

Facility Name & ID Number Lexington of Streamwood

0037002 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	7,104	2,179	12,016	21,299	8
9	SNF/PED					9
10	ICF	32,311	4,789	3,170	40,270	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,415	6,968	15,186	61,569	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.61%

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 7/8/91

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 11,544

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 Streamwood # 0037002 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	385,271	34,336	17,377	436,984		436,984		436,984		1
2	Food Purchase		294,756		294,756		294,756	(15,181)	279,575		2
3	Housekeeping	333,461	35,513		368,974		368,974	489	369,463		3
4	Laundry	75,077	17,422		92,499		92,499		92,499		4
5	Heat and Other Utilities			283,773	283,773		283,773	7,222	290,995		5
6	Maintenance	28,169		139,296	167,465		167,465	49,522	216,987		6
7	Other (specify):* Mgmt Co. Allocated B							5,379	5,379		7
8	TOTAL General Services	821,978	382,027	440,446	1,644,451		1,644,451	47,431	1,691,882		8
	B. Health Care and Programs										
9	Medical Director			68,650	68,650		68,650		68,650		9
10	Nursing and Medical Records	4,016,936	414,317	96,468	4,527,721		4,527,721	19,064	4,546,785		10
10a	Therapy			794,002	794,002		794,002		794,002		10a
11	Activities	257,722	30,642	14,734	303,098		303,098		303,098		11
12	Social Services	112,117		8,079	120,196		120,196		120,196		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co. Allocated B							3,211	3,211		15
16	TOTAL Health Care and Programs	4,386,775	444,959	981,933	5,813,667		5,813,667	22,275	5,835,942		16
	C. General Administration										
17	Administrative	110,423		1,152,135	1,262,558		1,262,558	(1,092,498)	170,060		17
18	Directors Fees										18
19	Professional Services			189,531	189,531		189,531	22,847	212,378		19
20	Dues, Fees, Subscriptions & Promotions			229,499	229,499		229,499	3,604	233,103		20
21	Clerical & General Office Expenses	324,210	33,546	20,578	378,334		378,334	424,852	803,186		21
22	Employee Benefits & Payroll Taxes			812,615	812,615		812,615	15,181	827,796		22
23	Inservice Training & Education			2,161	2,161		2,161		2,161		23
24	Travel and Seminar			5,808	5,808		5,808	624	6,432		24
25	Other Admin. Staff Transportation							21,299	21,299		25
26	Insurance-Prop.Liab.Malpractice			188,336	188,336		188,336	3,280	191,616		26
27	Other (specify):* Mgmt Co. Allocated B							64,495	64,495		27
28	TOTAL General Administration	434,633	33,546	2,600,663	3,068,842		3,068,842	(536,316)	2,532,526		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,643,386	860,532	4,023,042	10,526,960		10,526,960	(466,610)	10,060,350		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 Streamwood

#0037002

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			128,027	128,027		128,027	281,552	409,579			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			205,817	205,817		205,817	160,587	366,404			32
33	Real Estate Taxes							450,027	450,027			33
34	Rent-Facility & Grounds			1,838,627	1,838,627		1,838,627	(1,834,618)	4,009			34
35	Rent-Equipment & Vehicles			114,765	114,765		114,765	4,481	119,246			35
36	Other (specify):*											36
37	TOTAL Ownership			2,287,236	2,287,236		2,287,236	(937,971)	1,349,265			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		575,479		575,479		575,479		575,479			39
40	Barber and Beauty Shops			16,040	16,040		16,040		16,040			40
41	Coffee and Gift Shops			2,573	2,573		2,573		2,573			41
42	Provider Participation Fee			117,486	117,486		117,486		117,486			42
43	Other (specify):* Non-allowable cost			111,975	111,975		111,975	(111,975)				43
44	TOTAL Special Cost Centers		575,479	248,074	823,553		823,553	(111,975)	711,578			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,643,386	1,436,011	6,558,352	13,637,749		13,637,749	(1,516,556)	12,121,193			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,222)	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	(227,702)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,124)	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	(6,750)	43		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	(42,549)	43		24
25	Fund Raising, Advertising and Promotional	(21,179)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,463)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Sch 5A</u>	(184,503)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (490,495)		\$	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)	(1,026,061)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,026,061)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,516,556)		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 Streamwood

ID# 0037002

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salary	\$ (63,461)	21	1
2	Labs-Part A	(16,277)	43	2
3	X-Rays-Part A	(17,411)	43	3
4	Miscellaneous Income	(158)	21	4
5	Chamber of Commerce Dues	(1,440)	20	5
6	Trust Fees	(185)	43	6
7	Loss on Mortgage Cost	(68,127)	43	7
8	Out of period legal	(2,242)	19	8
9	Collections	(2,002)	19	9
10	Additional Marketing Salary	(11,909)	10	10
11	Non-allowable accounting	(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	(184,503)		49

Facility Name & ID Number Lexington of Streamwood

0037002

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 Streamwood	Streamwood	Real estate ptsp.
				Limited Partnership	Lombard	Mgmt. Co.
				Royal Mgmt. Corp.		
				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 Streamwood Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation		Sambell of Streamwood Limited Partnership	**	228,572	228,572	2
3	V	32 Interest expense		Sambell of Streamwood Limited Partnership	**	367,146	367,146	3
4	V	32 Amortization of mortgage costs		Sambell of Streamwood Limited Partnership	**	1,407	1,407	4
5	V	33 Property taxes		Sambell of Streamwood Limited Partnership	**	446,627	446,627	5
6	V	34 Rental expense	1,838,627	Sambell of Streamwood Limited Partnership	**		(1,838,627)	6
7	V	43 Trust fees		Sambell of Streamwood Limited Partnership	**	185	185	7
8	V	43 Loss on Mortgage Cost		Sambell of Streamwood Limited Partnership	**	68,127	68,127	8
9	V	21 Office Supplies		Sambell of Streamwood Limited Partnership	**	105	105	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,838,627			\$ 1,112,369	\$ * (726,258)	14

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

Facility Name & ID Number Lexington of Streamwood# 0037002Report 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	6 Security service		Royal Management Corp.	**				22
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,379		5,379	23
24	V	10 Medical consultant		Royal Management Corp.	**	4,691		4,691	24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	26,282		26,282	25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,211		3,211	26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	59,637		59,637	27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	22,495		22,495	28
29	V	19 Professional fees		Royal Management Corp.	**	5,687		5,687	29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	3,843		3,843	30
31	V	21 Communications		Royal Management Corp.	**				31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	1,201		1,201	32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	461,532		461,532	33
34	V	21 Bank charges		Royal Management Corp.	**	5,439		5,439	34
35	V	21 Office supplies & printing		Royal Management Corp.	**	10,277		10,277	35
36	V	21 Postage		Royal Management Corp.	**	3,277		3,277	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% or Royal Management Corp.							38
39	Total		\$			\$ 670,184	\$ *	670,184	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 7,841	\$ 7,841
16	V	24 Travel & seminar		Royal Management Corp.	**	624	624
17	V	25 Auto expense		Royal Management Corp.	**	21,299	21,299
18	V	26 Insurance general		Royal Management Corp.	**	3,280	3,280
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	64,495	64,495
20	V	30 Depreciation		Royal Management Corp.	**	52,983	52,983
21	V	32 Interest		Royal Management Corp.	**	19,706	19,706
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	30	30
23	V	33 Property taxes		Royal Management Corp.	**	3,400	3,400
24	V	34 Rent expense		Royal Management Corp.	**	4,009	4,009
25	V	35 Equipment rental		Royal Management Corp.	**	965	965
26	V	17 Management fees	1,152,135	Royal Management Corp.	**		(1,152,135)
27	V	35 Auto Lease Expense		Royal Management Corp.	**	3,516	3,516
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 1,152,135			\$ 182,148	\$ * (969,987)

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

Lexington Health Care Center of Streamwood, Inc.

Provider # 0037002

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

See Accountants' Compilation Report

Facility Name & ID Number

Lexington of Streamwood

0037002

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	23.33	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	185,600	185,600	185,600	12,904	182,679	752,383

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	\$ 78,324	\$ 489	1
2	5	Utilities - gas & electric	Bed Days	731,268	10	56,094	78,324	6,008	2
3	5	Utilities - water & sewer	Bed Days	731,268	10	1,425	78,324	153	3
4	5	Utilities - maintenance office	Bed Days	731,268	10	9,903	78,324	1,061	4
5	6	Management allocation - salaries	Bed Days	731,268	10	411,084	411,084	44,030	5
6	6	Repairs & maintenance	Bed Days	731,268	10	48,773	78,324	5,224	6
7	6	Scavenger & exterminating	Bed Days	731,268	10	2,504	78,324	268	7
8	6	Security service	Bed Days	731,268	10		78,324	0	8
9	7	Management allocation - employee	Bed Days	731,268	10	50,217	78,324	5,379	9
10	10	Medical consultant	Bed Days	731,268	10	43,800	78,324	4,691	10
11	10	Management allocation - salaries	Bed Days	731,268	10	245,385	245,385	26,282	11
12	15	Management allocation - employee	Bed Days	731,268	10	29,975	78,324	3,211	12
13	17	Management allocation - salaries	Bed Days	731,268	10	556,800	556,800	59,637	13
14	19	Computer consultant & supplies	Bed Days	731,268	10	210,020	78,324	22,495	14
15	19	Professional fees	Bed Days	731,268	10	53,093	78,324	5,687	15
16	20	Dues & subscriptions	Bed Days	731,268	10	35,880	78,324	3,843	16
17	21	Communications	Bed Days	731,268	10		78,324	0	17
18	20	Advertising - help wanted	Bed Days	731,268	10	11,214	78,324	1,201	18
19	21	Management allocation - salaries	Bed Days	731,268	10	4,309,068	4,309,068	461,532	19
20	21	Bank charges	Bed Days	731,268	10	50,778	78,324	5,439	20
21	21	Office supplies & printing	Bed Days	731,268	10	95,951	78,324	10,277	21
22	21	Postage	Bed Days	731,268	10	30,589	78,324	3,276	22
23	21	Telephone	Bed Days	731,268	10	73,204	78,324	7,841	23
24	24	Travel and Seminar	Bed Days	731,268	10	5,826	78,324	624	24
25	TOTALS					\$ 6,336,147	\$ 5,522,337	\$ 678,648	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	731,268	10	\$ 198,854	\$ 78,324	\$ 21,299	1
2	26	Insurance general	Bed Days	731,268	10	30,619	78,324	3,280	2
3	27	Management allocation - employee	Bed Days	731,268	10	602,157	78,324	64,495	3
4	30	Depreciation - leasehold improv.	Bed Days	731,268	10	494,680	78,324	52,984	4
5	32	Interest	Bed Days	731,268	10	183,980	78,324	19,706	5
6	32	Amortization of mortgage costs	Bed Days	731,268	10	283	78,324	30	6
7	33	Property taxes	Bed Days	731,268	10	31,746	78,324	3,400	7
8	34	Rent expense	Bed Days	731,268	10	37,431	78,324	4,009	8
9	35	Equipment rental	Bed Days	731,268	10	9,010	78,324	965	9
10	35	Auto lease	Bed Days	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

Facility Name & ID Number

Lexington of Streamwood

0037002

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	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					\$		\$		\$	1									
2	Services, L.L.C.	X		Mortgage	Varies	2/1/96	5,985,000			Variable	86,195	2								
3	Lexington Financial											3								
4	Services, L.L.C.	X		Mortgage	Varies	5/22/08	6,734,000	6,824,940	1/1/33	Variable	280,951	4								
5							Interest on financing insurance premium				2,357	5								
Working Capital																				
6	Shareholders	X		Working Capital	None	Various	1,154,048	5,357,672	Demand	Prime +1	193,032	6								
7	Bank of America		X	Working Capital	None	4/4/04	1,300,000	1,000,000	6/30/09	Prime/Libor	10,429	7								
8												8								
9	TOTAL Facility Related						\$ 15,173,048	\$ 13,182,612			\$ 572,963	9								
B. Non-Facility Related*																				
10										Amortization of mortgage costs	1,437	10								
11										Interest income offset	(34,670)	11								
12										Allocated from management company	19,706	12								
13										Less: Shareholder interest	(193,032)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (206,559)	14								
15	TOTALS (line 9+line14)						\$ 15,173,048	\$ 13,182,612			\$ 366,404	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.		\$	502,800	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	\$	492,792	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(10,008)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	507,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	38,196	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 36,976 For 2005 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(89,162)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	450,027	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	453,831	8
	2004	441,442	9
	2005	449,212	10
	2006	443,467	11
	2007	492,792	12

Accrual Computation			
See Attached Schedule			
Use: \$507,600			

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

NOTES:

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

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 Streamwood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4796

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-25-300-006-0000</u>	<u>Land & Building</u>	\$ <u>492,791.77</u>	\$ <u>492,791.77</u>
2. <u>Royal Management Corp(Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>174,993.86</u>	\$ <u>3,400.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>667,785.63</u>	\$ <u>496,191.77</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 Streamwood

0037002

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 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: N/A 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>30,000</u>	<u>1991</u>	<u>\$ 211,400</u>	<u>1</u>
2	<u>Allocated from Management Company</u>		<u>2002</u>	<u>17,607</u>	<u>2</u>
3	TOTALS	30,000		\$ 229,007	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002

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	200	1991	1991	\$ 5,248,322	\$		\$ 149,952	\$ 149,952	\$ 2,624,161	4
5		1993	1993	105,236			3,007	3,007	46,604	5
6	14	1995	1995	82,650	2,357		2,361	4	31,879	6
7										7
8										8
	Improvement Type**									
9	Building Improvement		1993	7,336			210	210	3,249	9
10	Land Improvements		1995	7,000	467	15	467		6,300	10
11	Kitchen & Nurses Station		1996	12,316	352	35	352		4,399	11
12	Piping		1996	3,139	90	35	90		1,121	12
13	Basement remodeling		1997	20,204		10			20,204	13
14	Floor repairs		1997	555		10			555	14
15	Corner Guards		1997	998		10			998	15
16	Corner Guards		1998	3,563	178	10	178		3,563	16
17	Wiring		1998	2,050	103	10	103		2,051	17
18	Tile		1998	11,697	1,170	10	1,170		11,697	18
19	Patio		1999	12,012	801	15	801		7,274	19
20	Parking lot		2000	1,773	177	10	177		1,507	20
21	110-ton A/C unit		2000	6,923	692	10	692		5,884	21
22	Rods for bedside curtains		2000	5,872	587	10	587		4,991	22
23	Automatic doors		2000	1,300	130	10	130		1,105	23
24	Rehab project: carpeting, wallcovering, handrails, painting		2000	85,195	8,519	10	8,519		72,415	24
25	Compressor/tube bundles-cooling system		2001	12,921	1,292	10	1,292		9,691	25
26	Rehab project: resident rooms, corridors, dining room		2001	212,217	10,611	20	10,611		79,582	26
27	Parking lot		2002	29,288	2,929	10	2,929		19,037	27
28	Office area rehab		2002	26,991	1,350	20	1,350		8,773	28
29	Elevator interior upgrade		2002	1,120	112	10	112		738	29
30	Gazebo		2002	3,393	339	10	339		2,205	30
31	Elevator electronic curtains		2002	4,500	450	10	450		3,113	31
32	Door frame protector		2003	5,276	528	10	528		3,122	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring		2003	9,392	939	10	939		5,087	33
34	Roof		2003	29,950	1,498	20	1,498		7,613	34
35	Kitchen Sewer/Dishroom		2004	6,224	622	10	622		2,697	35
36	Compressor/tube bundles-cooling system		2004	14,737	737	20	737		3,193	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

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	Kitchen fire protection upgrade	2004	\$ 1,427	\$ 143	10	\$ 143	\$	\$ 678	37
38	Landscaping	2005	8,495	425	20	425		1,381	38
39	Kitchen renovation	2005	12,034	602	20	602		1,805	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		5,616	40
41	Therapy room renovation	2005	11,628	581	20	581		1,938	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		8,956	42
43	Dialysis units	2005	66,426	3,783	20	3,783		12,125	43
44	Create transitional unit	2005	14,490	725	20	725		2,174	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		1,183	45
46	Basement renovation	2005	46,561	2,328	20	2,328		7,372	46
47	Landscaping enhancement	2006	3,414	228	15	228		569	47
48	HVAC	2006	17,125	856	20	856		1,784	48
49	Door closer	2006	4,446	222	20	222		611	49
50	Blinds	2006	1,566	313	5	313		652	50
51	Employee lunch room rehab	2006	2,883	144	20	144		384	51
52	Storeroom door lock	2006	2,843	142	20	142		355	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		8,116	53
54	Fine dining	2006	7,650	382	20	382		988	54
55	Automatic door	2006	2,259	113	20	113		254	55
56	Landscaping	2007	10,606	530	20	530		574	56
57	Parking lot	2007	2,777	139	20	139		174	57
58	HVAC	2007	1,501	75	20	75		131	58
59	Painting Building	2007	16,150	808	20	808		1,144	59
60	Landscaping	2008	33,747	187	15	187		187	60
61	Common areas-metal doors	2008	7,055	265	20	265		265	61
62	Wanderguard	2008	3,882	194	20	194		194	62
63	1st floor remodel-Carpentry, flooring, electrical, painting	2008	531,230		27	19,317	19,317	19,317	63
64	2nd Floor Remodel-Carpentry, Flooring, Electrical, painting	2008	487,332		27				64
65	Remodel special care units-carpentry, electrical, painting	2008	32,914		27				65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,455,553	\$ 57,764		\$ 230,255	\$ 172,491	\$ 3,073,736	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,455,553	\$ 57,764		\$ 230,255	\$ 172,491	\$ 3,073,736	1
2									2
3									3
4	Land Improvements-management company	2002	27,750		15	1,837	1,837	12,830	4
5	Building-management company	2002	215,891		40	41,415	41,415	37,318	5
6	HVAC, electrical, security system-management company	2003	2,140		30	150	150	803	6
7	Key card system-management company	2004	336		20	17	17	75	7
8	VAC TX controls-management company	2005	102		20	6	6	21	8
9	Build Imp-management company	2006	75		5	5	5	11	9
10	Building Improvement Management Co.	2008	45		5	5	5	5	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,701,892	\$ 57,764		\$ 273,690	\$ 215,926	\$ 3,124,799	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 Streamwood

0037002

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	\$ 427,628	\$ 68,392	\$ 68,384	\$ (8)	5	\$ 234,625	71
72	Current Year Purchases	510,235	1,871	57,958	56,087	5	57,958	72
73	Fully Depreciated Assets	4,979					4,979	73
74	Allocated from Management Company	276,455		4,462	4,462		169,270	74
75	TOTALS	\$ 1,219,297	\$ 70,263	\$ 130,804	\$ 60,541		\$ 466,832	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)	\$ 9,189,710	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 128,027	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 409,579	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 281,552	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,617,535	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	1st Floor remodel	\$ 60,713	92
93			93
94			94
95		\$ 60,713	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	Allocated from Mgmt. Co.				4,009			6
7	TOTAL				\$ 4,009			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: \$ 115,730 Description: Copier-\$7,357, Mailing System-\$184, Med Equip-\$63,713, Oxygen-43,511; Alloc 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	Allocated from Mgmt. Co.			3,516	20
21	TOTAL		\$	\$ 3,516	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	\$	7,067	\$ 289,842	\$	7,067	\$ 289,842	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		1,289	58,506		1,289	58,506	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		7,952	445,654		7,952	445,654	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				575,479		575,479	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			\$	16,308	\$ 794,002	\$ 575,479	16,308	\$ 1,369,481	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 Streamwood
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0037002
 As of 12/31/2008

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

Ending: 12/31/2008

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 551,580	\$ 563,528	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>609,473</u>)	3,056,045	3,056,045	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,614	15,614	6
7	Other Prepaid Expenses	7,846	7,846	7
8	Accounts Receivable (owners or related parties)	38,018	1,324,425	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,669,103	\$ 4,967,458	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,821	67,821	12
13	Land		229,007	13
14	Buildings, at Historical Cost		5,248,322	14
15	Leasehold Improvements, at Historical Cost	1,043,181	2,453,570	15
16	Equipment, at Historical Cost	507,692	1,258,811	16
17	Accumulated Depreciation (book methods)	(619,374)	(3,617,535)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec CIP _____)	60,713	60,713	22
23	Other(specify): <u>Mortgage Cost Net</u>		55,927	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,060,033	\$ 5,756,636	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,729,136	\$ 10,724,094	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 455,594	\$ 455,594	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,357,672	6,521,840	29
30	Accrued Salaries Payable	313,402	313,402	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,624	8,624	31
32	Accrued Real Estate Taxes(Sch.IX-B)		507,600	32
33	Accrued Interest Payable		39,255	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See schedule 17A</u>	6,711,766	1,456,778	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,847,058	\$ 9,303,093	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,660,772	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,660,772	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,847,058	\$ 15,963,865	46
47	TOTAL EQUITY (page 18, line 24)	\$ (9,117,922)	\$ (5,239,771)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,729,136	\$ 10,724,094	48

Lexington Health Care Center of Streamwood, Inc.

Provider #0037002

1/1/08-12/31/08

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other current liabilities

<u>Account</u>	<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
1107	Due to Royal	(119,514)	(119,514)
1242	Escrow - Insurance	(523,000)	(523,000)
1627	Accrued 401K	(21,109)	(21,109)
1647	Due to-Lexington Financial Svc.	(2,461)	(2,461)
1651	Accrued Expenses	(106,099)	(106,099)
1654	Accrued Royal Gen Mgmt Fees	(221,875)	(221,875)
1657	Accrued Rent	(5,396,700)	-
1662	Accrued Wage Assignments	(40)	(40)
1691	Defereed Income	(320,968)	(320,968)
1694.1	Interest Rate Swap	-	(141,712)
		<u>(6,711,766)</u>	<u>(1,456,778)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,301,789)	1
2	Restatements (describe):		2
3	Post closing adjustment	(90,646)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,392,435)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,725,487)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,725,487)	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)	\$ (9,117,922)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood# 0037002Report Period Beginning: 01/01/2008Ending: 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	\$ 15,842,286	1
2	Discounts and Allowances for all Levels	(7,280,405)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,561,881	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,371,682	6
7	Oxygen	6,181	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,377,863	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	4,709	12
13	Barber and Beauty Care	16,915	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	669,525	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	64,586	19
20	Radiology and X-Ray	17,513	20
21	Other Medical Services	189,956	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 963,204	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,675	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,675	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous & Investment Income</u>	639	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 639	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,912,262	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,644,451	31
32	Health Care	5,813,667	32
33	General Administration	3,068,842	33
	B. Capital Expense		
34	Ownership	2,287,236	34
	C. Ancillary Expense		
35	Special Cost Centers	706,067	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)*	\$ 13,637,749	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,725,487)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,725,487)	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 Streamwood

0037002

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	1,737	1,862	\$ 94,964	\$ 51.00	1
2	Assistant Director of Nursing	6,283	6,801	230,435	33.88	2
3	Registered Nurses	52,779	56,959	1,800,557	31.61	3
4	Licensed Practical Nurses	18,867	20,483	519,377	25.36	4
5	CNAs & Orderlies	96,011	102,569	1,219,406	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,526	10,165	121,367	11.94	8
9	Activity Director	2,079	2,079	32,998	15.87	9
10	Activity Assistants	19,282	20,746	224,724	10.83	10
11	Social Service Workers	6,351	6,878	112,117	16.30	11
12	Dietician					12
13	Food Service Supervisor	1,691	1,818	36,946	20.32	13
14	Head Cook	2,149	2,369	37,241	15.72	14
15	Cook Helpers/Assistants	12,421	13,556	130,555	9.63	15
16	Dishwashers	20,970	22,270	180,529	8.11	16
17	Maintenance Workers	2,026	2,126	28,169	13.25	17
18	Housekeepers	35,860	38,748	333,461	8.61	18
19	Laundry	8,712	9,297	75,077	8.08	19
20	Administrator	2,194	2,255	110,423	48.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,577	19,244	280,103	14.56	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	1,865	2,037	30,830	15.14	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Financial Coordin</u>	2,572	2,781	44,107	15.86	33
34	TOTAL (lines 1 - 33)	320,952	345,043	\$ 5,643,386 *	\$ 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	282	\$ 17,377	L1,C3	35
36	Medical Director	Monthly	68,650	L9,C3	36
37	Medical Records Consultant	29	1,598	L10,C3	37
38	Nurse Consultant	33	1,847	L10,C3	38
39	Pharmacist Consultant	Monthly	3,670	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	99	4,747	L11,C3	44
45	Social Service Consultant	111	5,775	L12,C3	45
46	Other(specify) <u>Psychosocial</u>	48	2,304	L12,C3	46
47	<u>MDS Consultant</u>	28	2,758	L10,C3	47
48	<u>Medical Consultanat</u>	Monthly	4,691	L10,C7	48
49	TOTAL (lines 35 - 48)	630	\$ 113,417		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	525	\$ 34,642	L10,C3	50
51	Licensed Practical Nurses	1,090	51,943	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,615	\$ 86,585		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
 Provider # 0037002
 1/1/08-12/31/08

Schedule 21C

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Royal Management	Benefits	28,875
RSM McGladrey, Inc.	Accounting	8,840
James Samatas	Legal	140
Action Computer Service	Computer Consulting	324
Converged Comm	Computer Consulting	140
Lintech LLC	Computer Consulting	5,468
National Data Solutions	Computer Consulting	2,066
E-Health Data Solutions	Computer Consulting	2,400
C.D.W. Direct	Computer Consulting	904
Krakau Business	Computer Consulting	143
Healthware Consulting	Computer Consulting	2,060
Alperian Technology	Computer Consulting	215
Information Control	Computer Consulting	1,260
Silver Chair Learning Systems	Computer Consulting	4,300
Microsoft License	Computer Consulting	4,820
Vision Share	Computer Consulting	580
B2B Computer Products	Computer Consulting	1,665
Lanac/GP	Computer Consulting	2,856
Gene Whitehorn	Medicaid Reimbursement Specialist	2,470
To Page 21C		<u>69,526</u>

Total, Agrees to Schedule V, Line 19, Column 3 189,531

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	1,623
Pension Administrators, Inc.	401(k) Administration	457
Personnel Planners, Inc	Unemployment Consultant	32
Beth Schwarz	Operations Consultant	18
Gene Whitehorn	Medicaid Reimb Specialist	838
Computer-See attached schedule	Computer Consulting	22,495
		<u>27,861</u>
Non-allowable accounting		(1,291)

Allocated from Samvest of Lombard II		
Gilson, Labus & Silverman	Accounting	<u>321</u>

Allocated from building partnership		
James Samatas	Filing and recording fees	<u>200</u>

Nonallowable Legal Fees		
Out of period legal	Legal	(2,242)
Grabowski Law Center	Collections	(2,002)
		<u>(4,244)</u>

Total, Agrees to Schedule V, Line 19, Column 8 212,378

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2005					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood# 0037002Report 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. \$ 51,204 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. \$ 15,181 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A 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