



Facility Name & ID Number Lexington of Orland Park

# 0041855 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>278</u>	Skilled (SNF)	<u>278</u>	<u>101,748</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>278</u>	TOTALS	<u>278</u>	<u>101,748</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>11,167</u>	<u>560</u>	<u>14,910</u>	<u>26,637</u>	8
9	SNF/PED					9
10	ICF	<u>52,028</u>	<u>5,976</u>	<u>3,155</u>	<u>61,159</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,195</u>	<u>6,536</u>	<u>18,065</u>	<u>87,796</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.29%

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 7/8/96

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 278 and days of care provided 13,432

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 Orland Park # 0041855 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	403,266	51,003	23,154	477,423		477,423		477,423		1
2	Food Purchase		429,032		429,032		429,032	(19,753)	409,279		2
3	Housekeeping	372,337	52,616		424,953		424,953	635	425,588		3
4	Laundry	90,717	22,660		113,377		113,377		113,377		4
5	Heat and Other Utilities			335,649	335,649		335,649	9,381	345,030		5
6	Maintenance	58,351		174,038	232,389		232,389	64,332	296,721		6
7	Other (specify):* <b>Mgmt Co - Allocated</b>							6,987	6,987		7
8	<b>TOTAL General Services</b>	924,671	555,311	532,841	2,012,823		2,012,823	61,582	2,074,405		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			63,200	63,200		63,200		63,200		9
10	Nursing and Medical Records	4,975,552	283,672	27,858	5,287,082		5,287,082	24,766	5,311,848		10
10a	Therapy			1,203,500	1,203,500		1,203,500		1,203,500		10a
11	Activities	303,524	36,756	6,581	346,861		346,861		346,861		11
12	Social Services	119,800		7,987	127,787		127,787		127,787		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Mgmt Co - Allocated</b>							4,171	4,171		15
16	<b>TOTAL Health Care and Programs</b>	5,398,876	320,428	1,309,126	7,028,430		7,028,430	28,937	7,057,367		16
	<b>C. General Administration</b>										
17	Administrative	131,994		1,531,227	1,663,221		1,663,221	(1,453,754)	209,467		17
18	Directors Fees										18
19	Professional Services			207,303	207,303		207,303	22,387	229,690		19
20	Dues, Fees, Subscriptions & Promotions			19,595	19,595		19,595	6,157	25,752		20
21	Clerical & General Office Expenses	469,413	36,176	29,587	535,176		535,176	562,097	1,097,273		21
22	Employee Benefits & Payroll Taxes			956,244	956,244		956,244	19,500	975,744		22
23	Inservice Training & Education			328	328		328		328		23
24	Travel and Seminar			7,130	7,130		7,130	811	7,941		24
25	Other Admin. Staff Transportation			6,177	6,177		6,177	27,668	33,845		25
26	Insurance-Prop.Liab.Malpractice			371,010	371,010		371,010	4,260	375,270		26
27	Other (specify):* <b>Mgmt Co - Allocated</b>							83,784	83,784		27
28	<b>TOTAL General Administration</b>	601,407	36,176	3,128,601	3,766,184		3,766,184	(727,090)	3,039,094		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,924,954	911,915	4,970,568	12,807,437		12,807,437	(636,571)	12,170,866		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 &amp; ID Number

Lexington of Orland Park

#0041855

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			80,248	80,248		80,248	396,693	476,941			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,141	64,141		64,141	579,802	643,943			32
33	Real Estate Taxes							483,802	483,802			33
34	Rent-Facility & Grounds			2,279,385	2,279,385		2,279,385	(2,274,177)	5,208			34
35	Rent-Equipment & Vehicles			80,773	80,773		80,773	5,822	86,595			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,504,547	2,504,547		2,504,547	(808,058)	1,696,489			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		416,936		416,936		416,936		416,936			39
40	Barber and Beauty Shops			28,193	28,193		28,193		28,193			40
41	Coffee and Gift Shops			4,600	4,600		4,600		4,600			41
42	Provider Participation Fee			152,622	152,622		152,622		152,622			42
43	Other (specify):* <b>Non-allowable cost</b>			131,555	131,555		131,555	(131,555)				43
44	<b>TOTAL Special Cost Centers</b>		416,936	316,970	733,906		733,906	(131,555)	602,351			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,924,954	1,328,851	7,792,085	16,045,890		16,045,890	(1,576,184)	14,469,706			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	(253)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,462)	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	3	30		9
10	Interest and Other Investment Income	(37,999)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,352)	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	(5,800)	43		18
19	Entertainment				19
20	Contributions	(1,425)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(56,939)	43		24
25	Fund Raising, Advertising and Promotional	(19,533)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,156)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(290,101)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (424,017)		\$	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)	(1,152,167)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,152,167)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,576,184)		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 of Orland Park

ID# 0041855

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (885)	21	1
2	Labs-Part A	(6,968)	43	2
3	X-Rays Part A	(30,069)	43	3
4	Marketing Salary	(71,541)	21	4
5	Chamber of Comence Dues	(395)	20	5
6	Trust Fees	(85)	43	6
7	Loss on Mortgage Cost	(106,647)	43	7
8	Disallow Collection Fees	(9,608)	19	8
9	Out of Period Legal	(3,236)	19	9
10	Nonallowable Marketing Expenses	(15,471)	10	10
11	Nonallowable Accounting Expenses	(1,678)	19	11
12	Disallow Shareholder Interest	(43,518)	32	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
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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	<b>Total</b>	(290,101)		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	30%			Lexington Health Care		
John Samatas Discretionary Trust	30%	See attached Schedule B		Systems of Orland		
Cynthia Thiem Discretionary Trust	30%			Park Ltd. Ptsp.	Orland Park	Real estate ptsp.
Dean Sweitzer	10%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	19 Professional Fees	\$	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	\$ 300	\$	300	1
2	V	21 Office Supplies		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	105		105	2
3	V	30 Depreciation		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	327,861		327,861	3
4	V	32 Interest expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	633,309		633,309	4
5	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	2,372		2,372	5
6	V	33 Property taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	479,385		479,385	6
7	V	34 Rental Expense	2,279,385	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**			(2,279,385)	7
8	V	43 Trust fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	85		85	8
9	V	43 State Replacement Tax		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	1,149		1,149	9
10	V	43 Loss on Mortgage Cost		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	106,647		106,647	10
11	V								11
12	V			** The owners of Lexington Health Care Center of Orland Park, Inc. own 100%					12
13	V			of Lexington Health Care Systems of Orland Park Ltd Ptsp.					13
14	Total		\$ 2,279,385			\$ 1,551,213	\$ *	(728,172)	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.	**	\$ 635	\$	635	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,805		7,805	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	198		198	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,378		1,378	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	57,198		57,198	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	6,786		6,786	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	348		348	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	6,987		6,987	22
23	V	10 Medical consultant		Royal Management Corp.	**	6,094		6,094	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	34,143		34,143	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	4,171		4,171	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	77,473		77,473	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	29,222		29,222	27
28	V	19 Professional fees		Royal Management Corp.	**	7,387		7,387	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	4,992		4,992	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	1,560		1,560	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	599,560		599,560	31
32	V	21 Bank charges		Royal Management Corp.	**	7,065		7,065	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	13,351		13,351	33
34	V	21 Postage		Royal Management Corp.	**	4,256		4,256	34
35	V								35
36	V								36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 870,609	\$ *	870,609	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.	**	\$ 10,186	\$	10,186	15	
16	V	24 Travel & seminar		Royal Management Corp.	**	811		811	16	
17	V	25 Auto expense		Royal Management Corp.	**	27,668		27,668	17	
18	V	26 Insurance general		Royal Management Corp.	**	4,260		4,260	18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	83,784		83,784	19	
20	V	30 Depreciation		Royal Management Corp.	**	68,829		68,829	20	
21	V	32 Interest		Royal Management Corp.	**	25,599		25,599	21	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	39		39	22	
23	V	33 Property taxes		Royal Management Corp.	**	4,417		4,417	23	
24	V	34 Rent expense		Royal Management Corp.	**	5,208		5,208	24	
25	V	35 Equipment rental		Royal Management Corp.	**	1,254		1,254	25	
26	V	17 Management fees	1,531,227	Royal Management Corp.	**			(1,531,227)	26	
27	V	35 Auto Lease		Royal Management Corp.	**	4,568		4,568	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V	** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.								38
39	Total		\$ 1,531,227			\$ 236,623	\$ *	(1,294,604)	39	

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

**Lexington Health Care Center of Orland Park, Inc.**

**Provider # 0041855**

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

**Schedule B**

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 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 Wheeling, Inc.	Wheeling

**See Accountants' Compilation Report**

Facility Name &amp; ID Number

Lexington of Orland Park

# 0041855

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	30.00	See Schedule 7A	4.87	9.70	Salary	\$ 25,825	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00	See Schedule 7A	4.87	9.70	Salary	25,825	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	30.00	See Schedule 7A	4.87	9.70	Salary	25,825	L17, C7	3
4	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	0.87	1.74	Salary	1,795	L21, C7	4
5	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	6.96	14.00	Salary	25,418	L17/21, C7	5
6											6
7	Dean Sweitzer	Owner*	Administrative	10.00	148,804	5	10.00	Salary	20,699	L21, C7	7
8		All individuals work in excess of 40 hours per week.									8
9											9
10		* Dean Sweitzer is an owner only in Lexington Health Care Center of Orland Park, Inc. He is an employee									10
11		of Royal Management Corp. and provides administrative services to Royal Management Corp. His compensation									11
12		has been allocated to all 10 Lexington facilities.									12
13								TOTAL	\$ 125,387		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 of Orland Park

# 0041855

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	\$ 101,748	\$ 635	1
2	5	Utilities - gas & electric	Bed Days	731,268	10	56,094	101,748	7,805	2
3	5	Utilities - water & sewer	Bed Days	731,268	10	1,425	101,748	198	3
4	5	Utilities - maintenance office	Bed Days	731,268	10	9,903	101,748	1,378	4
5	6	Management allocation - salaries	Bed Days	731,268	10	411,084	411,084	57,198	5
6	6	Repairs & maintenance	Bed Days	731,268	10	48,773	101,748	6,786	6
7	6	Scavenger & exterminating	Bed Days	731,268	10	2,504	101,748	348	7
8	7	Management allocation - employee	Bed Days	731,268	10	50,217	101,748	6,987	8
9	10	Medical consultant	Bed Days	731,268	10	43,800	101,748	6,094	9
10	10	Management allocation - salaries	Bed Days	731,268	10	245,385	245,385	34,143	10
11	15	Management allocation - employee	Bed Days	731,268	10	29,975	101,748	4,171	11
12	17	Management allocation - salaries	Bed Days	731,268	10	556,800	556,807	77,473	12
13	19	Computer consultant & supplies	Bed Days	731,268	10	210,020	101,748	29,222	13
14	19	Professional fees	Bed Days	731,268	10	53,093	101,748	7,387	14
15	20	Dues & subscriptions	Bed Days	731,268	10	35,880	101,748	4,992	15
16	20	Advertising - help wanted	Bed Days	731,268	10	11,214	101,748	1,560	16
17	21	Management allocation - salaries	Bed Days	731,268	10	4,309,068	4,039,070	599,560	17
18	21	Bank charges	Bed Days	731,268	10	50,778	101,748	7,065	18
19	21	Office supplies & printing	Bed Days	731,268	10	95,951	101,748	13,351	19
20	21	Postage	Bed Days	731,268	10	30,589	101,748	4,256	20
21	21	Telephone	Bed Days	731,268	10	73,204	101,748	10,186	21
22	24	Travel and Seminar	Bed Days	731,268	10	5,826	101,748	811	22
23									23
24									24
25	TOTALS					\$ 6,336,147	\$ 5,252,346	\$ 881,606	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

# 0041855

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	731,268	10	\$ 198,854	\$ 101,748	\$ 27,668	1
2	26	Insurance general	Bed Days	731,268	10	30,619	101,748	4,260	2
3	27	Management allocation - employee	Bed Days	731,268	10	602,157	101,748	83,784	3
4	30	Depreciation	Bed Days	731,268	10	494,680	101,748	68,829	4
5	32	Interest	Bed Days	731,268	10	183,980	101,748	25,599	5
6	32	Amortization of mortgage costs	Bed Days	731,268	10	283	101,748	39	6
7	33	Property taxes	Bed Days	731,268	10	31,746	101,748	4,417	7
8	34	Rent expense	Bed Days	731,268	10	37,431	101,748	5,208	8
9	35	Equipment rental	Bed Days	731,268	10	9,010	101,748	1,254	9
10	35	Auto Lease	Bed Days	731,268	10	32,828	101,748	4,568	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	\$	\$ 225,626	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Orland Park

# 0041855

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	Lexington Financial Services	X		Mortgage	Varies	12/29/98	\$ 9,000,000	\$			Variable	\$ 154,876						
2	L.L.C	X		Mortgage	Varies	5/22/08	11,354,000	11,230,524	1/1/2033	Variable	478,433	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Bank of America		X	Line of Credit	Varies	4/6/02	2,000,000	1,500,000	6/30/09	Prime	17,308	6						
7	Shareholder	X		Working Capital	None	Various		299,000	Demand	Prime + 1	43,518	7						
8							Interest on Financing Insurance Premium				3,315	8						
9	TOTAL Facility Related						\$ 22,354,000	\$ 13,029,524			\$ 697,450	9						
<b>B. Non-Facility Related*</b>																		
10										Amortization of Mortgage Cost	2,372	10						
11										Interest Income offset	(37,999)	11						
12										Shareholder Interest	(43,518)	12						
13										Allocated from Management Co.	25,638	13						
14	TOTAL Non-Facility Related						\$	\$			\$ (53,507)	14						
15	TOTALS (line 9+line14)						\$ 22,354,000	\$ 13,029,524			\$ 643,943	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>499,200</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>489,435</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(9,765)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>504,000</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>		\$	<b>19,879</b>	5
			<b>4,418</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 \$ 34,730 For 2005 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(34,730)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>483,802</b>	7

Allocated from Management Co.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>448,025</b>	8
	2004	<b>486,436</b>	9
	2005	<b>491,839</b>	10
	2006	<b>484,891</b>	11
	2007	<b>489,435</b>	12
<b>2007 tax bill paid:</b>		<b>\$489,435</b>	
<b>Est. tax with 3% increase:</b>		<b>\$504,118</b>	
<b>Use:</b>		<b>\$504,000</b>	

<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 of Orland Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

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>27-10-100-099-0000</u>	<u>Land &amp; Building</u>	\$ <u>489,435.20</u>	\$ <u>489,435.20</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land &amp; Building</u>	\$ <u>174,993.86</u>	\$ <u>4,418.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>664,429.06</u>	\$ <u>493,853.20</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 Orland Park

# 0041855

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block & 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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>152,460</u>	<u>1995</u>	<u>\$ 776,408</u>	<u>1</u>
2	<u>Allocated from Management Co.</u>		<u>2002</u>	<u>21,221</u>	<u>2</u>
3	<b>TOTALS</b>	<b>152,460</b>		<b>\$ 797,629</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Orland Park

# 0041855

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	250		1996	1996	\$ 8,569,286	\$		\$ 214,232	\$ 214,232	\$ 2,675,327	4
5	10		1998	1998	63,790	1,595	40	1,595		15,948	5
6	18		2001	2001							6
7											7
8											8
	<b>Improvement Type**</b>										
9	Electrical wiring		1996	1996	2,304	58	40	58		701	9
10	Paving		1997	1997	11,589		40	773	773	8,885	10
11	Wiring		1998	1998	3,932	197	40	197		3,932	11
12	Additional building costs - 10 bed addition		1999	1999	1,808	45	10	45		452	12
13	Seal/restrip parking lot		1999	1999	3,450	230	40	230		2,185	13
14	Wiring		1999	1999	1,798	45	15	45		427	14
15	Roof repairs		2000	2000	23,201	1,547	40	1,547		13,148	15
16	Electrical wiring		2000	2000	5,732	164	15	164		1,392	16
17	Ceiling mount curtain rod hardware		2000	2000	6,952	199	35	199		1,689	17
18	Automatic door closer/sensors		2000	2000	3,624	242	35	242		2,054	18
19	Seal and restripe parking lot		2001	2001	2,277	228	15	228		1,708	19
20	HVAC control		2001	2001	2,548	255	10	255		1,911	20
21	Infrared curtains for elevator doors		2001	2001	4,500	450	10	450		3,375	21
22	Fire alarm panel		2002	2002	5,120	512	10	512		3,328	22
23	Parking lot lights		2002	2002	9,975	998	10	998		6,484	23
24	Chiller room compressor		2002	2002	8,879		10			8,879	24
25	Carpeting		2002	2002	7,038		5			7,038	25
26	Pave and seal parking lot		2005	2005	4,180	209	5	209		697	26
27	HVAC		2005	2005	6,143	307	20	307		947	27
28	Electrical wiring		2005	2005	3,637	182	20	182		576	28
29	Kitchen rehab		2005	2005	6,360	318	20	318		1,192	29
30	Elevator rehab		2005	2005	8,948	447	20	447		1,640	30
31	Lounge, lobby, and reception area rehab		2005	2005	27,662	1,383	20	1,383		4,380	31
32	Landscaping enhancements		2006	2006	5,795	386	20	386		901	32
33	HVAC		2006	2006	9,300	465	15	465		969	33
34	LHI-therapy room rehab LL TCU/main therapy		2006	2006	33,184	1,659	20	1,659		3,871	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Orland Park

# 0041855

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	Landscaping	2007	\$ 17,383	\$ 1,159	15	\$ 1,159	\$	\$ 1,642	37
38	Parking lot	2007	1,120	56	20	56		75	38
39	Plumbing-Fine Dining	2007	2,068	103	20	103		198	39
40	Laundry Room Rehab	2007	37,283	1,864	20	1,864		3,262	40
41	Employee lunch room	2007	2,865	143	20	143		250	41
42	Basement Renovation	2007	1,148	57	20	57		81	42
43	Patio Improvements	2007	7,000	350	20	350		438	43
44	1st floor remodel-carpentry, flooring, plumbing, electrical-	2007	1,481,886		40	37,426	37,426	53,021	44
45	fixtures, painting	2007							45
46					40				46
47	Basement Renovation	2007	20,192	1,010	20	1,010		1,010	47
48	Therapy Room Renovation	2007	978	49		49		49	48
49	Landscaping	2008	4,300	24	15	24		24	49
50	Spot Coolers	2008	3,790		20				50
51	Emergency A/C	2008	32,295	336	40	336		336	51
52	Plumbing & Sprinkler-Showers	2008	5,047		40				52
53	Parking lot repairs	2008	5,285	154	20	154		154	53
54	Phone closet	2008	5,954	87	40	87		87	54
55									55
56									56
57	Land improvements - management company	2002	33,448		15	10,819	10,819	15,448	57
58	Building - management company	2002	260,227		40	44,998	44,998	44,998	58
59	HVAC, electrical, security system - management company	2003	2,582		30	491	491	964	59
60	Key card system - management company	2004	406		20	77	77	91	60
61	VAV TX controls - management company	2005	124		20	22	22	22	61
62	Interior Signs - Management Company	2006	88		20	12	12	12	62
63	Building improvements - management company	2008	54		20	9	9	9	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,768,535	\$ 17,513		\$ 326,372	\$ 308,859	\$ 2,896,207	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Orland Park

# 0041855

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$ 772,609	\$ 60,207	\$ 135,639	\$ 75,432	5	\$ 340,290	71
72	Current Year Purchases	99,899	2,528	2,528		5	2,528	72
73	Fully Depreciated Assets	22,520				5	22,520	73
74	Allocated from management co.	333,226		5,795	5,795		204,026	74
75	TOTALS	\$ 1,228,254	\$ 62,735	\$ 143,962	\$ 81,227		\$ 569,364	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.			47,626		6,607	6,607		31,227	79
80	TOTALS			\$ 47,626	\$	\$ 6,607	\$ 6,607		\$ 31,227	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)	\$ 12,842,044	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,248	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 476,941	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 396,693	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,496,798	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	1st floor remodel	\$ 737,187	92
93			93
94			94
95		\$ 737,187	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?  YES  NO

If NO, see instructions.

	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	Allocated from Management Co.			5,208			6
7	TOTAL			\$ 5,208			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: \$ 82,027 Description: Copier- \$ 9,240; Mailing System- \$ 179; Medical Equip- \$40,595; Oxygen-\$30,759; Mgmt. Co.-\$1,254

(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	Allocated from Management Co.			4,568	20
21	TOTAL		\$	\$ 4,568	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><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	\$	7,642	\$ 523,838	\$	7,642	\$ 523,838	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,656	96,799		1,656	96,799	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,598	582,863		8,598	582,863	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				416,936		416,936	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>			\$	17,896	\$ 1,203,500	\$ 416,936	17,896	\$ 1,620,436	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 &amp; ID Number Lexington of Orland Park

# 0041855

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	\$ 997,222	\$ 1,015,343	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,426,161</u> )	3,679,615	3,679,615	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,555	54,555	6
7	Other Prepaid Expenses	26,055	26,055	7
8	Accounts Receivable (owners or related parties)	97,835	1,603,962	8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,855,282	\$ 6,379,530	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	114,352	114,352	12
13	Land		797,629	13
14	Buildings, at Historical Cost		8,633,076	14
15	Leasehold Improvements, at Historical Cost	401,807	2,135,459	15
16	Equipment, at Historical Cost	508,296	1,275,880	16
17	Accumulated Depreciation (book methods)	(339,258)	(3,496,798)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>CIP</u> )		737,187	22
23	Other(specify): <u>Mortgage Cost, net</u>		94,275	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 685,197	\$ 10,291,060	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,540,479	\$ 16,670,590	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 492,632	\$ 492,632	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,799,000	1,799,000	29
30	Accrued Salaries Payable	472,405	472,405	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,083	7,083	31
32	Accrued Real Estate Taxes(Sch.IX-B)		504,000	32
33	Accrued Interest Payable		66,187	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	1,091,003	834,752	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 3,862,123	\$ 4,176,059	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,230,524	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</b> (sum of lines 39 thru 44)	\$	\$ 11,230,524	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,862,123	\$ 15,406,583	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,678,356	\$ 1,264,007	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 5,540,479	\$ 16,670,590	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington Health Care Center of Orland Park, Inc.

Provider # 0041855

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 from Royal	(47,651)	(47,651)
Due from Lexington Financial Services	-	(41,421)
Accrued 401K	(22,713)	(22,713)
Due to LLC I	(3,623)	(3,623)
Accrued expenses	(137,301)	(137,301)
Accrued Royal General Mgmt. Fees	(82,902)	(82,902)
Accrued Rent	(541,956)	4,918
Deferred Income	(243,265)	(243,265)
Advance-Biweekly Part A Payments	(11,592)	(11,592)
Interest Rate Swap Liability	-	(249,202)
	<u>(1,091,003)</u>	<u>(834,752)</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>1,553,813</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post closing adjustments</b>	<b>(706,736)</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>847,077</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>831,279</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>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>831,279</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>1,678,356</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	\$ 22,640,768	1
2	Discounts and Allowances for all Levels	(8,924,506)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,716,262	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,455,238	6
7	Oxygen	1,417	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,456,655	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	4,585	12
13	Barber and Beauty Care	32,817	13
14	Non-Patient Meals	253	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	482,117	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,890	19
20	Radiology and X-Ray	30,834	20
21	Other Medical Services	110,688	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 693,184	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	9,371	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,371	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	1,697	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,697	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 16,877,169	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,012,823	31
32	Health Care	7,028,430	32
33	General Administration	3,766,184	33
	<b>B. Capital Expense</b>		
34	Ownership	2,504,547	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	581,284	35
36	Provider Participation Fee	152,622	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 16,045,890	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	831,279	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 831,279	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 cash basis taxpayer

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

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

Facility Name & ID Number Lexington of Orland Park

# 0041855

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	2,073	2,313	\$ 109,580	\$ 47.38	1
2	Assistant Director of Nursing	7,774	8,807	285,661	32.44	2
3	Registered Nurses	37,403	41,379	1,295,580	31.31	3
4	Licensed Practical Nurses	45,946	50,844	1,349,943	26.55	4
5	CNAs & Orderlies	133,631	143,589	1,665,741	11.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17,698	19,286	230,865	11.97	8
9	Activity Director	1,709	1,792	30,589	17.07	9
10	Activity Assistants	21,895	23,619	272,935	11.56	10
11	Social Service Workers	6,620	7,087	119,800	16.90	11
12	Dietician	792	867	15,057	17.37	12
13	Food Service Supervisor	2,061	2,191	42,681	19.48	13
14	Head Cook	2,029	2,191	33,904	15.47	14
15	Cook Helpers/Assistants	14,663	15,808	149,428	9.45	15
16	Dishwashers	18,715	20,032	162,196	8.10	16
17	Maintenance Workers	4,196	4,508	58,351	12.94	17
18	Housekeepers	40,004	43,612	372,337	8.54	18
19	Laundry	10,339	11,276	90,717	8.05	19
20	Administrator	2,192	2,326	131,994	56.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,738	27,690	469,413	16.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,242	2,387	38,182	16.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	397,720	431,604	\$ 6,924,954 *	\$ 16.04	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	457	\$ 23,154	L1, C3	35
36	Medical Director	Monthly	63,200	L9, C3	36
37	Medical Records Consultant	28	1,543	L10, C3	37
38	Nurse Consultant	8	631	L10, C3	38
39	Pharmacist Consultant	Monthly	5,595	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	134	6,418	L11, C3	44
45	Social Service Consultant	107	5,347	L12, C3	45
46	Other(specify) <u>Psychosocial</u>		2,640	L12, C3	46
47	<u>MDS Consultant</u>		1,000	L10,C3	47
48	<u>See Schedule 20B</u>		15,278	Various	48
49	TOTAL (lines 35 - 48)	734	\$ 124,806		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	992	\$ 9,905	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	992	\$ 9,905		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Orland Park, Inc.

Provider # 0041855

1/1/08-12/31/08

Schedule 20B

Consultant Services

<u>Type</u>	<u>Hours</u>	<u>Amount</u>	<u>Line</u>
PA Application	368	9,184	L10, C3
Medical Consultant	Montly	6,094	L10, C7
		<u>15,278</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

# 0041855

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	
Lawrence Putz	Administrator	0%	\$ 131,994	Workers' Compensation Insurance	\$ 97,757	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	72,023	Advertising: Employee Recruitment	14,199	
				FICA Taxes	510,880	Health Care Worker Background Check		
				Employee Health Insurance	203,968	(Indicate # of checks performed <u>27</u> )	326	
				Employee Meals	19,500	Patient Background Checks	674	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,559	
				401K Contributions	22,713	Miscellaneous Dues & Subscriptions	847	
				Other Employee Benefits	48,903			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 131,994	TOTAL (agree to Schedule V, line 22, col.8)			\$ 975,744	
(List each licensed administrator separately.)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
B. Administrative - Other				Description			Amount	
Management Fees-Royal Operating (Eliminated in col. 7)			\$ 1,028,874	Description			Amount	
Management Fees-Royal General (Eliminated in col. 7)			502,353	Line #			Amount	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,531,227	N/A				
(Attach a copy of any management service agreement)				TOTAL			\$	
C. Professional Services				Vendor/Payee			Type	
Grabowski Law Center			\$ 9,608	Amount				
Cassiday Schade, LLP			77,407	Description				
Duane Morris			706	Line #				
ING Life Insurance & Annuity			1,065	Amount				
James Samatas			264	Description				
McGladrey & Pullen			3,025	Line #				
Kimberlyn Wright-Mayfield			2,500	Amount				
McGladrey & Pullen			22,588	Description				
Moody's			904	Line #				
Personnel Planners			2,740	Amount				
Reed Smtih/Sachnoff & Weaver			28,513	Description				
See attached Schedule 21C			57,983	Line #				
TOTAL (agree to Schedule V, line 19, column 3)			\$ 207,303	TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)				G. Schedule of Travel and Seminar**				
				Description			Amount	
				Out-of-State Travel			\$	
				In-State Travel				
				Seminar Expense			7,130	
				Allocated from Mgmt. Co.			811	
				Entertainment Expense			( )	
				TOTAL (agree to Sch. V, line 24, col. 8)			\$ 7,941	

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

\*\*See instructions.

Lexington Health Care Center of Orland Park, Inc.

FYE: 12/31/08

Provider Number: 0041855

Schedule 21C

XIX. Support Schedules

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
North Huron Insurance	Insurance	8,519
RSM McGladrey	Accounting	15,411
Action Computer Service	Computer Consulting	389
Converged Comm	Computer Consulting	210
Lintech LLC	Computer Consulting	5,468
National Datacare	Computer Consulting	3,234
E-Health Data Solutions	Computer Consulting	2,400
C.D.W. Direct	Computer Consulting	324
Krakau Business	Computer Consulting	126
Healthware Consulting	Computer Consulting	2,060
Alperian Technology	Computer Consulting	215
Information Control	Computer Consulting	2,153
Silverchair Learning Systems	Computer Consulting	4,300
Microsoft License	Computer Consulting	4,820
Vision Share	Computer Consulting	580
Lanac. GP	Computer Consulting	3,522
B2B Computer Products	Computer Consulting	1,665
Johnson Controls	Computer Consulting	436
Gene Whitehorn	Medicaid Reimb. Specialist	2,016
Contrac Healthcare	Regulatory Consultant	135
		<u>57,983</u>
Total Professional Services		<u>207,303</u>
Allocated from management co.		
James Samatas	Legal-filing fees	36
Sachnoff & Weaver	Legal	1,966
Duane Morris	Legal	17
McGladrey & Pullen LLP	Accounting	534
RSM McGladrey	Accounting	565
Gilson Labus & Silverman	Accounting	2,102
Pension Administrators, Inc.	401K Administration	593
Personnel Planners, Inc.	Unemployment Consulting	41
Beth Schwarz	Operations Consultant	25
Gene Whitehorn	Medicaid Reimb. Specialist	1,090
See Schedule 21D for Vendor Listing	Computer Consulting	29,222
		<u>36,191</u>
Allocated from Samvest of Lombard II		
Gilson, Labus & Silverman	Accounting	<u>419</u>
Allocated from building partnership		<u>300</u>
Non-Allowable Legal		
MCD 4 & 5	Grabowski Law Center (Collections)	(9,608)
	Cassiday Shade	(2,891)
	Reed Smith	(181)
	James Samatas	(165)
		<u>(12,845)</u>
Nonallowable Accounting Fees		(1,678)
Total, Agrees to Schedule V, Line 19, Column 8		<u>229,690</u>

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 Orland Park# 0041855Report 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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 92,262 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. \$ 152,622  
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. \$ 19,500 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 253
- (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?  
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**