

Facility Name & ID Number Lexington of Schaumburg

0036095 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	214	Skilled (SNF)	214	78,324	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	214	TOTALS	214	78,324	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	4,863	1,596	10,870	17,329	8
9	SNF/PED					9
10	ICF	42,767	3,913	5,584	52,264	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,630	5,509	16,454	69,593	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.85%

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 4/1/90

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

YES Date New Construction NO

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

YES NO If YES, enter number

of beds certified 214 and days of care provided 10,537

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 Schaumburg # 0036095 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	396,663	33,153	16,435	446,251	446,251		446,251		1	
2	Food Purchase		326,235		326,235	326,235	(16,246)	309,989		2	
3	Housekeeping	370,768	38,235		409,003	409,003	489	409,492		3	
4	Laundry	91,793	20,336		112,129	112,129		112,129		4	
5	Heat and Other Utilities			281,135	281,135	281,135	7,222	288,357		5	
6	Maintenance	36,811		129,050	165,861	165,861	49,522	215,383		6	
7	Other (specify):* Mgmt Co Alloc Benef						5,379	5,379		7	
8	TOTAL General Services	896,035	417,959	426,620	1,740,614	1,740,614	46,366	1,786,980		8	
	B. Health Care and Programs										
9	Medical Director			40,750	40,750	40,750		40,750		9	
10	Nursing and Medical Records	4,380,833	372,642	152,570	4,906,045	4,906,045	19,064	4,925,109		10	
10a	Therapy			1,135,830	1,135,830	1,135,830		1,135,830		10a	
11	Activities	299,100	33,181	8,724	341,005	341,005		341,005		11	
12	Social Services	64,896		7,258	72,154	72,154		72,154		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* Mgmt Co Alloc Benef						3,211	3,211		15	
16	TOTAL Health Care and Programs	4,744,829	405,823	1,345,132	6,495,784	6,495,784	22,275	6,518,059		16	
	C. General Administration										
17	Administrative	105,191		1,208,289	1,313,480	1,313,480	(1,148,652)	164,828		17	
18	Directors Fees									18	
19	Professional Services			100,257	100,257	100,257	8,961	109,218		19	
20	Dues, Fees, Subscriptions & Promotions			37,431	37,431	37,431	5,044	42,475		20	
21	Clerical & General Office Expenses	333,801	27,964	26,902	388,667	388,667	428,931	817,598		21	
22	Employee Benefits & Payroll Taxes			856,226	856,226	856,226	16,062	872,288		22	
23	Inservice Training & Education			1,471	1,471	1,471		1,471		23	
24	Travel and Seminar			7,312	7,312	7,312	624	7,936		24	
25	Other Admin. Staff Transportation			2,261	2,261	2,261	21,299	23,560		25	
26	Insurance-Prop.Liab.Malpractice			233,032	233,032	233,032	3,280	236,312		26	
27	Other (specify):* Mgmt Co Alloc Benef						64,495	64,495		27	
28	TOTAL General Administration	438,992	27,964	2,473,181	2,940,137	2,940,137	(599,956)	2,340,181		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,079,856	851,746	4,244,933	11,176,535	11,176,535	(531,315)	10,645,220		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 Schaumburg

#0036095

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			139,130	139,130		139,130	279,063	418,193			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,092	35,092		35,092	412,425	447,517			32
33	Real Estate Taxes							337,749	337,749			33
34	Rent-Facility & Grounds			1,726,349	1,726,349		1,726,349	(1,722,340)	4,009			34
35	Rent-Equipment & Vehicles			91,066	91,066		91,066	4,481	95,547			35
36	Other (specify):*											36
37	TOTAL Ownership			1,991,637	1,991,637		1,991,637	(688,622)	1,303,015			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		438,460		438,460		438,460		438,460			39
40	Barber and Beauty Shops			24,777	24,777		24,777		24,777			40
41	Coffee and Gift Shops			9,180	9,180		9,180		9,180			41
42	Provider Participation Fee			117,486	117,486		117,486		117,486			42
43	Other (specify):* Non-allowable cost			112,183	112,183		112,183	(112,183)				43
44	TOTAL Special Cost Centers		438,460	263,626	702,086		702,086	(112,183)	589,903			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,079,856	1,290,206	6,500,196	13,870,258		13,870,258	(1,332,120)	12,538,138			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	(184)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,181)	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	(735)	30		9
10	Interest and Other Investment Income	(52,157)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,554)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,796)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,776)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(268,907)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (383,290)		\$	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)	(948,830)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (948,830)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,332,120)		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 Schaumburg

ID# 0036095

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non-allowable marketing	\$ (10,795)	43	1
2	Labs-Part A	(10,122)	43	2
3	X-Rays-Part A	(29,977)	43	3
4	Miscellaneous Income	(62)	21	4
5	Marketing Salary	(59,477)	21	5
6	Trust Fees	(135)	43	6
7	Loss on early extinguishment of debt	(127,109)	43	7
8	Nonallowable Collection Fees	(17,800)	19	8
9	Nonallowable Out of Period Legal	(230)	19	9
10	Nonallowable Marketing expenses	(11,909)	10	10
11	Nonallowable Accounting expenses	(1,291)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(268,907)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Schaumburg		
				Ltd. Ptsp.	Schaumburg	Real estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Fees	\$	Sambell of Schaumburg Limited Partnership	**	\$ 100	\$ 100	1
2	V	30 Depreciation		Sambell of Schaumburg Limited Partnership	**	226,814	226,814	2
3	V	32 Amortization of mortgage costs		Sambell of Schaumburg Limited Partnership	**	1,668	1,668	3
4	V	32 Interest expense		Sambell of Schaumburg Limited Partnership	**	443,178	443,178	4
5	V	33 Property taxes		Sambell of Schaumburg Limited Partnership	**	334,349	334,349	5
6	V	34 Rental expense	1,726,349	Sambell of Schaumburg Limited Partnership	**		(1,726,349)	6
7	V	43 State replacement tax		Sambell of Schaumburg Limited Partnership	**	18	18	7
8	V	43 Trust fees		Sambell of Schaumburg Limited Partnership	**	135	135	8
9	V	21 Office Supplies		Sambell of Schaumburg Limited Partnership	**	105	105	9
10	V	43 Loss on early extinguishment of debt		Sambell of Schaumburg Limited Partnership	**	127,109	127,109	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,726,349			\$ 1,133,476	\$ * (592,873)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg# 0036095Report 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.	**	\$ 489	\$ 489	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,008	6,008	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	153	153	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,061	1,061	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	44,030	44,030	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,224	5,224	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	268	268	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,379	5,379	22
23	V	10 Medical consultant		Royal Management Corp.	**	4,691	4,691	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	26,282	26,282	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,211	3,211	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	59,637	59,637	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	22,495	22,495	27
28	V	19 Professional fees		Royal Management Corp.	**	5,687	5,687	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	3,843	3,843	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	1,201	1,201	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	461,532	461,532	31
32	V	21 Bank charges		Royal Management Corp.	**	5,439	5,439	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,277	10,277	33
34	V	21 Postage		Royal Management Corp.	**	3,276	3,276	34
35	V							35
36	V							36
37	V							37
38	V	** Certain owners of Lexington Health Care Center of Schaumburg, Inc. own 100% or Royal Management Corp.						38
39	Total		\$			\$ 670,183	\$ * 670,183	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg# 0036095Report 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	21 Telephone	\$	Royal Management Corp.	**	\$ 7,841	\$ 7,841	15
16	V	24 Travel & seminar		Royal Management Corp.	**	624	624	16
17	V	25 Auto expense		Royal Management Corp.	**	21,299	21,299	17
18	V	26 Insurance general		Royal Management Corp.	**	3,280	3,280	18
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	64,495	64,495	19
20	V	30 Depreciation		Royal Management Corp.	**	52,984	52,984	20
21	V	32 Interest		Royal Management Corp.	**	19,706	19,706	21
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	30	30	22
23	V	33 Property taxes		Royal Management Corp.	**	3,400	3,400	23
24	V	34 Rent expense		Royal Management Corp.	**	4,009	4,009	24
25	V	35 Equipment rental		Royal Management Corp.	**	965	965	25
26	V	17 Management fees	1,208,289	Royal Management Corp.	**		(1,208,289)	26
27	V	35 Auto Lease Expense		Royal Management Corp.	**	3,516	3,516	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 Schaumburg, Inc. own 100% or Royal Management Corp.						38
39	Total		\$ 1,208,289			\$ 182,149	\$ * (1,026,140)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Schaumburg, Inc.
Provider # 0036095
1/1/08 - 12/31/08

Schedule B

VII. Related Parties

Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

Related Nursing Homes

City

Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
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 Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/Officer	Administrative	22.33%	See Schedule 7A	3.75	7.50	Salary	\$ 19,879	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33%	See Schedule 7A	3.75	7.50	Salary	19,879	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34%	See Schedule 7A	3.75	7.50	Salary	19,879	L17, C7	3
4	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	0.67	1.34	Salary	1,382	L21, C7	4
5	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	5.36	11.00	Salary	19,566	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	\$ 80,585		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	<u>185,600</u>	<u>185,600</u>	<u>185,600</u>	<u>12,904</u>	<u>182,679</u>	<u>752,383</u>

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Schaumburg

0036095

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	731,268	10	\$ 4,564		78,324	\$ 489	1
2	5	Utilities - gas & electric	731,268	10	56,094		78,324	6,008	2
3	5	Utilities - water & sewer	731,268	10	1,425		78,324	153	3
4	5	Utilities - maintenance office	731,268	10	9,903		78,324	1,061	4
5	6	Management allocation - salaries	731,268	10	411,084	411,084	78,324	44,030	5
6	6	Repairs & maintenance	731,268	10	48,773		78,324	5,224	6
7	6	Scavenger & exterminating	731,268	10	2,504		78,324	268	7
8	7	Management allocation - employe	731,268	10	50,217		78,324	5,379	8
9	10	Medical consultant	731,268	10	43,800		78,324	4,691	9
10	10	Management allocation - salaries	731,268	10	245,385	245,385	78,324	26,282	10
11	15	Management allocation - employe	731,268	10	29,975		78,324	3,211	11
12	17	Management allocation - salaries	731,268	10	556,800	556,807	78,324	59,637	12
13	19	Computer consultant & supplies	731,268	10	210,020		78,324	22,495	13
14	19	Professional fees	731,268	10	53,093		78,324	5,687	14
15	20	Dues & subscriptions	731,268	10	35,880		78,324	3,843	15
16	20	Advertising - help wanted	731,268	10	11,214		78,324	1,201	16
17	21	Management allocation - salaries	731,268	10	4,309,068	4,039,070	78,324	461,532	17
18	21	Bank charges	731,268	10	50,778		78,324	5,439	18
19	21	Office supplies & printing	731,268	10	95,951		78,324	10,277	19
20	21	Postage	731,268	10	30,589		78,324	3,276	20
21	21	Telephone	731,268	10	73,204		78,324	7,841	21
22	24	Travel and Seminar	731,268	10	5,826		78,324	624	22
23									23
24									24
25	TOTALS				\$ 6,336,147	\$ 5,252,346		\$ 678,648	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095 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	731,268	10	\$ 198,854	\$	78,324	\$ 21,299	1
2	26	Insurance general	731,268	10	30,619		78,324	3,280	2
3	27	Management allocation - employee	731,268	10	602,157		78,324	64,495	3
4	30	Depreciation	731,268	10	494,680		78,324	52,984	4
5	32	Interest	731,268	10	183,980		78,324	19,706	5
6	32	Amortization of mortgage costs	731,268	10	283		78,324	30	6
7	33	Property taxes	731,268	10	31,746		78,324	3,400	7
8	34	Rent expense	731,268	10	37,431		78,324	4,009	8
9	35	Equipment rental	731,268	10	9,010		78,324	965	9
10	35	Auto Lease	731,268	10	32,828		78,324	3,516	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	\$		\$ 173,684	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lexington Financial	X		Mortgage	Varies	4/25/01	\$ 6,200,000	\$		Variable	\$ 112,073	1								
2	Services, LLC	X		Mortgage	Varies	5/22/08	7,982,000	7,895,198	1/1/2033	Variable	331,105	2								
3												3								
4												4								
5							Interest on financing insurance premium				2,709	5								
Working Capital																				
6	Bank of America		X	Working Capital	Varies	4/6/02	1,700,000	1,025,000	6/30/09	Prime/libor	12,781	6								
7	Shareholder Interest	X		Working Capital	None	Varies	830,000		Demand	Various	19,602	7								
8												8								
9	TOTAL Facility Related						\$ 16,712,000	\$ 8,920,198			\$ 478,270	9								
B. Non-Facility Related*																				
10										Amortization of loan costs	1,668	10								
11										Disallow shareholder interest expense	(19,602)	11								
12										Offset Interest Income	(32,555)	12								
13										Allocated from Home Office	19,736	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (30,753)	14								
15	TOTALS (line 9+line14)						\$ 16,712,000	\$ 8,920,198			\$ 447,517	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Schaumburg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036095

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

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

A. **Summary of Real Estate Tax Cos**

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>07-27-201-039-000</u>	<u>Land & Building</u>	<u>\$ 415,098.57</u>	<u>\$ 415,098.57</u>
2. <u>Royal Management Corp. (Samvest of</u>	<u></u>	<u>\$</u>	<u>\$</u>
3. <u>Lombard II)</u>	<u>Land & Building</u>	<u>\$ 174,993.86</u>	<u>\$ 3,400.00</u>
4. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
5. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
6. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
7. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
8. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
9. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
10. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
TOTALS		\$ <u>590,092.43</u>	\$ <u>418,498.57</u>

B. **Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 Schaumburg

0036095 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,541 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: _____ 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>230,000</u>	<u>1988</u>	<u>\$ 211,532</u>	<u>1</u>
2	<u>Allocated from Management Company</u>			<u>17,607</u>	<u>2</u>
3	TOTALS	230,000		\$ 229,139	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095

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	205		1990	1990	\$ 6,091,126	\$	35	\$ 174,032	\$ 174,032	\$ 3,260,279	4
5	9		1995	1995	146,217	4,178	35	4,178		56,398	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements		1991		3,521		10			3,491	9
10	Building improvements		1992		860	25	35	25		406	10
11	Land improvements		1992		5,764		20	288	288	4,754	11
12	Land improvements		1992		5,000		20	250	250	3,875	12
13	Fan coil units in offices		1996		5,149	147	35	147		1,839	13
14	Basement rehab		1997		14,697		10			14,697	14
15	Brick		1997		1,500	43	35	43		489	15
16	Dining room rehab		1997		6,422		10			6,422	16
17	Parking lot repave and restripe		1998		2,777	139	10	139		2,777	17
18	Wiring		1998		3,667	183	10	183		3,667	18
19	Retile 2nd and 3rd floor corridors		1998		10,100	505	10	505		10,100	19
20	Plumbing for HVAC		1998		2,263		5			2,263	20
21	Lobby-floor tile		1999		7,478	748	10	748		7,353	21
22	Wallpaper-labor		1999		9,705	970	10	970		9,462	22
23	New patio		1999		19,039	1,269	15	1,269		11,740	23
24	New pay phone/wiring		1999		2,975	298	10	298		2,753	24
25	Roof repairs		2000		9,625	963	10	963		8,182	25
26	Water heater		2000		6,688	669	10	669		5,685	26
27	Automatic door		2000		1,300	130	10	130		1,105	27
28	Rehab project - paint resident rooms, carpet hallways, and tile		2000		52,760	5,276	10	5,276		44,846	28
29	Water heater and storage tanks		2001		12,102	1,210	10	1,210		9,682	29
30	Garbage area		2001		4,788	479	20	479		3,591	30
31											31
32											32
33											33
34											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 & ID Number Lexington of Schaumburg

0036095

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	Roof	2002	\$ 25,600	\$ 2,560	10	\$ 2,560		\$ 16,213	37
38	Facility rehab - paint resident rooms, carpet hallways, and tile	2002	327,253	16,363	20	16,363		120,912	38
39	Elevator electronic curtain	2002	4,500	450	10	450		2,925	39
40	Elevator upgrade	2002	5,471	547	10	547		3,556	40
41	Painting and decorating	2003	13,477	1,348	10	1,348		6,739	41
42	Electrical improvements	2003	844	42	20	42		214	42
43	Repave parking lot	2004	28,840	721	40	721		3,184	43
44	Dining room remodel - paint	2004	11,387	569	20	569		2,657	44
45	Landscaping	2005	593	30	20	30		102	45
46	HVAC upgrade	2005	17,734	887	20	887		2,734	46
47	Generator upgrade	2005	19,650	983	20	983		3,931	47
48	Window replacement	2005	3,899	195	20	195		650	48
49	Flooring replacement	2005	1,483	74	20	74		247	49
50	Lobby, lounge and reception rehab	2005	27,180	1,359	20	1,359		4,077	50
51	Therapy room rehab	2005	35,135	1,757	20	1,757		5,563	51
52	Create first floor therapy room	2005	32,045	1,602	20	1,602		6,142	52
53	Create transitional care unit	2005	29,170	1,458	20	1,458		4,497	53
54	Basement renovation	2005	5,996	300	20	300		900	54
55	Countertops	2005	845	169	5	169		620	55
56	Interior signs	2005	4,412	882	5	882		2,794	56
57	Window treatments	2005	912	182	5	182		623	57
58	Wall covering	2005	439	88	5	88		286	58
59	Panel Brick Replacement	2006	17,387	869	20	869		1,883	59
60	Landscaping Enhancement	2006	7,608	507	15	507		1,141	60
61	HVAC	2006	12,232	612	20	612		1,275	61
62	Sink	2006	2,331	117	20	117		311	62
63	TCU Units	2006	16,379	819	20	819		1,843	63
64	Employee lunch room rehab	2006	8,127	406	20	406		1,016	64
65	Dining room rehab	2006	2,357	118	20	118		295	65
66	Basement renovation	2006	9,465	473	20	473		1,104	66
67	Oxygen room rehab	2006	2,664	133	20	133		311	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,100,938	\$ 53,852		\$ 228,422	\$ 174,570	\$ 3,674,601	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 Schaumburg

0036095

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,100,938	\$ 53,852		\$ 228,422	\$ 174,570	\$ 3,674,601	1
2	Replace Sidewalk	2007	14,625	731	20	731		1,036	2
3	Landscaping	2007	15,700	785	20	785		981	3
4	Emergency A/C	2007	15,545	777	20	777		1,230	4
5	1st Floor Remodel - Carpentry, Flooring, Plumbing, Paint	2007	676,072		40	16,902	16,902	22,536	5
6	Bathroom Faucets	2007	12,358	618	20	618		669	6
7	Landscaping	2008	10,000	444	15	444		444	7
8	Roofing	2008	11,950	199	20	199		199	8
9	HVAC-Air tank	2008	2,671	28	40	28		28	9
10	HVAC-Spot Cooler	2008	3,790		40				10
11	Electrical-Fire panel upgrade	2008	71,077	1,185	40	1,185		1,185	11
12	Electrical-Replace Gasket	2008	6,125	306	10	306		306	12
13	2nd floor remodel-carpentry, painting, plumbing,electrical	2008	558,949		27	3,388	3,388	3,388	13
14									14
15									15
16									16
17	Land improvements - management company	2002	27,750		15	4,893	5,630	12,819	17
18	Building - management company	2002	215,891		40	37,331	37,331	37,331	18
19	HVAC, electrical, security system - management company	2003	2,140		30	377	377	799	19
20	Key card system - management company	2004	336		20	59	59	74	20
21	VAV TX controls - management company	2005	102		20	18	18	20	21
22	Interior Signs - management company	2006	75		5	11	11	11	22
23	Building improvements - management company	2008	45		5	9	9	9	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)		\$ 8,746,139	\$ 58,925		\$ 296,483	\$ 238,295	\$ 3,757,666	34

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 Schaumburg # 0036095 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	\$ 660,549	\$ 75,302	\$ 103,802	\$ 28,500	5-10	\$ 309,732	71
72	Current Year Purchases	236,043	4,903	8,360	3,457	5	8,360	72
73	Fully Depreciated Assets	25,920				5-10	25,920	73
74	Allocated from management company	276,455		4,462	4,462		169,270	74
75	TOTALS	\$ 1,198,967	\$ 80,205	\$ 116,624	\$ 36,419		\$ 513,282	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management company			39,514		5,086	5,086		25,905	79
80	TOTALS			\$ 39,514	\$	\$ 5,086	\$ 5,086		\$ 25,905	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,213,759	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 139,130	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 418,193	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 279,063	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,296,853	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Third floor remodel	\$ 58,266	92
93			93
94			94
95		\$ 58,266	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 co.</u>				<u>4,009</u>			6
7	TOTAL				\$ 4,009			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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: \$ 92,031 Description: Copier- \$8,713, Mailing System-\$179, Medical Equip-\$38,493, Oxygen-\$43,680, Mgmt. Co.-\$965
(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 management co.</u>			<u>3,516</u>	20
21	TOTAL		\$	\$ 3,516	21

* 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>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>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<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	\$	6,812	\$ 405,194	\$	6,812	\$ 405,194	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,487	100,550		1,487	100,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		7,188	630,086		7,188	630,086	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescripts				438,460		438,460	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			\$	15,487	\$ 1,135,830	\$ 438,460	15,487	\$ 1,574,290	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 Schaumburg# 0036095Report 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 231,756	\$ 246,518	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>761,568</u>)	2,736,190	2,736,190	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,186	15,186	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	12,678	1,146,002	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,995,810	\$ 4,143,896	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	80,390	80,390	12
13	Land		229,139	13
14	Buildings, at Historical Cost		6,237,343	14
15	Leasehold Improvements, at Historical Cost	1,168,557	2,508,796	15
16	Equipment, at Historical Cost	649,954	1,238,481	16
17	Accumulated Depreciation (book methods)	(694,321)	(4,296,853)	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 (spe CIP)	58,266	58,266	22
23	Other(specify): <u>Mortgage Cost</u>		66,269	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,262,846	\$ 6,121,831	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,258,656	\$ 10,265,727	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 545,739	\$ 545,739	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,025,000	1,025,000	29
30	Accrued Salaries Payable	341,450	341,450	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,420	4,420	31
32	Accrued Real Estate Taxes(Sch.IX-B)		428,400	32
33	Accrued Interest Payable		46,530	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	1,242,136	701,424	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,158,745	\$ 3,092,963	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,895,198	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)	\$	\$ 7,895,198	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,158,745	\$ 10,988,161	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,099,911	\$ (722,434)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,258,656	\$ 10,265,727	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Schaumburg, Inc.
Provider #0036095
1/1/08-12/31/08

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other current liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to Royal	(35,669)	(35,669)
Due from Lombard	(884)	(884)
Due from S/B of Schaumburg	(49,272)	-
Due from Bloomingdale	(618)	(618)
Due from Lake Zurich	2,304	2,304
Due from Streamwood	(274)	(274)
Escrow-Insurance	38,438	38,438
Accrued 401K	(26,099)	(26,099)
Due to Lexington Financial Service	(2,567)	(2,567)
Due to Republic Construction	(11,268)	(11,268)
Accrued Expenses	(96,912)	(96,912)
Accrued Royal Gen Mgmt Fees	(34,694)	(34,694)
Accrued Rent	(671,759)	-
Accrued Wage Assignments	(609)	(609)
Deferred Income	(328,891)	(328,891)
Advance Bi-Weekly Payments	(39,367)	(39,367)
Uncollectible Part A Co Pmts	16,005	16,005
Interest Rate Swap	-	(180,319)
	<u>(1,242,136)</u>	<u>(701,424)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 955,787	1
2	Restatements (describe):		2
3	Post Closing Adjustment	638,842	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,594,629	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	225,282	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	(720,000)	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)	\$ (494,718)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,099,911	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	\$ 17,674,601	1
2	Discounts and Allowances for all Levels	(7,185,816)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,488,785	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,769,465	6
7	Oxygen	8,454	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,777,919	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	10,804	12
13	Barber and Beauty Care	27,262	13
14	Non-Patient Meals	184	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	552,293	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,044	19
20	Radiology and X-Ray	15,060	20
21	Other Medical Services	166,392	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 818,039	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,859	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,859	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	(62)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (62)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,095,540	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,740,614	31
32	Health Care	6,495,784	32
33	General Administration	2,940,137	33
B. Capital Expense			
34	Ownership	1,991,637	34
C. Ancillary Expense			
35	Special Cost Centers	584,600	35
36	Provider Participation Fee	117,486	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,870,258	40
41	Income before Income Taxes (line 30 minus line 40)**	225,282	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 225,282	43

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

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

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

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

Facility Name & ID Number Lexington of Schaumburg

0036095

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,694	1,719	\$ 93,244	\$ 54.24	1
2	Assistant Director of Nursing	5,416	5,829	208,580	35.78	2
3	Registered Nurses	50,014	54,621	1,825,126	33.41	3
4	Licensed Practical Nurses	15,524	17,152	447,716	26.10	4
5	CNAs & Orderlies	132,039	141,582	1,790,042	12.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,878	4,013	64,338	16.03	9
10	Activity Assistants	21,370	22,651	234,762	10.36	10
11	Social Service Workers	3,902	4,118	64,896	15.76	11
12	Dietician	1,914	2,040	37,418	18.34	12
13	Food Service Supervisor	1,969	2,079	41,375	19.90	13
14	Head Cook	1,875	2,079	30,934	14.88	14
15	Cook Helpers/Assistants	11,858	12,948	132,348	10.22	15
16	Dishwashers	17,683	18,918	154,588	8.17	16
17	Maintenance Workers	1,956	2,181	36,811	16.88	17
18	Housekeepers	39,949	43,298	370,768	8.56	18
19	Laundry	10,214	11,019	91,793	8.33	19
20	Administrator	2,040	2,195	105,191	47.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,715	22,090	333,801	15.11	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	989	1,070	16,125	15.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	344,999	371,602	\$ 6,079,856 *	\$ 16.36	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	281	\$ 16,435	L1,C3	35
36	Medical Director	Monthly	40,750	L9,C3	36
37	Medical Records Consultant	22	1,227	L10,C3	37
38	Nurse Consultant	395	25,599	L10,C3	38
39	Pharmacist Consultant	Monthly	4,815	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	116	5,573	L11,C3	44
45	Social Service Consultant	107	5,338	L12,C3	45
46	Other(specify) <u>Psychosocial</u>	40	1,920	L12,C3	46
47	<u>PA Application</u>	1	500	L10,C3	47
48	<u>See Schedule 20A</u>	Monthly	8,691	L10,C3&7	48
49	TOTAL (lines 35 - 48)	962	\$ 110,848		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	15,637	\$ 116,429	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	15,637	\$ 116,429		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Schaumburg, Inc.
Provider # 0036095
1/1/08 - 12/31/08

Schedule 20A

XVIII. B. Consultant Services

<u>Consultant Service</u>	<u>Number of Hrs. Paid & Accrued</u>	<u>Total Consultant Cost for Reporting Period</u>	<u>Schedule V Line & Column Reference</u>
Pulmonary Director	Monthly	4,000	L10,C3
Medical Consultant	Monthly	4,691	L10,C7
		<u>8,691</u>	

See Accountants' Compilation Report

Lexington Health Care Center of Schaumburg, Inc.
 Provider #0036095
 1/1/08 - 12/31/08

Schedule 21C

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
RSM McGladrey, Inc.	Accounting	10,097
Action Computer Service	Computer Consulting	324
Converged Comm	Computer Consulting	140
Lintech LLC	Computer Consulting	5,468
National Datacare	Computer Consulting	1,750
E-Health Data Solutions	Computer Consulting	2,400
C.D.W. Direct	Computer Consulting	324
Krakau Business	Computer Consulting	289
Healthware Consulting	Computer Consulting	2,060
Alperian Technology	Computer Consulting	215
Information Control	Computer Consulting	1,545
Silverchair Learning Systems	Computer Consulting	4,300
Microsoft License	Computer Consulting	4,533
Mnj Technologies	Computer Consulting	351
Vision Share	Computer Consulting	580
B2B Computer Products	Computer Consulting	1,665
Lanac/GP	Computer Consulting	2,708
Gene Whitehorn	Medicaid Reimb. Specialist	957
Confrac Healthcare	Regulatory Consultant	4,155
		<u>43,861</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u>100,257</u>
Allocated from management co.		
James Samatas	Legal-filing fees	28
Sachnoff & Weaver	Legal	1,512
Duane Morris	Legal	12
McGladrey & Pullen LLP	Accounting	411
RSM McGladrey	Accounting	435
Gilson Labus & Silverman	Accounting	1,622
Pension Administrators, Inc.	401(k) Administration	457
Personnel Planners, Inc.	Unemployment Consultant	32
Beth Schwarz	Operations Consultant	18
Gene Whitehorn	Medicaid Reimb. Specialist	838
See attached Schedule 21D for Vendor Listing	Computer Consulting	22,496
		<u>27,861</u>
Real estate entity		
James Samtas	Legal-filing fees	100
Allocated from Samvest of Lombard II		
Gilson, Labus & Silverman	Accounting	321
Nonallowable legal fees		
Cassiday Schade	Legal	(9)
James Samatas	Legal	(46)
Reed Smith/Sachnoff & Weaver	Legal	(175)
Grabowski Law Center, LLC	Collections	(17,800)
		<u>(18,030)</u>
Nonallowable accounting fees		
		(1,291)
Total, Agrees to Schedule V, Line 19, Column 8		<u>109,218</u>

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 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 Schaumburg

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. \$ 40,105 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. \$ 117,486
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. \$ 16,062 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 182
- (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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT