

Facility Name & ID Number Lexington of Lake Zurich

0039768 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	209	Skilled (SNF)	209	76,494	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	209	TOTALS	209	76,494	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	1,962	1,623	11,120	14,705	8
9	SNF/PED					9
10	ICF	41,512	4,790	3,282	49,584	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,474	6,413	14,402	64,289	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.04%

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 08/20/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 209 and days of care provided 10,865

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 of Lake Zurich # 0039768 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	370,709	33,221	13,108	417,038		417,038		417,038		1
2	Food Purchase		310,261		310,261		310,261	(15,115)	295,146		2
3	Housekeeping	325,242	33,518		358,760		358,760	477	359,237		3
4	Laundry	86,369	17,678		104,047		104,047		104,047		4
5	Heat and Other Utilities			259,457	259,457		259,457	7,053	266,510		5
6	Maintenance	37,027		140,196	177,223		177,223	48,365	225,588		6
7	Other (specify):* Allocated Benefits							5,253	5,253		7
8	TOTAL General Services	819,347	394,678	412,761	1,626,786		1,626,786	46,033	1,672,819		8
	B. Health Care and Programs										
9	Medical Director			57,125	57,125		57,125		57,125		9
10	Nursing and Medical Records	3,754,036	262,316	30,720	4,047,072		4,047,072	18,619	4,065,691		10
10a	Therapy			945,897	945,897		945,897		945,897		10a
11	Activities	276,462	30,699	6,136	313,297		313,297		313,297		11
12	Social Services	139,372		6,826	146,198		146,198		146,198		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Allocated Benefits							3,136	3,136		15
16	TOTAL Health Care and Programs	4,169,870	293,015	1,046,704	5,509,589		5,509,589	21,755	5,531,344		16
	C. General Administration										
17	Administrative	122,722		1,149,860	1,272,582		1,272,582	(1,091,616)	180,966		17
18	Directors Fees										18
19	Professional Services			114,953	114,953		114,953	13,662	128,615		19
20	Dues, Fees, Subscriptions & Promotions			23,173	23,173		23,173	4,421	27,594		20
21	Clerical & General Office Expenses	322,137	35,831	19,452	377,420		377,420	422,049	799,469		21
22	Employee Benefits & Payroll Taxes			797,182	797,182		797,182	15,115	812,297		22
23	Inservice Training & Education			1,878	1,878		1,878		1,878		23
24	Travel and Seminar			8,342	8,342		8,342	609	8,951		24
25	Other Admin. Staff Transportation			2,892	2,892		2,892	20,801	23,693		25
26	Insurance-Prop.Liab.Malpractice			209,613	209,613		209,613	3,203	212,816		26
27	Other (specify):* Allocated Benefits							62,988	62,988		27
28	TOTAL General Administration	444,859	35,831	2,327,345	2,808,035		2,808,035	(548,768)	2,259,267		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,434,076	723,524	3,786,810	9,944,410		9,944,410	(480,980)	9,463,430		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Lexington of Lake Zurich

#0039768

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			101,825	101,825		101,825	283,574	385,399			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			125,690	125,690		125,690	344,142	469,832			32
33	Real Estate Taxes							150,833	150,833			33
34	Rent-Facility & Grounds			1,503,512	1,503,512		1,503,512	(1,499,597)	3,915			34
35	Rent-Equipment & Vehicles			53,983	53,983		53,983	4,376	58,359			35
36	Other (specify):*											36
37	TOTAL Ownership			1,785,010	1,785,010		1,785,010	(716,672)	1,068,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		475,227		475,227		475,227		475,227			39
40	Barber and Beauty Shops			30,613	30,613		30,613		30,613			40
41	Coffee and Gift Shops			14,245	14,245		14,245		14,245			41
42	Provider Participation Fee			114,741	114,741		114,741		114,741			42
43	Other (specify):* Non-allowable cost			72,968	72,968		72,968	(72,968)				43
44	TOTAL Special Cost Centers		475,227	232,567	707,794		707,794	(72,968)	634,826			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,434,076	1,198,751	5,804,387	12,437,214		12,437,214	(1,270,620)	11,166,594			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	(5,586)	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	200	30		9
10	Interest and Other Investment Income	(32,534)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,273)	43		13
14	Non-Care Related Interest	(94,289)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,258)	43		24
25	Fund Raising, Advertising and Promotional	(19,159)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(270)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(110,804)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (280,973)		\$	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)	(989,647)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (989,647)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,270,620)		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 of Lake Zurich

ID# 0039768

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	X-Rays-Part A	\$ (18,859)	43	1
2	Labs-Part A	(10,563)	43	2
3	Misc. Income	(60)	21	3
4	Collections	(11,812)	19	4
5	Trust Fees	(75)	43	5
6	Nonallowable Legal Fees	(1,088)	19	6
7	Marketing Salaries	(66,581)	21	7
8	Chamber of Commerce Expense	(505)	20	8
9	Nonallowable Accounting Fees	(1,261)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(110,804)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas Discretionary Trust	33.33			Lexington Health Care Systems of		
John Samatas Discretionary Trust	33.33	See Attached Schedule B		Lake Zurich Ltd Ptsp	Lake Zurich	Real Estate Ptsp.
Cynthia Thiem Discretionary Trust	33.34			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II,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	\$	Lexington Helath Care Systems of Lake Zurich Ltd Ptsp	**	\$ 300	\$ 300	1	
2	V	21 Clerical & General Office		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp	**	105	105	2	
3	V	30 Depreciation		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp	**	231,628	231,628	3	
4	V	32 Interest Expense		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp	**	450,422	450,422	4	
5	V	32 Amortization of Mortgage Costs	1,503,512	Lexington Helath Care Systems of Lake Zurich Ltd Ptsp	**	1,268	(1,502,244)	5	
6	V	33 Property Taxes		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp	**	147,512	147,512	6	
7	V	34 Rental Expense		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp	**			7	
8	V	43 Trust Fees		Lexington Helath Care Systems of Lake Zurich Ltd Ptsp	**	75	75	8	
9	V							9	
10	V							10	
11	V	** The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Lexington Health Care Systems of Lake Zurich Limited Partnership.							11
12	V							12	
13	V							13	
14	Total		\$ 1,503,512			\$ 831,310	\$ * (672,202)	14	

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

Facility Name & ID Number Lexington of Lake Zurich# 0039768Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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.	**	\$ 477	\$	477	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	5,868		5,868	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	149		149	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,036		1,036	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	43,001		43,001	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,102		5,102	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	262		262	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,253		5,253	22	
23	V	10 Medical consultant		Royal Management Corp.	**	4,582		4,582	23	
24	V	10 Management allocation - salaries		Royal Management Corp.	**	25,668		25,668	24	
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,136		3,136	25	
26	V	17 Management allocation - salaries		Royal Management Corp.	**	58,244		58,244	26	
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	21,969		21,969	27	
28	V	19 Professional fees		Royal Management Corp.	**	5,554		5,554	28	
29	V	20 Dues & subscriptions		Royal Management Corp.	**	3,753		3,753	29	
30	V	20 Advertising - help wanted		Royal Management Corp.	**	1,173		1,173	30	
31	V	21 Management allocation - salaries		Royal Management Corp.	**	450,748		450,748	31	
32	V	21 Bank charges		Royal Management Corp.	**	5,312		5,312	32	
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,037		10,037	33	
34	V	21 Postage		Royal Management Corp.	**	3,200		3,200	34	
35	V								35	
36	V								36	
37	V								37	
38	V	**Certain owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management Corp								38
39	Total		\$			\$ 654,524	\$ *	654,524	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 7,657	\$ 7,657	
16	V	24 Travel & seminar		Royal Management Corp.	**	609	609	
17	V	25 Auto expense		Royal Management Corp.	**	20,801	20,801	
18	V	26 Insurance general		Royal Management Corp.	**	3,203	3,203	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	62,988	62,988	
20	V	30 Depreciation		Royal Management Corp.	**	51,746	51,746	
21	V	32 Interest		Royal Management Corp.	**	19,245	19,245	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	30	30	
23	V	33 Property taxes		Royal Management Corp.	**	3,321	3,321	
24	V	34 Rent expense		Royal Management Corp.	**	3,915	3,915	
25	V	35 Equipment rental		Royal Management Corp.	**	942	942	
26	V	17 Management fees	1,149,860	Royal Management Corp.	**		(1,149,860)	
27	V	35 Auto Lease		Royal Management Corp.	**	3,434	3,434	
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 Lake Zurich, Inc. own 100% of Royal Management Corp						
38	V							
39	Total		\$ 1,149,860			\$ 177,891	\$ * (971,969)	

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

Lexington Health Care Center of Lake Zurich, Inc.

Provider # 0039768

1/1/08-12/31/08

Schedule 6B

VII. Related Parties

Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of 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 of Lake Zurich

0039768

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	3.66	7.30	Salary	\$ 19,415	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	33.33	See Schedule 7A	3.66	7.30	Salary	19,415	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	33.34	See Schedule 7A	3.66	7.30	Salary	19,415	L17, C7	3
4	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	0.65	1.31	Salary	1,350	L21, C7	4
5	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	5.23	10.00	Salary	19,109	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	\$ 78,704		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 of Lake Zurich

0039768

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	\$ 76,494	\$ 477	1
2	5	Utilities - gas & electric	Bed Days	731,268	10	56,094	76,494	5,868	2
3	5	Utilities - water & sewer	Bed Days	731,268	10	1,425	76,494	149	3
4	5	Utilities - maintenance office	Bed Days	731,268	10	9,903	76,494	1,036	4
5	6	Management allocation - salaries	Bed Days	731,268	10	411,084	411,084	43,001	5
6	6	Repairs & maintenance	Bed Days	731,268	10	48,773	76,494	5,102	6
7	6	Scavenger & exterminating	Bed Days	731,268	10	2,504	76,494	262	7
8	7	Management allocation - employee	Bed Days	731,268	10	50,217	76,494	5,253	8
9	10	Medical consultant	Bed Days	731,268	10	43,800	76,494	4,582	9
10	10	Management allocation - salaries	Bed Days	731,268	10	245,385	245,385	25,668	10
11	15	Management allocation - employee	Bed Days	731,268	10	29,975	76,494	3,136	11
12	17	Management allocation - salaries	Bed Days	731,268	10	556,800	556,807	58,244	12
13	19	Computer consultant & supplies	Bed Days	731,268	10	210,020	76,494	21,969	13
14	19	Professional fees	Bed Days	731,268	10	53,093	76,494	5,554	14
15	20	Dues & subscriptions	Bed Days	731,268	10	35,880	76,494	3,753	15
16	20	Advertising - help wanted	Bed Days	731,268	10	11,214	76,494	1,173	16
17	21	Management allocation - salaries	Bed Days	731,268	10	4,309,068	4,039,070	450,748	17
18	21	Bank charges	Bed Days	731,268	10	50,778	76,494	5,312	18
19	21	Office supplies & printing	Bed Days	731,268	10	95,951	76,494	10,037	19
20	21	Postage	Bed Days	731,268	10	30,589	76,494	3,200	20
21	21	Telephone	Bed Days	731,268	10	73,204	76,494	7,657	21
22	24	Travel and Seminar	Bed Days	731,268	10	5,826	76,494	609	22
23									23
24									24
25	TOTALS					\$ 6,336,147	\$ 5,252,346	\$ 662,790	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

0039768

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) 458-476

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	\$ 76,494	\$ 20,801	1
2	26	Insurance general	Bed Days	731,268	10	30,619	76,494	3,203	2
3	27	Management allocation - employee	Bed Days	731,268	10	602,157	76,494	62,988	3
4	30	Depreciation	Bed Days	731,268	10	494,680	76,494	51,746	4
5	32	Interest	Bed Days	731,268	10	183,980	76,494	19,245	5
6	32	Amortization of mortgage costs	Bed Days	731,268	10	283	76,494	30	6
7	33	Property taxes	Bed Days	731,268	10	31,746	76,494	3,321	7
8	34	Rent expense	Bed Days	731,268	10	37,431	76,494	3,915	8
9	35	Equipment rental	Bed Days	731,268	10	9,010	76,494	942	9
10	35	Auto Lease	Bed Days	731,268	10	32,828	76,494	3,434	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	\$	\$ 169,625	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Lake Zurich

0039768

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						\$	\$			\$	1						
2	Services II, LLC	X		Mortgage	Varies	4/30/07	6,790,000	7,423,552	5/1/2017	0.0625	450,422	2						
3												3						
4												4						
5							Interest on financing insurance premium				2,357	5						
	Working Capital																	
6	Shareholders	X		Working Capital	None	Varies	270,033	2,153,179	Demand	Prime +1	94,289	6						
7	JP Morgan Chase N.A.		X	Line of Credit	Varies	4/30/07	1,100,000	850,000	5/1/2010	Libor	29,044	7						
8												8						
9	TOTAL Facility Related						\$ 8,160,033	\$ 10,426,731			\$ 576,112	9						
	B. Non-Facility Related*																	
10									Amortization of loan cost		1,268	10						
11									Interest Income offset		(32,534)	11						
12									Allocated from Management Co.		19,275	12						
13									Nonallowable shareholder interest		(94,289)	13						
14	TOTAL Non-Facility Related						\$	\$			\$ (106,280)	14						
15	TOTALS (line 9+line14)						\$ 8,160,033	\$ 10,426,731			\$ 469,832	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.		\$	<u>135,600</u>	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	\$	<u>137,671</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>2,071</u>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>146,400</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
			<u>3,321</u>	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>959</u> For <u>2004 & 2005</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	<u>(959)</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>150,833</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<u>132,805</u>	8
	2004	<u>113,096</u>	9
	2005	<u>111,054</u>	10
	2006	<u>116,252</u>	11
	2007	<u>137,671</u>	12

Est. 07 taxes payable 08

Use: \$146,400

	FOR BHF USE ONLY		
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 of Lake Zurich COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0039768

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>14-28-100-020</u>	<u>Nursing Facility</u>	\$ <u>125,799.20</u>	\$ <u>125,799.20</u>
2. <u>14-29-200-033</u>	<u>Nursing Facility</u>	\$ <u>11,871.42</u>	\$ <u>11,871.42</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
4. <u>05-01-202-021</u>		\$ <u>174,993.86</u>	\$ <u>3,321.00</u>
5. _____		\$ _____	\$ _____
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
TOTALS		\$ <u>312,664.48</u>	\$ <u>140,991.62</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 of Lake Zurich

0039768 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,901 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

N/A

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

1. Total Amount Incurred: _____ 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>250,344</u>	<u>1990</u>	<u>\$ 495,000</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>15,956</u>	<u>2</u>
3	TOTALS	250,344		\$ 510,956	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768

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	199		1994	1994	\$ 6,418,908	\$	40	\$ 160,473	\$ 160,473	\$ 2,300,109	4
5	10		2003	2003							5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements		1994		10,701		10			10,701	9
10	Land Improvements		1994		13,330		10			13,330	10
11	Leasehold Improvements		1994		4,737	316	15	316		4,579	11
12	Leasehold Improvements		1995		4,005	267	15	267		3,605	12
13	Land Improvements		1995		3,221		10			3,221	13
14	Building Improvements		1995		3,019		40	75	75	1,057	14
15	Building Improvements		1995		64,500	1,654	39	1,654		22,673	15
16	Patio		1996		1,168	78	15	78		974	16
17	Compressor		1996		5,145		10			5,145	17
18	Road sidewalk		1997		18,094		20	905	905	10,405	18
19	Foundation/Sprinkler		1997		2,068	59	35	59		679	19
20	Flagpoles		1997		1,573	105	15	105		1,206	20
21	Basement rehab		1998		12,867	843	10	843		12,867	21
22	MDS Telnet wiring		1998		3,365	168	10	168		3,365	22
23	Flag Pole		1998		787	52	15	52		551	23
24	Resurface/restripe parking lot		1998		4,977	249	10	249		4,977	24
25	Transfer 10 beds from shelter care		1998		2,260	57	40	57		574	25
26	1st floor lobby tile		1999		12,153	1,215	10	1,215		11,546	26
27	Parking lot repair		2000		3,740	374	10	374		3,179	27
28	Roof repair		2000		10,770	1,077	10	1,077		9,155	28
29	Automatic door		2000		1,300	130	10	130		1,105	29
30	Kitchen rehab		2000		16,886	1,689	10	1,689		14,354	30
31	Compressor		2001		4,350	435	10	435		3,262	31
32	Boiler vent		2001		3,228	323	10	323		2,421	32
33	Fire pump		2001		1,766	177	10	177		1,324	33
34	Kitchen rehab		2001		721	72	10	72		540	34
35	Elevator infrared curtains		2001		4,500	450	10	450		3,375	35
36			2004		64,473	3,224	20	3,224		13,969	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

0039768

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	Elevator Upgrade	2004	\$ 3,487	\$ 174	20	\$ 174		\$ 712	37
38	HVAC Compressor	2004	11,845	592	20	592		2,517	38
39	Sidewalk, raise and support	2005	700	35	20	35		117	39
40	Pavement for parking lot	2005	6,650	333	20	333		1,191	40
41	Water softner	2005	2,635	132	20	132		516	41
42	Plumbing and sprinkler	2005	4,469	223	20	223		875	42
43	Lobby and lounge rehab	2005	44,560	2,228	20	2,228		8,726	43
44	Therapy room rehab	2005	1,721	86	20	86		280	44
45	First floor therapy room	2005	42,424	2,121	20	2,121		7,818	45
46	Transitional unit	2005	9,898	495	20	495		1,650	46
47	Countertop	2005	845	169	5	169		620	47
48	Wallcovering	2005	439	88	5	88		285	48
49	Panel Brick Replacement	2006	16,001	800	20	800		1,934	49
50	Landscaping Improvement	2006	4,640	928	5	928		2,320	50
51	HVAC	2006	3,999	400	10	400		833	51
52	Kitchen Rehab	2006	2,553	255	10	255		702	52
53	Wall Mounted Cabinets	2006	10,451	1,045	10	1,045		2,439	53
54	Therapy room rehab	2006	2,829	283	10	283		613	54
55	Solo step install	2006	3,689	369	10	369		799	55
56	Transitional unit	2006	31,685	1,584	20	1,584		3,301	56
57	Employee Lunchroom rehab	2006	1,766	177	10	177		412	57
58	Fine Dining	2006	22,517	1,126	20	1,126		2,627	58
59	Land Improvements	2006	5,374	358	15	358		806	59
60	Emergency AC	2006	7,564	756	10	756		1,513	60
61	Wood Flooring	2006	1,526		10	153	153	305	61
62	HVAC	2007	2,716	272	10	272		407	62
63	Emergency AC	2007	18,731	1,873	10	1,873		2,810	63
64	First floor remodel-carpentry, flooring, plumbing, painting, fixtures	2007	700,039		40	17,539	17,539	30,693	64
65									65
66	Landscaping	2008	15,920	973	15	973		973	66
67	Parking Lot Repairs	2008	4,224	53	20	53		53	67
68	Roof	2008	33,700	983	20	983		983	68
69	Employee Locker Rooms	2008	3,732	23	40	23		23	69
70	TOTAL (lines 4 thru 69)		\$ 7,721,941	\$ 31,948		\$ 211,093	\$ 179,145	\$ 2,544,101	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,721,941	\$ 31,948		\$ 211,093	\$ 179,145	\$ 2,544,101	1
2	Second floor remodel - carpentry, electrical, flooring,	2008	555,633		27	8,419	8,419	8,419	2
3	painting								3
4									4
5									5
6									6
7	Land improvements - management company	2002	25,148		15	4,779	4,779	11,617	7
8	Building - management company	2002	195,651		40	37,177	37,177	33,831	8
9	HVAC, electrical, security system - management company	2003	1,939		30	368	368	724	9
10	Key card system - management company	2004	305		20	58	58	67	10
11	VAV TX controls - management company	2005	93		20	18	18	18	11
12	Building improvements - management company	2006	68		20	13	13	10	12
13	Building improvements - management company	2008	41		20	8	8	8	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	TOTAL (lines 1 thru 33)		\$ 8,500,819	\$ 31,948		\$ 261,933	\$ 229,985	\$ 2,598,795	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	\$ 613,705	\$ 68,156	\$ 103,757	\$ 35,601	5	\$ 312,382	71
72	Current Year Purchases	166,144	1,721	10,385	8,664	5	10,385	72
73	Fully Depreciated Assets	449,422				5	449,422	73
74	Allocated from management co.	250,537		4,357	4,357		153,398	74
75	TOTALS	\$ 1,479,808	\$ 69,877	\$ 118,499	\$ 48,622		\$ 925,587	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management co.			35,809		4,967	4,967		23,477	79
80	TOTALS			\$ 35,809	\$	\$ 4,967	\$ 4,967		\$ 23,477	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)	\$ 10,527,392	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,825	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 385,399	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 283,574	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,547,859	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			N/A		88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Third Floor Remodel	\$ 166,578	92
93			93
94			94
95		\$ 166,578	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>3,915</u>			6
7	TOTAL				\$ <u>3,915</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: \$ 54,925 Description: Copier-\$8,530; Medical Equip-\$26,901; Oxygen Equip-\$18,552; Mgmt. Co.-\$942

(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>Allocated from Mgmt. Co.</u>			<u>3,434</u>	20
21	TOTAL		\$	\$ <u>3,434</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	L10A, C3	hrs	\$	5,046	\$ 296,649	\$	5,046	\$ 296,649	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,412	71,229		1,412	71,229	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,660	578,019		8,660	578,019	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				475,227		475,227	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	TOTAL			\$	15,118	\$ 945,897	\$ 475,227	15,118	\$ 1,421,124	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0039768
 As of 12/31/2008

Report Period Beginning: 01/01/2008
 (last day of reporting year)

Ending: 12/31/2008

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 701,114	\$ 711,372	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 502,700)	2,666,084	2,666,084	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,526	41,526	6
7	Other Prepaid Expenses	57,992	57,992	7
8	Accounts Receivable (owners or related parties)	13,108	1,021,949	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,479,824	\$ 4,498,923	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,609	7,609	12
13	Land		510,956	13
14	Buildings, at Historical Cost		6,418,908	14
15	Leasehold Improvements, at Historical Cost	566,431	2,081,911	15
16	Equipment, at Historical Cost	505,414	1,515,617	16
17	Accumulated Depreciation (book methods)	(438,013)	(3,547,859)	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	166,578	166,578	22
23	Other(specify): <u>Mortgage cost</u>		33,372	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 808,019	\$ 7,187,092	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,287,843	\$ 11,686,015	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 463,205	\$ 463,205	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,896	3,896	28
29	Short-Term Notes Payable	3,003,179	3,140,087	29
30	Accrued Salaries Payable	194,603	194,603	30
31	Accrued Taxes Payable (excluding real estate taxes)	146,263	146,263	31
32	Accrued Real Estate Taxes(Sch.IX-B)		146,400	32
33	Accrued Interest Payable		39,085	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached schedule 17A</u>	3,697,020	943,186	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,508,166	\$ 5,076,725	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,286,644	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)	\$	\$ 7,286,644	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,508,166	\$ 12,363,369	46
47	TOTAL EQUITY (page 18, line 24)	\$ (3,220,323)	\$ (677,354)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,287,843	\$ 11,686,015	48

Lexington Health Care Center of Lake Zurich, Inc.

Provider # 0039768

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/from LHCS LZ - Remodel	(124,362)	(124,362)
Due to Royal (OPS)	(30,227)	(30,227)
Due to/from-LHCC Schaumburg	(2,304)	(2,304)
Due to/from Lex Fin Svcs II/I	-	124,362
Due to/from - Streamwood	(1,707)	(1,707)
Due to/from - LHCC Bloomingdale	(1,634)	(1,634)
Due to/from - La Grange	(7,364)	(7,364)
Due to/from - Wheeling	(14,805)	(14,805)
Due to/from - Chicago Ridge	(14,795)	(14,795)
Due to/from - Elmhurst	(35)	(35)
Due to/from - LHCC Lombard	(3,441)	(3,441)
Due to/from - LHCC Orland Park	(39,718)	(39,718)
Accrued 401K	(16,020)	(16,020)
Accrued expenses	(92,490)	(92,490)
Accrued Royal Genl Mgmt Fees	(34,491)	(34,491)
Accrued Rent	(2,999,772)	-
Accrued wage Assignments	12	12
Deferred Income	(313,867)	(313,867)
Interest Rate Swap Liability	-	(370,300)
	<u>(3,697,020)</u>	<u>(943,186)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,558,307)	1
2	Restatements (describe):		2
3	Post closing entries	111,143	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,447,164)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	226,841	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)	\$ 226,841	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)	\$ (3,220,323)	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	\$ 16,253,323	1
2	Discounts and Allowances for all Levels	(6,924,055)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,329,268	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,506,975	6
7	Oxygen	14,519	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,521,494	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	15,165	12
13	Barber and Beauty Care	32,745	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	542,934	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,588	19
20	Radiology and X-Ray	15,808	20
21	Other Medical Services	142,417	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 808,657	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,356	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,356	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	280	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 280	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,664,055	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,626,786	31
32	Health Care	5,509,589	32
33	General Administration	2,808,035	33
	B. Capital Expense		
34	Ownership	1,785,010	34
	C. Ancillary Expense		
35	Special Cost Centers	593,053	35
36	Provider Participation Fee	114,741	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,437,214	40
41	Income before Income Taxes (line 30 minus line 40)**	226,841	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 226,841	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a tax basis taxpayer.

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

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

Facility Name & ID Number Lexington of Lake Zurich

0039768

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	2,236	2,455	\$ 120,354	\$ 49.02	1
2	Assistant Director of Nursing	8,172	8,946	313,236	35.01	2
3	Registered Nurses	33,539	36,705	1,216,291	33.14	3
4	Licensed Practical Nurses	17,585	19,721	524,757	26.61	4
5	CNAs & Orderlies	103,764	111,445	1,396,572	12.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,322	13,186	165,956	12.59	8
9	Activity Director	1,702	1,766	32,441	18.37	9
10	Activity Assistants	20,021	21,603	244,021	11.30	10
11	Social Service Workers	6,963	7,396	139,372	18.84	11
12	Dietician	1,003	1,083	18,746	17.31	12
13	Food Service Supervisor	2,062	2,171	40,259	18.54	13
14	Head Cook	2,006	2,154	34,780	16.15	14
15	Cook Helpers/Assistants	11,985	12,972	120,985	9.33	15
16	Dishwashers	18,620	19,629	155,939	7.94	16
17	Maintenance Workers	1,915	2,142	37,027	17.29	17
18	Housekeepers	35,687	38,339	325,242	8.48	18
19	Laundry	10,254	10,872	86,369	7.94	19
20	Administrator	2,204	2,408	122,722	50.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,719	21,047	322,137	15.31	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	986	1,071	16,870	15.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	312,745	337,111	\$ 5,434,076 *	\$ 16.12	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	258	\$ 13,108	L1, C3	35
36	Medical Director	Monthly	57,125	L9, C3	36
37	Medical Records Consultant	26	1,515	L10, C3	37
38	Nurse Consultant	24	2,255	L10, C3	38
39	Pharmacist Consultant	Monthly	4,825	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	94	4,618	L11, C3	44
45	Social Service Consultant	90	4,522	L12, C3	45
46	Other(specify) <u>Psychsocial</u>	48	2,304	L12, C3	46
47	<u>MDS</u>	Monthly	10	L10, C3	47
48	<u>Medical Consultant</u>	Monthly	4,582	L10, C7	48
49	TOTAL (lines 35 - 48)	540	\$ 94,864		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	65	\$ 17,315	L10, C3	50
51	Licensed Practical Nurses	108	4,800	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	173	\$ 22,115		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	
<u>Gina McCarthy</u>	<u>Administrator</u>	<u>0</u>	\$ <u>122,722</u>	<u>Workers' Compensation Insurance</u>	\$ <u>84,828</u>	<u>IDPH License Fee</u>	\$ <u>16,315</u>	
				<u>Unemployment Compensation Insurance</u>	<u>49,322</u>	<u>Advertising: Employee Recruitment</u>	<u>16,315</u>	
				<u>FICA Taxes</u>	<u>395,425</u>	<u>Health Care Worker Background Check</u>	<u>532</u>	
				<u>Employee Health Insurance</u>	<u>212,815</u>	(Indicate # of checks performed <u>44</u>)		
				<u>Employee Meals</u>	<u>15,115</u>	<u>Patient Background Checks</u>	<u>2,468</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses, Permits & Inspection</u>	<u>2,544</u>	
				<u>401K Contribution</u>	<u>16,020</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>809</u>	
				<u>Other Employee Benefits</u>	<u>38,772</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 122,722					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Description	Amount	
<u>Management Fees (eliminated in column 7)</u>			\$ <u>1,149,860</u>			<u>Out-of-State Travel</u>	\$	
						<u>In-State Travel</u>		
						<u>Seminar Expense</u>	<u>8,342</u>	
						<u>Allocated from Mgmt. Co.</u>	<u>609</u>	
						<u>Entertainment Expense</u>	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,149,860	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 27,594	
(Attach a copy of any management service agreement)				(agree to Sch. V, line 24, col. 8)				
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type			Amount				
<u>Grabowski Law Center, LLC</u>	<u>Collections</u>			\$ <u>11,812</u>				
<u>Cassiday Schade LLP</u>	<u>Legal</u>			<u>31,028</u>				
<u>ING Life Insurance Annuity</u>	<u>Pension Consultation</u>			<u>720</u>				
<u>James Samatas, Atty. At law</u>	<u>Legal</u>			<u>100</u>				
<u>McGladrey & Pullen</u>	<u>Accounting</u>			<u>19,495</u>				
<u>Pension Administrators, Inc.</u>	<u>Pension Consultation</u>			<u>543</u>				
<u>Personnel Planners</u>	<u>U/C Consulting</u>			<u>840</u>				
<u>Reed Smith/Sachnoff & Weaver</u>	<u>Legal</u>			<u>9,703</u>				
<u>RSM McGladrey</u>	<u>Accounting</u>			<u>8,517</u>				
<u>Serpico, Petrosino, Dipiero, LTD</u>	<u>Legal</u>			<u>1,018</u>				
<u>See attached schedule 21C</u>				<u>31,177</u>				
TOTAL (agree to Schedule V, line 19, column 3)			\$ 114,953	\$			\$ 8,951	
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington HealthCare Center of Lake Zurich, Inc.
 Provider #0039768
 1/1/07-12/31/07

XIX. Support Schedules **Schedule 21C**
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Action Computer Service	Computer Consulting	259
Alperian Technology	Computer Consulting	215
B2B Computer	Computer Consulting	1,665
C.D.W Direct	Computer Consulting	324
Converged Comm	Computer Consulting	280
E-Health Data Solutions	Computer Consulting	2,400
Healthware Consulting	Computer Consulting	2,060
Information Control	Computer Consulting	1,260
Krakau Business	Computer Consulting	126
Lanac Technology	Computer Consulting	2,501
Lintech LLC	Computer Consulting	5,468
Microsoft 2	Computer Consulting	4,820
MNJ Technologies Direct	Computer Consulting	917
National Datacare	Computer Consulting	1,820
Silver Chair Learning Systems	Computer Consulting	4,300
Vision Share, Inc.	Computer Consulting	830
Photo Lunch	Computer Consulting	225
Gene Whitehorn	Medicaid Reim. Specialist	957
Contrac Healthcare	Regulatory Consultant	750
		<u>31,177</u>

Total, Agrees to Schedule V, Line 19, Column 3 114,953

Allocated from Management co.

James Samatas	Legal-filing fees	27
Sachnoff & Weaver	Legal	1,477
Duane Morris	Legal	12
McGladrey & Pullen LLP	Accounting	401
RSM McGladrey	Accounting	425
Gilson Labus & Silverman	Accounting	1,585
Pension Administrators, Inc.	401K Administration	446
Personnel Planners	Unemployment Consultant	31
Beth Schwarz	Operations Consultant	17
Gene Whitehorn	Medicaid Reim. Specialist	818
See Schedule 21D for Vendor Listing	Computer Consulting	21,970
		<u>27,209</u>

Allocated from Samvest of Lombard II

Gilson, Labus & Silverman	Accounting	314
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Allocated from building partnership 300

Nonallowable legal fees
 Collections (11,812)
 Out of Period (1,088)

Nonallowable accounting fees (1,261)

Total, Agrees to Schedule V, Line 19, Column 8 128,615

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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768Report 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. \$ 57,232 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. \$ 114,741
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. \$ 15,115 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? Yes
- 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