

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	172	Skilled (SNF)	172	62,780	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	172	TOTALS	172	62,780	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,741	445	8,798	12,984	8
9	SNF/PED					9
10	ICF	34,733	5,221	2,357	42,311	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,474	5,666	11,155	55,295	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.08%

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

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 05/01/89

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 172 and days of care provided 8,698

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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale # 0035188 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	303,976	24,818	13,648	342,442		342,442		342,442		1
2	Food Purchase		231,687		231,687		231,687	(10,183)	221,504		2
3	Housekeeping	228,253	31,703		259,956		259,956	176	260,132		3
4	Laundry	60,500	16,596		77,096		77,096		77,096		4
5	Heat and Other Utilities			197,668	197,668		197,668	4,116	201,784		5
6	Maintenance	19,969		108,586	128,555		128,555	37,435	165,990		6
7	Other (specify):* Allocated Benefits							4,289	4,289		7
8	TOTAL General Services	612,698	304,804	319,902	1,237,404		1,237,404	35,833	1,273,237		8
	B. Health Care and Programs										
9	Medical Director			11,300	11,300		11,300		11,300		9
10	Nursing and Medical Records	2,743,356	170,242	267,053	3,180,651		3,180,651	74,759	3,255,410		10
10a	Therapy			719,698	719,698		719,698		719,698		10a
11	Activities	262,397	16,146	6,375	284,918		284,918		284,918		11
12	Social Services	76,786		8,424	85,210		85,210		85,210		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Allocated Benefits							9,150	9,150		15
16	TOTAL Health Care and Programs	3,082,539	186,388	1,012,850	4,281,777		4,281,777	83,909	4,365,686		16
	C. General Administration										
17	Administrative	95,325		856,086	951,411		951,411	(777,731)	173,680		17
18	Directors Fees										18
19	Professional Services			76,985	76,985		76,985	11,558	88,543		19
20	Dues, Fees, Subscriptions & Promotions			47,840	47,840		47,840	1,131	48,971		20
21	Clerical & General Office Expenses	198,144	27,516	22,475	248,135		248,135	260,293	508,428		21
22	Employee Benefits & Payroll Taxes			569,908	569,908		569,908	10,183	580,091		22
23	Inservice Training & Education			1,311	1,311		1,311		1,311		23
24	Travel and Seminar			7,220	7,220		7,220	2,926	10,146		24
25	Other Admin. Staff Transportation			9,577	9,577		9,577	4,473	14,050		25
26	Insurance-Prop.Liab.Malpractice			154,639	154,639		154,639	2,877	157,516		26
27	Other (specify):* Allocated Benefits							40,934	40,934		27
28	TOTAL General Administration	293,469	27,516	1,746,041	2,067,026		2,067,026	(443,356)	1,623,670		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,988,706	518,708	3,078,793	7,586,207		7,586,207	(323,614)	7,262,593		29

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

Facility Name & ID Number Lexington Health Care Center-Bloomington

#0035188

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			107,820	107,820		107,820	174,002	281,822			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,463	52,463		52,463	265,150	317,613			32
33	Real Estate Taxes							123,203	123,203			33
34	Rent-Facility & Grounds			1,081,143	1,081,143		1,081,143	(1,077,909)	3,234			34
35	Rent-Equipment & Vehicles			45,200	45,200		45,200	8,735	53,935			35
36	Other (specify):*											36
37	TOTAL Ownership			1,286,626	1,286,626		1,286,626	(506,819)	779,807			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		289,686	3,321	293,007		293,007		293,007			39
40	Barber and Beauty Shops			17,547	17,547		17,547		17,547			40
41	Coffee and Gift Shops			780	780		780		780			41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):* Nonallowable Cost			133,624	133,624		133,624	(133,624)				43
44	TOTAL Special Cost Centers		289,686	249,442	539,128		539,128	(133,624)	405,504			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,988,706	808,394	4,614,861	9,411,961		9,411,961	(964,057)	8,447,904			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 Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	OHF 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	(3,465)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(54)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(599)	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	(2,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,442)	43		24
25	Fund Raising, Advertising and Promotional	(16,519)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,875)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Schedule 5A</u>	11,471			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (96,983)		\$	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)	(867,074)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (867,074)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (964,057)		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	Exceptional Care Program		x			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 Health Care Center-Bloomington

ID# 0035188

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Radiology	\$ (9,866)	43	1
2	Laboratory	(9,461)	43	2
3	Collections	(6,887)	43	3
4	Personal Item Replcaement	(2,210)	43	4
5	Shareholder Interest	(7,856)	32	5
6	Travel & Entertainment	(151)	43	6
7	Trust Fees	(50)	43	7
8	Unrealized Loss On FMV of Swap	47,952	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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	11,471		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington Health Care Center-Bloomington# 0035188

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	176	0	0	0	0	0	0	0	0	176	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,116	0	0	0	0	0	0	0	0	4,116	5
6	Maintenance	0	0	37,435	0	0	0	0	0	0	0	0	37,435	6
7	Other (specify):*	0	0	4,289	0	0	0	0	0	0	0	0	4,289	7
8	TOTAL General Services	0	0	46,016	0	0	0	0	0	0	0	0	46,016	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	2,447	72,312	0	0	0	0	0	0	0	74,759	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	2,447	72,312	0	0	0	0	0	0	0	74,759	16
	C. General Administration													
17	Administrative	0	0	78,355	(846,936)	0	0	0	0	0	0	0	(768,581)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	280	11,278	0	0	0	0	0	0	0	0	11,558	19
20	Fees, Subscriptions & Promotions	0	0	1,131	0	0	0	0	0	0	0	0	1,131	20
21	Clerical & General Office Expenses	0	192	255,969	4,132	0	0	0	0	0	0	0	260,293	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	2,926	0	0	0	0	0	0	0	2,926	24
25	Other Admin. Staff Transportation	0	0	0	11,932	0	0	0	0	0	0	0	11,932	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,877	0	0	0	0	0	0	0	2,877	26
27	Other (specify):*	0	0	0	40,934	0	0	0	0	0	0	0	40,934	27
28	TOTAL General Administration	0	472	346,733	(784,135)	0	0	0	0	0	0	0	(436,930)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	472	395,196	(711,823)	0	0	0	0	0	0	0	(316,155)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	148,998	0	25,004	0	0	0	0	0	0	0	174,002	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,910)	258,850	0	14,210	0	0	0	0	0	0	0	265,150	32
33	Real Estate Taxes	0	121,143	0	2,060	0	0	0	0	0	0	0	123,203	33
34	Rent-Facility & Grounds	0	(1,081,143)	0	3,234	0	0	0	0	0	0	0	(1,077,909)	34
35	Rent-Equipment & Vehicles	0	0	0	1,276	0	0	0	0	0	0	0	1,276	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,910)	(552,152)	0	45,784	0	(514,278)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(89,073)	(44,702)	0	151	0	0	0	0	0	0	0	(133,624)	43
44	TOTAL Special Cost Centers	(89,073)	(44,702)	0	151	0	(133,624)	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(96,983)	(596,382)	395,196	(665,888)	0	(964,057)	45						

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 Bloomingtondale		
				Limited Partnership Bloomingtondale		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	34 Rental expense	\$ 1,081,143	Sambell of Bloomingtondale Limited Partnership	**	\$	(1,081,143)	1
2	V	19 Professional fees		Sambell of Bloomingtondale Limited Partnership	**	280	280	2
3	V	21 Office supplies		Sambell of Bloomingtondale Limited Partnership	**	192	192	3
4	V	30 Depreciation		Sambell of Bloomingtondale Limited Partnership	**	148,998	148,998	4
5	V	32 Interest expense		Sambell of Bloomingtondale Limited Partnership	**	254,219	254,219	5
6	V	32 Amortization of mortgage costs		Sambell of Bloomingtondale Limited Partnership	**	4,631	4,631	6
7	V	33 Property taxes		Sambell of Bloomingtondale Limited Partnership	**	121,143	121,143	7
8	V	43 State replacement tax		Sambell of Bloomingtondale Limited Partnership	**	3,200	3,200	8
9	V	43 Penalties		Sambell of Bloomingtondale Limited Partnership	**			9
10	V	43 Trust fees		Sambell of Bloomingtondale Limited Partnership	**	50	50	10
11	V	43 Unrealized gain		Sambell of Bloomingtondale Limited Partnership	**	(47,952)	(47,952)	11
12	V			** Certain owners of Lexington Health Care Center of Bloomingtondale, Inc. own 100%				12
13	V			of Sambell of Bloomingtondale Limited Partnership				13
14	Total		\$ 1,081,143			\$ 484,761	\$ * (596,382)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.

Provider # 0035188

1/1/06 - 12/31/06

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%

VII. Related Parties

Related Nursing Homes

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
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

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.	**	\$ 176	\$	176	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,333		3,333	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	105		105	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	678		678	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	33,894		33,894	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	3,426		3,426	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	115		115	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	4,289		4,289	22
23	V	10 Medical consultant		Royal Management Corp.	**	2,447		2,447	23
24	V	17 Management allocation - salaries		Royal Management Corp.	**	78,355		78,355	24
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	6,381		6,381	25
26	V	19 Professional fees		Royal Management Corp.	**	4,897		4,897	26
27	V	20 Dues & subscriptions		Royal Management Corp.	**	669		669	27
28	V	20 Advertising - help wanted		Royal Management Corp.	**	462		462	28
29	V	21 Management allocation - salaries		Royal Management Corp.	**	245,132		245,132	29
30	V	21 Bank charges		Royal Management Corp.	**	327		327	30
31	V	21 Office supplies & printing		Royal Management Corp.	**	7,815		7,815	31
32	V	21 Postage		Royal Management Corp.	**	2,695		2,695	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 Bloomington, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 395,196	\$ *	395,196	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 4,132	\$ 4,132
16	V	24 Travel & seminar		Royal Management Corp.	**	2,926	2,926
17	V	25 Auto expense		Royal Management Corp.	**	11,932	11,932
18	V	26 Insurance general		Royal Management Corp.	**	2,877	2,877
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	40,934	40,934
20	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,859	3,859
21	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	5,348	5,348
22	V	30 Depreciation - equipment		Royal Management Corp.	**	15,797	15,797
23	V	32 Interest		Royal Management Corp.	**	14,185	14,185
24	V	32 Amortization of mortgage costs		Royal Management Corp.	**	25	25
25	V	33 Property taxes		Royal Management Corp.	**	2,060	2,060
26	V	34 Rent expense		Royal Management Corp.	**	3,234	3,234
27	V	35 Equipment rental		Royal Management Corp.	**	1,276	1,276
28	V	43 Travel & entertainment		Royal Management Corp.	**	151	151
29	V	17 Management fees	856,086	Royal Management Corp.	**		(856,086)
30	V	10 Management Allocation - Salaries		Royal Management Corp.	**	72,312	72,312
31	V	17 Management Allocation - Salaries		Royal Management Corp.	**	9,150	9,150
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Bloomington, Inc. own 100% of Royal Management Corp.					
39	Total		\$			\$ 190,198	\$ * (665,888)

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

Facility Name & ID Number Lexington Health Care Center-Bloomington # 0035188 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 C	2.9	7.00	Salary	\$ 26,474	L17,C7	1	
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2.9	7.00	Salary	18,910	L17,C7	2	
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2.9	7.00	Salary	18,910	L17,C7	3	
4	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	2.9	7.00	Salary	14,061	L17,C7	4	
5	Daniel Thiem	Staff Accountant	Accounting	0.00%	See Schedule C	1.5	3.50	Salary	2,783	L21,C7	5	
6	Jeremy Samatas	Corporate Director	Quality Assurance	0.00%	See Schedule C	2.9	7.00	Salary	6,698	L10,C7	6	
7											7	
8					All individuals worked in excess of 40 hours per week							8
9												9
10												10
11												11
12												12
13								TOTAL	\$ 87,836			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

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	744,965	10	\$ 2,086	\$ 62,780	\$ 176	1
2	5	Utilities - gas & electric	Bed Days	744,965	10	39,549	62,780	3,333	2
3	5	Utilities - water & sewer	Bed Days	744,965	10	1,244	62,780	105	3
4	5	Utilities - maintenance office	Bed Days	744,965	10	8,043	62,780	678	4
5	6	Management allocation - salaries	Bed Days	744,965	10	402,200	402,200	33,894	5
6	6	Repairs & maintenance	Bed Days	744,965	10	40,648	62,780	3,426	6
7	6	Scavenger & exterminating	Bed Days	744,965	10	1,366	62,780	115	7
8	7	Management allocation - employee	Bed Days	744,965	10	50,893	62,780	4,289	8
9	10	Medical consultant	Bed Days	744,965	10	29,034	62,780	2,447	9
10	17	Management allocation - salaries	Bed Days	744,965	10	929,789	929,789	78,356	10
11	19	Computer consultant & supplies	Bed Days	744,965	10	75,717	62,780	6,381	11
12	19	Professional fees	Bed Days	744,965	10	58,113	62,780	4,897	12
13	20	Dues & subscriptions	Bed Days	744,965	10	7,935	62,780	669	13
14	20	Advertising - help wanted	Bed Days	744,965	10	5,488	62,780	462	14
15	21	Management allocation - salaries	Bed Days	744,965	10	2,908,810	2,908,810	245,132	15
16	21	Bank charges	Bed Days	744,965	10	3,883	62,780	327	16
17	21	Office supplies & printing	Bed Days	744,965	10	92,737	62,780	7,815	17
18	21	Postage	Bed Days	744,965	10	31,985	62,780	2,695	18
19	21	Telephone	Bed Days	744,965	10	49,035	62,780	4,132	19
20	24	Travel and seminar	Bed Days	744,965	10	34,717	62,780	2,926	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,773,272	\$ 4,240,799	\$ 402,255	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	744,965	10	\$ 141,593	\$ 62,780	\$ 11,932	1
2	26	Insurance general	Bed Days	744,965	10	34,142	62,780	2,877	2
3	27	Management allocation - employee	Bed Days	744,965	10	485,728	62,780	40,933	3
4	30	Depreciation - vehicles	Bed Days	744,965	10	45,792	62,780	3,859	4
5	30	Depreciation - leasehold improv.	Bed Days	744,965	10	63,466	62,780	5,348	5
6	30	Depreciation - equipment	Bed Days	744,965	10	187,456	62,780	15,797	6
7	32	Interest	Bed Days	744,965	10	168,318	62,780	14,185	7
8	32	Amortization of mortgage costs	Bed Days	744,965	10	299	62,780	25	8
9	33	Property taxes	Bed Days	744,965	10	24,448	62,780	2,060	9
10	34	Rent expense	Bed Days	744,965	10	38,371	62,780	3,234	10
11	35	Equipment rental	Bed Days	744,965	10	15,142	62,780	1,276	11
12	43	Travel & entertainment	Bed Days	744,965	10	1,795	62,780	151	12
13	10	Management allocation - Salaries	Bed Days	744,965	10	858,074	858,074	72,312	13
14	15	Management allocation - employee	Bed Days	744,965	10	108,579	62,780	9,150	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,173,203	\$ 858,074	\$ 183,139	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Lexington Financial						\$	\$			\$	1						
2	Services, L.L.C.	X		Mortgage	Varies	2/1/96	5,575,000	3,985,413	02/01/26	Variable	254,219	2						
3												3						
4												4						
5												5						
	Working Capital																	
6	LaSalle Bank N.A.		X	Working Capital	Varies	04/06/02	750,000	285,000	05/31/07	Prime	44,606	6						
7	Shareholder	X								Prime + 1	7,856	7						
8												8						
9	TOTAL Facility Related						\$ 6,325,000	\$ 4,270,413			\$ 306,681	9						
	B. Non-Facility Related*																	
10										Amortization of mortgage costs	4,656	10						
11										Interest Income offset	(53)	11						
12										Management company allocation	14,185	12						
13										Non-Allowable Shareholder Interest	(7,856)	13						
14	TOTAL Non-Facility Related						\$	\$			\$ 10,932	14						
15	TOTALS (line 9+line14)						\$ 6,325,000	\$ 4,270,413			\$ 317,613	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 2005 report.		\$	140,100	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.)	2005	\$	131,254	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(8,846)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	138,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
			2,060	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>8,011</u> For <u>2005</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(8,011)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	123,203	7

Allocated From Management Co.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	119,600	8
	2002	125,102	9
	2003	106,875	10
	2004	111,257	11
	2005	131,254	12

Est. 06 taxes payable 07: \$133,117
Est tax with 3% increase: \$137,110
Use: \$138,000

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Bloomingtondale COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>02-15-401-003</u>	<u>Land & Building</u>	\$ <u>131,253.66</u>	\$ <u>131,253.66</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>32,335.00</u>	\$ <u>2,060.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>163,588.66</u>	\$ <u>133,313.66</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? YES X 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>43,000</u>	<u>1987</u>	<u>\$ 402,548</u>	<u>1</u>
2	<u>Management Company allocation</u>			<u>13,578</u>	<u>2</u>
3	TOTALS	43,000		\$ 416,126	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	88	1989	1989	\$ 2,980,863	\$	35	\$ 85,192	\$ 85,192	\$ 1,505,059	4
5	9	1992	1992	178,974		35	5,114	5,114	76,705	5
6	75	1994	1994	2,022,894		35	57,797	57,797	722,462	6
7										7
8										8
	Improvement Type**									
9	Capitalized repairs		1989	9,080		10			9,080	9
10	Building Improvements		1990	3,674		10			3,674	10
11	Building Improvements		1991	2,586		10			2,586	11
12	Building Improvements		1992	3,154		10			2,997	12
13	Building Improvements		1993	1,582		10			1,503	13
14	Building Improvements		1994	15,734		10			15,734	14
15	Land Improvements		1994	1,381		10			1,381	15
16	Land Improvements		1995	1,074		15	72	72	823	16
17	Building Improvements		1995	1,288		35	37	37	440	17
18	Building Improvements		1995	9,433	270	35	270		3,105	18
19	Building Improvements		1995	43,839	1,252	35	1,252		14,398	19
20	Concrete flooring, fire doors, tile, sprinkler heads,									20
21	and basement renovation		1996	8,706	260	10-35	260		3,086	21
22	Land Improvements		1996	7,858		15	524	524	5,501	22
23	Resident room heaters		1997	3,563	102	35	102		1,018	23
24	Automatic doors		1997	12,950	370	35	370		3,361	24
25	Basement renovation		1997	58,806	5,936	10	5,936		54,411	25
26	Land Improvement - outdoor flagpoles		1997	1,574	105	15	105		997	26
27	1st Floor Remodel (Nurses Station/Lounge)		1998	76,487	7,649	10	7,649		65,015	27
28	Wiring for MDS		1998	4,506	451	10	451		3,831	28
29	Flag Pole		1998	787	79	10	79		669	29
30	Resurface/Stripe Parking Lot		1998	9,777	978	10	978		8,310	30
31	Kitchen tile/paint		1999	718	72	10	72		539	31
32	1st Floor Remodel		1999	3,296	330	10	330		2,636	32
33	Roof repairs		2000	5,748	383	15	383		2,491	33
34	Sump pump		2000	2,534	253	10	253		1,647	34
35	Sump pump basin repair		2000	6,307	631	10	631		4,100	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 Health Care Center-Bloomingtondale

0035188

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	Automatic door closers	2000	\$ 1,300	\$ 87	15	\$ 87		\$ 563	37
38	Infrared curtains for elevator doors	2001	3,000	300	10	300		1,650	38
39	Ejector pump	2002	3,050	610	5	610		2,999	39
40	Lift station pump	2002	3,359	672	5	672		2,911	40
41	New asphalt parking lot	2003	16,450	1,645	10	1,645		5,209	41
42	Roof repairs	2003	2,900	290	10	290		894	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		684	43
44	Kitchen remodel	2003	7,188	359	20	359		1,228	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		11,902	45
46	Floor tile	2003	16,305	815	20	815		3,261	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		11,682	47
48	Rehab-floor tile	2003	8,117	406	20	406		1,251	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		6,583	49
50	Foundation repair	2003	4,800	240	20	240		820	50
51	Parking lot	2004	24,550	2,455	10	2,455		5,933	51
52	Kitchen walk-in cooler floor	2004	7,161	716	10	716		1,671	52
53	Old Towne rehab	2004	13,967	698	20	698		1,571	53
54	Alzheimers remodel	2004	208,935	10,447	20	10,447		21,764	54
55	Landscaping	2005	8,814	441	20	441		514	55
56	Roof repairs	2005	3,250	163	20	163		190	56
57	HVAC upgrade	2005	7,048	352	20	352		469	57
58	Kitchen repair	2005	1,631	82	20	82		122	58
59	Lobby, reception and office rehabilitation	2005	19,900	995	20	995		995	59
60	Window treatments	2005	3,606	721	5	721		964	60
61	Lower level therapy rehabilitation	2005	7,167	358	20	358		716	61
62	Therapy room rehabilitation	2005	42,149	2,107	20	2,107		2,108	62
63	Alzheimers remodel	2005	35,986	1,799	20	1,799		2,099	63
64	Basement renovation	2005	14,176	709	20	709		710	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,125,971	\$ 55,688		\$ 204,423	\$ 148,735	\$ 2,609,021	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 Health Care Center-Bloomington

0035188

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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		\$ 6,125,971	\$ 55,688		\$ 204,423	\$ 148,735	\$ 2,609,021	1
2	Landscaping Enhancement	2006	7,084	157	15	157		157	2
3	Install Kitchen Sink	2006	2,915	109	20	109		109	3
4	Common area rehab	2006	2,382	79	20	79		79	4
5	Paint Building Exterior	2006	19,500	1,625	5	1,625		1,625	5
6	Patio	2006	53,305	296	15	296		296	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	Land improvements - management company	2002	21,400		15	1,163	1,163	7,015	24
25	Building - management company	2002	166,493		40	3,393	3,393	20,465	25
26	HVAC, electrical, security system - management company	2003	1,650		30	93	93	386	26
27	Key card system - management company	2004	259		20	10	10	31	27
28	VAV TX controls - management company	2005	79		20	4	4	7	28
29	Interior Signs - management company	2006	57		5	1	1	1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,401,095	\$ 57,954		\$ 211,353	\$ 153,399	\$ 2,639,192	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 390,025	\$ 47,021	\$ 48,462	\$ 1,441	5-10	\$ 189,364	71
72	Current Year Purchases	69,638	2,845	2,845		5-10	2,845	72
73	Fully Depreciated Assets	112,797					112,797	73
74	Allocated from Mgmt. Co.	151,572		15,797	15,797		73,981	74
75	TOTALS	\$ 724,032	\$ 49,866	\$ 67,104	\$ 17,238		\$ 378,987	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 Mgmt. Co.			44,066		3,365	3,365		30,144	79
80	TOTALS			\$ 44,066	\$	\$ 3,365	\$ 3,365		\$ 30,144	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)	\$ 7,585,319	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,820	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 281,822	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 174,002	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,048,323	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	Transitional room	\$ 213	92
93	Therapy room	185	93
94			94
95		\$ 398	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from management company</u>				<u>3,234</u>			6
7	TOTAL				\$ <u>3,234</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO Allocated From Management Co.-\$1,276

16. Rental Amount for movable equipment: \$ 46,476 Description: Copier-\$3,933; Mailing System- \$179; Fax Machine-\$4,054; Medical Equip-\$28,702; Oxygen Equip-\$8,332;

(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	<u>Administrative</u>		\$	\$ <u>5,917</u>	17
18					18
19					19
20	<u>Allocation from Management Co</u>			<u>1,542</u>	20
21	TOTAL		\$	\$ <u>7,459</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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	\$	5,048	\$ 273,349	\$	5,048	\$ 273,349	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		866	63,454		866	63,454	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		5,589	382,895		5,589	382,895	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39C2	# of prescripts				289,686		289,686	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Dentist Other (specify): <u>Wound Therapy</u>	L39,C3 L39, C3				2,901 420			2,901 420	13
14	TOTAL			\$	11,503	\$ 723,019	\$ 289,686	11,503	\$ 1,012,705	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingtondale

0035188

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 266,515	\$ 320,621	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 390,700)	1,500,826	1,500,826	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,584	47,584	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		199	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,814,925	\$ 1,869,230	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	60,553	60,553	12
13	Land		416,126	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	1,040,177	1,218,364	15
16	Equipment, at Historical Cost	547,034	768,098	16
17	Accumulated Depreciation (book methods)	(602,966)	(3,048,323)	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 Construction In Prog)	398	398	22
23	Other(specify): Mortgage Costs		68,141	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,045,196	\$ 4,666,088	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,860,121	\$ 6,535,318	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 147,424	\$ 147,424	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	285,000	285,000	29
30	Accrued Salaries Payable	195,998	195,998	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,205	4,205	31
32	Accrued Real Estate Taxes(Sch.IX-B)		138,000	32
33	Accrued Interest Payable		13,299	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Schedule 17A	471,494	365,558	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,104,121	\$ 1,149,484	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		3,985,413	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	Interest Rate Swap		33,391	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,018,804	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,104,121	\$ 5,168,288	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,756,000	\$ 1,367,030	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,860,121	\$ 6,535,318	48

Lexington Health Care Center of Bloomingdale, Inc.

Provider # 0035188

1/1/06 - 12/31/06

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	14,346	14,346
Federal Income tax withholding	(255)	(255)
Bond Withholding	541	541
Accrued PTP	89,268	89,268
401K Withholding	4,823	4,823
Accrued 401K	16,958	16,958
Due to Lex Financial Svcs	286	286
Accrued Expenses	239,362	239,362
Accrued Roysl genl Mgmt	4,974	4,974
Accrued Rent	105,936	-
Accrued Wage assignment	(885)	(885)
Biweekly Part A	(3,860)	(3,860)
Total line 36	<u>471,494</u>	<u>365,558</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,349,767	1
2	Restatements (describe):		2
3	Post closing adjustments	136,121	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,485,888	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	639,112	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	(369,000)	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)	\$ 270,112	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)	\$ 1,756,000	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,609,009	1
2	Discounts and Allowances for all Levels	(4,452,815)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,156,194	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,124,928	6
7	Oxygen	6,233	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,131,161	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	1,062	12
13	Barber and Beauty Care	20,961	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	6	15
16	Rental of Facility Space		16
17	Sale of Drugs	534,197	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,472	19
20	Radiology and X-Ray	20,968	20
21	Other Medical Services	147,090	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 759,756	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 54	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Investment Income</u>	3,908	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,908	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,051,073	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,237,404	31
32	Health Care	4,281,777	32
33	General Administration	2,067,026	33
	B. Capital Expense		
34	Ownership	1,286,626	34
	C. Ancillary Expense		
35	Special Cost Centers	444,958	35
36	Provider Participation Fee	94,170	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,411,961	40
41	Income before Income Taxes (line 30 minus line 40)**	639,112	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 639,112	43

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

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

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

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

Facility Name & ID Number Lexington Health Care Center-Bloomington

0035188

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	1,893	2,103	\$ 107,349	\$ 51.05	1
2	Assistant Director of Nursing	1,870	2,112	70,989	33.61	2
3	Registered Nurses	40,307	43,928	1,337,545	30.45	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	81,496	86,025	1,034,804	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,001	11,661	192,669	16.52	8
9	Activity Director	2,054	2,192	31,952	14.58	9
10	Activity Assistants	20,718	22,152	230,445	10.40	10
11	Social Service Workers	3,440	3,691	76,786	20.80	11
12	Dietician	1,984	2,080	29,393	14.13	12
13	Food Service Supervisor	2,032	2,160	35,291	16.34	13
14	Head Cook	1,552	1,847	23,061	12.49	14
15	Cook Helpers/Assistants	13,461	14,563	120,419	8.27	15
16	Dishwashers	13,032	13,708	95,812	6.99	16
17	Maintenance Workers	1,358	1,466	19,969	13.62	17
18	Housekeepers	28,715	30,312	228,253	7.53	18
19	Laundry	7,514	8,259	60,500	7.33	19
20	Administrator	1,839	1,928	95,325	49.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,285	12,393	198,144	15.99	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	245,551	262,580	\$ 3,988,706 *	\$ 15.19	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	269	\$ 13,648	L1,C3	35
36	Medical Director	Monthly	11,300	L9,C3	36
37	Medical Records Consultant	11	822	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	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	112	5,425	L11,C3	44
45	Social Service Consultant	96	4,810	L12,C3	45
46	Other(specify) <u>MDS</u>	16	832	L10,C3	46
47	<u>Psychosocial</u>	70	3,614	L12,C3	47
48					48
49	TOTAL (lines 35 - 48)	574	\$ 42,851		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,512	\$ 257,509	L10,C3	50
51	Licensed Practical Nurses	97	5,490	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,609	\$ 262,999		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jeff Baker	Administrator	0%	\$ 95,325	Workers' Compensation Insurance	\$ 42,832	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	42,137	Advertising: Employee Recruitment	37,072	
				FICA Taxes	296,074	Health Care Worker Background Check (Indicate # of checks performed <u>184</u>)	1,840	
				Employee Health Insurance	144,792	Patient Background Checks <u>393</u>	3,930	
				Employee Meals	10,183	Miscellaneous Licenses, Permits	1,795	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	1,213	
				401 (k) Contributions	16,293			
				Life Insurance	8,564			
				Other Employee Benefits	19,216			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,325	TOTAL (agree to Schedule V, line 22, col.8)		\$ 48,971		
B. Administrative - Other								
Description			Amount					
Management Fees (Eliminated In Column 7)			\$ 856,086				Management Company Allocation	
							Less: Public Relations Expense ()	
							Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 856,086				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Altschuler, Melvoin & Glasser LLP	Accounting		\$ 20,108				Out-of-State Travel	\$
Amalgamated Bank	Bond Consulting		441					
RSM McGladrey	Accounting		7,139				In-State Travel	
Aronberg Goldgehn Davis & Garmis	Accounting		103					
Cassiday Schade LLP	Legal		7,025				Seminar Expense	7,220
Gilson, Labus & Silverman	Accounting		435					
ING	401 (k)		735				Management Company Allocation	2,926
James Samtas, Atty. At law	Legal		237				Entertainment Expense ()	
Moody's Investor Service	Financial Consulting		515				(agree to Sch. V, line 24, col. 8)	
Personnel Planners	U/C Consulting		1,560				TOTAL	\$ 10,146
See attached Schedule 21C			38,687					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 76,985	TOTAL				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Bloomingdale, Inc.

Provider # 0035188

1/1/06 - 12/31/06

Schedule F

XIX. Support Schedules

C. Professional Services

Vendor/Payee

Sachnoff & Weaver	Legal	6,492
Scott & Krause	Legal	850
Systematic Management Systems	Billing Services	9,612
Royal/Shaker Advertising	Computer Consulting	1,990
XO Communications	Computer Consulting	581
National Data Care Corp	Computer Consulting	2,005
Information Controls	Computer Consulting	3,046
AAOD	Computer Consulting	2,010
Ehealth	Computer Consulting	2,800
Adminastar	Computer Consulting	363
Krakau	Computer Consulting	348
Action Computer Service	Computer Consulting	324
Microsoft	Computer Consulting	2,509
Gigatrend	Computer Consulting	215
Visual Click	Computer Consulting	120
CDW	Computer Consulting	902
Lanac	Computer Consulting	1,524
Lintech	Computer Consulting	2,994
		<u>38,687</u>

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

76,985

Allocated from management co.

RSM McGladrey	Accounting	172
Altschuler, Melvoin and Glasser LLP	Accounting	379
ING Administration Fee	Accounting	158
Gene Whitehorn	Medicaid Billing Consultant	3,058
Personnel Planners	U/C Consulting	11
Aronberg, Goldgehn, Davis	Accounting	7
Tax Caps	Real Estate Tax Savings	139
James Samatas	Legal	48
ILIAC / Pension Administrators	401 (k) Administration	925
Various	Computer Consulting	6,381

Allocated from building partnership

James Samatas	Annual report	280
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Nonallowable legal fees

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

88,543

88,543

See accountants' compilation report

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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								
FY2003					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
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 Health Care Center-Bloomington# 0035188Report Period Beginning: 01/01/2006Ending: 12/31/2006**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. \$ 32,937 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. \$ 94,170
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. \$ 10,183 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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 \$2500, 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