days	731,268	10	35,880	81,984	4,023	16	
17	21	Communications	Bed Days	731,268	10		81,984	0	17	
18	20	Advertising - help wanted	Bed Days	731,268	10	11,214	81,984	1,257	18	
19	21	Management allocation - salaries	Bed Days	731,268	10	4,309,068	4,309,068	81,984	483,099	19
20	21	Bank charges	Bed Days	731,268	10	50,778	81,984	5,693	20	
21	21	Office supplies & printing	Bed Days	731,268	10	95,951	81,984	10,757	21	
22	21	Postage	Bed Days	731,268	10	30,589	81,984	3,429	22	
23	21	Telephone	Bed Days	731,268	10	73,204	81,984	8,207	23	
24	24	Travel and Seminar	Bed Days	731,268	10	5,826	81,984	653	24	
25	TOTALS					\$ 6,336,147	\$ 5,522,337	\$ 710,360	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard

# 0028860

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	731,268	10	\$ 198,854	\$ 81,984	\$ 22,294	1
2	26	Insurance general	Bed Days	731,268	10	30,619	81,984	3,433	2
3	27	Management allocation - employee	Bed Days	731,268	10	602,157	81,984	67,509	3
4	30	Depreciation - leasehold improv.	Bed Days	731,268	10	494,680	81,984	55,460	4
5	32	Interest	Bed Days	731,268	10	183,980	81,984	20,626	5
6	32	Amortization of mortgage costs	Bed Days	731,268	10	283	81,984	32	6
7	33	Property taxes	Bed Days	731,268	10	31,746	81,984	3,559	7
8	34	Rent expense	Bed Days	731,268	10	37,431	81,984	4,196	8
9	35	Equipment rental	Bed Days	731,268	10	9,010	81,984	1,010	9
10		Auto Lease	Bed Days	731,268	10	32,828	81,984	3,680	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	\$	\$ 181,799	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Lexington Health Care Center-Lombard

# 0028860

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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	GMAC		X	Mortgage	\$39,766.00	4/11/94	\$ 3,978,766	\$ 194,553	4/11/09	0.0875	\$ 47,379	1						
2												2						
3												3						
4												4						
5							Interest on financing insurance premium				2,695	5						
<b>Working Capital</b>																		
6	Bank of America		X	Line of Credit	Varies	4/6/02	1,200,000	725,000	6/30/09	Prime	20,896	6						
7	Shareholder Interest	X		Line of Credit	Varies	7/16/08	499,000	499,000	Demand	Prime	6,393	7						
8												8						
9	TOTAL Facility Related				\$39,766.00		\$ 5,677,766	\$ 1,418,553			\$ 77,363	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income offset		(5,302)	10						
11									Amortization of mortgage costs		2,486	11						
12									Allocation of management company		20,626	12						
13									Shareholder Interest		(6,393)	13						
14	TOTAL Non-Facility Related						\$	\$			\$ 11,417	14						
15	TOTALS (line 9+line14)						\$ 5,677,766	\$ 1,418,553			\$ 88,780	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 2007 report.		\$	<b>153,600</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	<b>146,240</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(7,360)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>151,200</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
			<b>Allocated from Mgmt Co. 3,558</b>	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>147,398</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>141,173</b>	8
	2004	<b>140,451</b>	9
	2005	<b>131,207</b>	10
	2006	<b>138,583</b>	11
	2007	<b>146,240</b>	12

Accrual calculation: See schedule attached.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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-Lombard COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0028860

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>06-19-307-002</u>	<u>Building and Land</u>	\$ <u>146,239.74</u>	\$ <u>146,239.74</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ <u>174,993.86</u>	\$ <u>3,558.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>321,233.60</u>	\$ <u>149,797.74</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

Facility Name & ID Number Lexington Health Care Center-Lombard

# 0028860

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 78,770 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).

Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square feet

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>30,000</u>	<u>1984</u>	<u>\$ 616,761</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>17,607</u>	<u>2</u>
3	<b>TOTALS</b>	<b>30,000</b>		<b>\$ 634,368</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington Health Care Center-Lombard

# 0028860

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	215	1984	1984	\$ 3,661,472	\$	35	\$ 104,614	\$ 104,614	\$ 2,534,695	4
5	9	1995	1995	284,156	8,119	35	8,119		109,603	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Building Improvements		1990	96,217		10			96,217	9
10	Leasehold Improvements Additions		1995	71,493		10			71,493	10
11	Building Improvements		1994	20,200		10			20,200	11
12	Building Improvements		1995	14,535	415	35	415		5,606	12
13	Building Improvements - dishwasher hood		1996	2,748		10			2,748	13
14	Building Improvements - outside painting		1996	11,308		10			11,308	14
15	Building Improvements - dining room		1996	3,752		10			3,752	15
16	Leasehold Improvements		1992	16,299	466	35	466		7,685	16
17	Leasehold Improvements		1994	21,836		10			21,836	17
18	Leasehold Improvements - 2nd floor		1996	19,319		10			18,353	18
19	Leasehold Improvements - bathroom rehab		1996	9,216		10			8,909	19
20	Leasehold Improvements - fan coil repairs		1996	6,669	191	35	191		2,351	20
21	Land Improvements		1993	2,985	99	15	99		2,985	21
22	Land Improvements		1995	4,596	306	15	306		4,136	22
23	Capitalized Repairs		1986	1,730		10			1,730	23
24	Building Improvements - basement		1996	18,993		10			18,993	24
25	Leasehold Improvements - Corner Guards		1997	520		10			520	25
26	Leasehold Improvements - Corridor flooring		1997	10,380		10			10,380	26
27	BI: Kitchen Rehab		1998	2,494	125	10	125		2,494	27
28	Wiring for MDS project		1998	3,365	168	10	168		3,365	28
29	Install Fire Sprinklers in Mechanical Rms		1998	4,600	131	35	131		1,380	29
30	Tile for Lobby		1998	20,530	1,026	10	1,026		20,530	30
31	Walk in Freezers/Coolers		1998	3,183	91	35	91		955	31
32	Fire Wall Repairs		1998	12,411	355	35	355		3,724	32
33	Underground storage tank		1998	2,613		10			2,613	33
34	Repave parking lot		1999	7,625	508	15	508		4,829	34
35	Lounge Floor Tile		1999	2,963	296	10	296		2,815	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington Health Care Center-Lombard

# 0028860

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	Rewire Building	1999	\$ 9,083	\$ 260	35	\$ 260	\$	\$ 2,466	37
38	Heat exchanger for water heater	1999	1,660		5			1,660	38
39	Compressor and tank for freezer	1999	2,924		5			2,924	39
40	Plumbing Improvements	2000	2,833	283	10	283		2,408	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		534	41
42	Water heater repairs	2000	3,831		5			3,831	42
43	Automatic door	2000	4,556	130	35	130		1,106	43
44	Install sprinklers	2001	6,082	608	10	608		4,612	44
45	Infrared curtains for elevator	2001	4,500	450	10	450		3,225	45
46	Elevator upgrade	2002	3,006		5			3,006	46
47	Condensor	2002	2,679		5			2,679	47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		8,312	48
49	Plumbing loop repairs	2003	6,125	613	10	613		3,114	49
50	Fire alarm panel/call system	2003	8,495	425	20	425		2,513	50
51	Facility Rehab - Painting	2003	6,872	687	10	687		3,596	51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		7,636	52
53	Nurse call system	2003	49,451	2,473	20	2,473		12,569	53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		1,586	54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		94,344	55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		82,898	56
57	Floor Tile	2003	58,720	2,936	20	2,936		17,616	57
58	Carpeting/cove base	2003	29,518	2,952	10	2,952		17,711	58
59	Water heater	2004	9,209	921	10	921		3,837	59
60	Kitchen sewer and dishroom	2004	31,233	1,562	20	1,562		6,377	60
61	Landscaping	2005	3,255	163	20	163		556	61
62	HVAC	2005	8,028	401	20	401		1,271	62
63	Kitchen sewer, dishroom and ceiling	2005	22,924	1,146	20	1,146		4,107	63
64	Lobby and reception redecorating - painting/wallpaper	2005	37,999	1,900	20	1,900		6,967	64
65	Rehab therapy room - electrical, carpet, tile	2005	66,393	3,320	20	3,320		12,172	65
66	Rehab 1st floor therapy room - electrical, carpet, tile	2005	39,341	1,967	20	1,967		7,212	66
67	Wallpaper, tile, electrical for transitional unit	2005	22,946	1,147	20	1,147		4,302	67
68	Window treatments	2005	8,053	403	20	403		1,443	68
69	Tile, flooring, and wallpaper	2005	57,699	2,885	20	2,885		10,338	69
70	TOTAL (lines 4 thru 69)		\$ 5,504,061	\$ 72,803		\$ 177,417	\$ 104,614	\$ 3,335,133	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,504,061	\$ 72,803		\$ 177,417	\$ 104,614	\$ 3,335,133	1
2	Countertops	2005	845	169	5	169		620	2
3	Curtains and blinders	2005	4,672	935	5	935		3,141	3
4	Mini scroll	2005	527	105	5	105		342	4
5	Medical Records Storage/Office Room	2006	5,901	148	40	148		320	5
6	Office Remodel	2006	5,537	138	40	138		276	6
7	Piping	2006	4,511	301	15	301		702	7
8	HVAC	2006	7,985	200	40	200		400	8
9	Emergency A/C	2006	9,385	235	40	235		470	9
10	Adm Office-HVAC	2006	6,421	161	40	161		388	10
11	Sink installation	2006	2,561	64	40	64		176	11
12	Land Improvements Patio	2006	23,736	1,582	15	1,582		3,692	12
13	Brick Pavers	2007	8,500	567	15	567		945	13
14	Landscaping	2007	16,420	821	20	821		1,163	14
15	Parking Lot	2007	13,219	661	20	661		936	15
16	Roof	2007	9,800	490	20	490		858	16
17	HVAC	2007	8,197	410	20	410		615	17
18	LHI-Emergency A/C	2007	11,126	556	20	556		649	18
19	LHI-Plumbing & Sprinkler	2007	6,799	680	10	680		850	19
20	Automatic Doors in Common Areas	2007	20,874	1,044	20	1,044		1,479	20
21	Tike System & Foundation	2007	4,500	225	20	225		244	21
22	Exterior of Building Painting	2007	16,600	830	20	830		1,038	22
23	Landscaping	2008	21,600	1,080	15	1,080		1,080	23
24	Parking Lot	2008	9,625	281	20	281		281	24
25	Roof Repair	2008	11,001	183	20	183		183	25
26	HVAC	2008	20,164	547	20	547		547	26
27	Sink and Toilet	2008	4,000	267	10	267		267	27
28	Elevator Upgrades	2008	171,955	1,075	40	1,075		1,075	28
29	Metal Doors	2008	3,907	147	20	147		147	29
30	Basement Renovation	2008	25,195	840	20	840		840	30
31	Trash Compactor	2008	11,590	290	20	290		290	31
32	Painting Gazebo	2008	4,450	93	20	93		93	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,975,666	\$ 87,928		\$ 192,542	\$ 104,614	\$ 3,359,240	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lexington Health Care Center-Lombard

# 0028860

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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,975,666	\$ 87,928		\$ 192,542	\$ 104,614	\$ 3,359,240	1
2	2nd floor remodel-Electric, flooring,painting	2008	561,165		27	1,701	1,701	1,701	2
3	Kitchen Upgrade-Carpentry, painting, plumbing	2008	18,364		27	56	56	56	3
4	1st floor remodel-painting, electrical, flooring,plumbing	2008	547,836		27	18,261	18,261	18,261	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18	Land Improvements-management company	2002	27,750		15	2,000	2,000	2,345	18
19	Building-management company	2002	215,891		40	43,351	43,351	47,968	19
20	HVAC, electrical, security system-management company	2003	2,140		30	71	71	831	20
21	Key card system-management company	2004	336		20	33	33	154	21
22	VAV TX controls-management compnay	2005	102		20	5	5	9	22
23	Building Improvements-management company	2006	75		20	4	4	5	23
24	Building Improvements-management company	2008	45		20	2	2	1	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,349,370	\$ 87,928		\$ 258,026	\$ 170,098	\$ 3,430,571	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	\$ 664,158	\$ 98,033	\$ 98,033	\$	5	\$ 394,916	71
72	Current Year Purchases	498,570	2,519	55,550	53,031	5	55,550	72
73	Fully Depreciated Assets	79,631					79,631	73
74	Allocated from management company	276,455		4,670	4,670		169,270	74
75	TOTALS	\$ 1,518,814	\$ 100,552	\$ 158,253	\$ 57,701		\$ 699,367	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			39,514		5,324	5,324		25,905	79
80	TOTALS			\$ 39,514	\$	\$ 5,324	\$ 5,324		\$ 25,905	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,542,065	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 188,480	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 421,602	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 233,122	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,155,842	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	3rd floor remodel	\$ 70,410	92
93			93
94			94
95		\$ 70,410	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		Allocation from management company			4,196			6
7	TOTAL				\$ 4,196			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: \$ 61,587 Description: Medical Equip- \$27,804; Copier- \$6,384; Fax Machine- \$1,056; Oxygen- \$ 25,333, Allocated Mgmt. Co. -1010  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocation from management company			3,680	20
21	TOTAL		\$	\$ 3,680	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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	5,077	\$ 349,840	\$	5,077	\$ 349,840	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,948	133,787		1,948	133,787	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,706	529,453		8,706	529,453	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				438,159		438,159	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	15,731	\$ 1,013,081	\$ 438,159	15,731	\$ 1,451,240	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-Lombard

# 0028860

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 264,675	\$ 1,533,688	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 401,893 )	2,624,831	2,625,072	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	125,509	125,509	6
7	Other Prepaid Expenses	53,313	53,313	7
8	Accounts Receivable (owners or related parties)	579,440	3,441	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,647,768	\$ 4,341,023	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		634,368	13
14	Buildings, at Historical Cost		3,661,473	14
15	Leasehold Improvements, at Historical Cost	2,103,655	3,687,897	15
16	Equipment, at Historical Cost	732,954	1,558,328	16
17	Accumulated Depreciation (book methods)	(1,025,138)	(4,155,842)	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 CIP	70,410	70,410	22
23	Other(specify): Mortgage Cost Net		821	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,881,881	\$ 5,457,455	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,529,649	\$ 9,798,478	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 482,632	\$ 482,632	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,250	1,250	28
29	Short-Term Notes Payable	1,224,000	1,224,000	29
30	Accrued Salaries Payable	430,740	430,740	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,286	9,286	31
32	Accrued Real Estate Taxes(Sch.IX-B)		151,200	32
33	Accrued Interest Payable		8,995	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See attached schedule 17A	416,397	2,711,397	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,564,305	\$ 5,019,500	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		194,553	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 194,553	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,564,305	\$ 5,214,053	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,965,344	\$ 4,584,425	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,529,649	\$ 9,798,478	48

Lexington Health Care Center of Lombard, Inc.

Provider #0028660

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>
Notes Payable		(65,000)
401K Withholding	(52)	(52)
Accrued 401K	(27,946)	(27,946)
Due to Royal	(37,065)	(37,065)
Due to Replublic Construction	(6,666)	(6,666)
Accrued Expenses	(111,593)	(111,593)
Accrued Royal Gen Mgmt Fees	(73,241)	(73,241)
Accrued Rent	(241)	(241)
Accrued Wage Assignments	(167)	(167)
Deferred Income	(159,426)	(159,426)
Due to J. Samatas		(1,115,000)
Due to C Thiem Discretionary		(1,115,000)
	<u>(416,397)</u>	<u>(2,711,397)</u>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,999,611</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior period adjustment</b>	<b>(20,888)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,978,723</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,507,621</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,521,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(13,379)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,965,344</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 17,332,056	1
2	Discounts and Allowances for all Levels	(6,374,163)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,957,893	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,351,069	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,351,069	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,716	12
13	Barber and Beauty Care	33,726	13
14	Non-Patient Meals	906	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	524,592	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44,888	19
20	Radiology and X-Ray	19,317	20
21	Other Medical Services	163,671	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 791,816	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	5,302	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,302	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Bed hold early discharge</u>	670,164	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 670,164	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,776,244	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,828,955	31
32	Health Care	5,889,437	32
33	General Administration	2,972,106	33
	<b>B. Capital Expense</b>		
34	Ownership	1,893,745	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	561,404	35
36	Provider Participation Fee	122,976	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,268,623	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,507,621	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,507,621	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 tax payer

\*\*\* 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-Lombard

# 0028860

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	2,142	\$ 114,410	\$ 53.41	1
2	Assistant Director of Nursing	8,337	9,038	316,409	35.01	2
3	Registered Nurses	55,009	59,450	1,893,879	31.86	3
4	Licensed Practical Nurses	9,794	11,273	324,138	28.75	4
5	CNAs & Orderlies	99,161	106,469	1,264,040	11.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,799	14,053	197,648	14.06	8
9	Activity Director	1,865	2,152	34,105	15.85	9
10	Activity Assistants	19,384	21,223	256,270	12.08	10
11	Social Service Workers	5,004	5,114	88,145	17.24	11
12	Dietician	1,948	2,032	34,380	16.92	12
13	Food Service Supervisor	1,956	2,173	40,350	18.57	13
14	Head Cook	1,939	2,173	47,896	22.04	14
15	Cook Helpers/Assistants	13,126	14,265	136,028	9.54	15
16	Dishwashers	20,009	21,054	171,104	8.13	16
17	Maintenance Workers	2,134	2,262	34,217	15.13	17
18	Housekeepers	38,268	41,405	361,579	8.73	18
19	Laundry	10,339	11,202	94,563	8.44	19
20	Administrator	1,986	2,129	103,173	48.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,397	16,040	291,525	18.17	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	953	1,031	15,533	15.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Financial Coordin</u>	2,458	2,745	44,310	16.14	33
34	TOTAL (lines 1 - 33)	322,757	349,425	\$ 5,863,702 *	\$ 16.78	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	266	\$ 15,448	L1, C3	35
36	Medical Director	Monthly	52,800	L9, C3	36
37	Medical Records Consultant	17	1,460	L10, C3	37
38	Nurse Consultant	25	1,365	L10, C3	38
39	Pharmacist Consultant	Monthly	4,815	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	87	4,387	L11, C3	44
45	Social Service Consultant	104	5,222	L12, C3	45
46	Other(specify) <u>Psychosocial</u>	48	2,304	L12, C3	46
47	<u>MDS Consultant</u>	122	9,800	L10, C3	47
48	<u>Medical Consultant</u>	Monthly	4,911	L10, C7	48
49	TOTAL (lines 35 - 48)	669	\$ 102,512		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ N/A		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	
Christopher Correl	Administrator	0%	\$ 16,746	Workers' Compensation Insurance	\$ 98,103	IDPH License Fee	\$ 995	
Susan Polier	Administrator	0%	86,427	Unemployment Compensation Insurance	86,947	Advertising: Employee Recruitment	9,233	
				FICA Taxes	431,861	Health Care Worker Background Check (Indicate # of checks performed <u>129</u> )	416	
				Employee Health Insurance	216,202	Patient Background Checks	584	
				Employee Meals	15,131	Miscellaneous Licenses & Fees	2,911	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	1,133	
				401K Contributions	28,044			
				Other Employee Benefits	40,838			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 103,173	TOTAL (agree to Schedule V, line 22, col.8)		\$ 917,126	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,552
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)			\$ 1,247,060				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	8,709
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,247,060				Allocation from Management Co.	653
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Grawbowski Law Center	Legal-Collection Fees		\$ 4,404					
Cassiday Shade, LLP	Legal		661					
James Samatas	Legal		325					
McGladrey & Pullen, LLP	Accounting		19,737					
Pension Administrators, Inc.	401K Administration		989					
Personnel Planners	U/C Consulting		3,340					
Reed Smith/Sachnoff & Weaver	Legal		8,448					
RSM McGladrey	Accounting		8,643					
Serpico, Petrosino, Depiero, LTD	Legal		1,623					
ING Life Insurance Annuity	401K Administration		1,185					
Alperian Technology	Computer Consulting		215					
See attached schedule 21C			34,657					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 84,227				\$ 9,362	

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

\*\*See instructions.

Lexington Health Care Center of Lombard, Inc.  
 Provider #0028660  
 1/1/08-12/31/08

Schedule 21C

XIX. Support Schedules  
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Gene Whitehorn	Medicaid Reimbursement Specialist	957
Contrac Healthcare	Regulatory Consultant	300
Action Computer Service	Computer Consulting	259
B2B Computer	Computer Consulting	1,665
Brook Electrical Distribution	Computer Consulting	454
C.D.W Direct	Computer Consulting	324
Converged Comm	Computer Consulting	4,485
E-Health Data Solutions	Computer Consulting	2,400
HealthWare Consulting	Computer Consulting	2,060
Information Control	Computer Consulting	1,260
Krakau Business Computers	Computer Consulting	158
Lanac Technology	Computer Consulting	2,782
Lintech LLC	Computer Consulting	5,468
Microsoft2	Computer Consulting	4,389
MNJ Technologies Direct	Computer Consulting	1,158
National Datacare	Computer Consulting	1,658
SilverChair Learning Systems	Computer Consulting	4,300
Vision Share, Inc.	Computer Consulting	580
		<u>34,657</u>

Total Legal 84,227

<u>Non-allowable Legal</u>		
Grawboswki Law Center	Collections	(4,404)
Out of period legal	Legal	(425)

<u>Allocated from Lexington Health Care Centers Lombard</u>		
James Samatas	Legal	300
Less Out of period		(100)
		<u>200</u>

<u>Allocated from Management Company</u>		
James Samatas	Legal	29
Sachnoff & Weaver	Legal	1,583
Duane Morris	Legal	13
McGladrey & Pullen LLP	Accounting	430
RSM McGladrey	Accounting	456
Gilson Labus & Silverman	Accounting	1,699
Pension Administrators	401K Administration	478
Personnel Planners, Inc	Unemployment Consultant	33
Beth Schwarz	Operations Consultant	18
Gene Whitehorn	Legal	877
Computer-See attached schedule	Computer consulting	23,546
		<u>29,162</u>

Gilson Labus & Silverman-Non allowable Accounting (1,352)

<u>Allocated from Samvest of Lombard II</u>		
Gilson, Labus & Silverman	Accounting	336

Total, Agrees to Schedule V, Line 19, Column 8 107,744

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard# 0028860Report 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? 6 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,347 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. \$ 122,976  
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. \$ 15,131 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 906
- (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

**SEE ACCOUNTANTS' COMPILATION REPORT**