

Facility Name & ID Number Lexington Health Care Center of Lombard, Inc.

0028660 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	224	Skilled (SNF)	224	81,760	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	224	TOTALS	224	81,760	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	2,435	566	9,748	12,749	8
9	SNF/PED					9
10	ICF	40,491	18,766	1,217	60,474	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,926	19,332	10,965	73,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.56%

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 10/09/1984

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 224 and days of care provided 9,379

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 of Lombard, IL # 0028660 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	355,276	33,371	13,541	402,188		402,188		402,188		1
2	Food Purchase		316,328		316,328		316,328	(14,240)	302,088		2
3	Housekeeping	331,506	44,150		375,656		375,656	229	375,885		3
4	Laundry	50,665	19,721		70,386		70,386	333	70,719		4
5	Heat and Other Utilities			256,405	256,405		256,405	5,360	261,765		5
6	Maintenance	28,821		139,614	168,435		168,435	48,752	217,187		6
7	Other (specify):* Allocated Benefits							5,586	5,586		7
8	TOTAL General Services	766,268	413,570	409,560	1,589,398		1,589,398	46,020	1,635,418		8
	B. Health Care and Programs										
9	Medical Director			52,800	52,800		52,800		52,800		9
10	Nursing and Medical Records	4,026,164	189,863	30,530	4,246,557		4,246,557	97,360	4,343,917		10
10a	Therapy			745,687	745,687		745,687		745,687		10a
11	Activities	264,276	23,842	5,425	293,543		293,543		293,543		11
12	Social Services	95,857		6,851	102,708		102,708		102,708		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Allocated Benefits							11,917	11,917		15
16	TOTAL Health Care and Programs	4,386,297	213,705	841,293	5,441,295		5,441,295	109,277	5,550,572		16
	C. General Administration										
17	Administrative	132,029		1,105,642	1,237,671		1,237,671	(1,003,598)	234,073		17
18	Directors Fees										18
19	Professional Services			90,094	90,094		90,094	13,645	103,739		19
20	Dues, Fees, Subscriptions & Promotions			42,985	42,985		42,985	848	43,833		20
21	Clerical & General Office Expenses	229,098	35,012	17,216	281,326		281,326	337,413	618,739		21
22	Employee Benefits & Payroll Taxes			820,236	820,236		820,236	13,792	834,028		22
23	Inservice Training & Education			1,914	1,914		1,914		1,914		23
24	Travel and Seminar			20,747	20,747		20,747	3,810	24,557		24
25	Other Admin. Staff Transportation			15	15		15	13,532	13,547		25
26	Insurance-Prop.Liab.Malpractice			186,453	186,453		186,453	3,747	190,200		26
27	Other (specify):* Allocated Benefits							53,308	53,308		27
28	TOTAL General Administration	361,127	35,012	2,285,302	2,681,441		2,681,441	(563,503)	2,117,938		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,513,692	662,287	3,536,155	9,712,134		9,712,134	(408,206)	9,303,928		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.

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			152,065	152,065		152,065	143,246	295,311			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,437	42,437		42,437	124,488	166,925			32
33	Real Estate Taxes							137,018	137,018			33
34	Rent-Facility & Grounds			1,334,335	1,334,335		1,334,335	(1,330,124)	4,211			34
35	Rent-Equipment & Vehicles			28,313	28,313		28,313	3,670	31,983			35
36	Other (specify):*											36
37	TOTAL Ownership			1,557,150	1,557,150		1,557,150	(921,702)	635,448			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		316,296	1,161	317,457		317,457		317,457			39
40	Barber and Beauty Shops			37,232	37,232		37,232		37,232			40
41	Coffee and Gift Shops			2,865	2,865		2,865		2,865			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable Cost			111,985	111,985		111,985	(111,985)				43
44	TOTAL Special Cost Centers		316,296	275,883	592,179		592,179	(111,985)	480,194			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,513,692	978,583	5,369,188	11,861,463		11,861,463	(1,441,893)	10,419,570			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 of Lombard, Inc.

0028660

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	(448)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,950)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	333	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,150)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,488)	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	(3,525)	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	(35,593)	43		24
25	Fund Raising, Advertising and Promotional	(11,705)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(41,217)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Schedule 5A</u>	(31,514)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (132,257)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	(1,309,636)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,309,636)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,441,893)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.

ID# 0028660

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (11,726)	43	1
2	X-Rays - Part A	(12,258)	43	2
3	Non-Allowable Collection Fees	(2,042)	43	3
4	Personal Item Replacement	(1,192)	43	4
5	Wound Management	(520)	43	5
6	Non-Allowable Out of Period Fees	(1,179)	19	6
7	Miscellaneous Income	(1,325)	21	7
8	Trust Fees	(450)	43	8
9	Travel and Entertainment	(197)	43	9
10	Chamber of Commerce Dues	(625)	20	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	(31,514)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington Health Care Center of Lombard, Inc.# 0028660

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(448)	0	0	0	0	0	0	0	0	0	0	(448)	2
3	Housekeeping	0	0	229	0	0	0	0	0	0	0	0	229	3
4	Laundry	333	0	0	0	0	0	0	0	0	0	0	333	4
5	Heat and Other Utilities	0	0	5,360	0	0	0	0	0	0	0	0	5,360	5
6	Maintenance	0	0	48,752	0	0	0	0	0	0	0	0	48,752	6
7	Other (specify):*	0	0	5,586	0	0	0	0	0	0	0	0	5,586	7
8	TOTAL General Services	(115)	0	59,927	0	0	0	0	0	0	0	0	59,812	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	3,186	94,174	0	0	0	0	0	0	0	97,360	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	11,917	0	0	0	0	0	0	0	11,917	15
16	TOTAL Health Care and Programs	0	0	3,186	106,091	0	109,277	16						
	C. General Administration													
17	Administrative	0	0	102,044	(1,105,642)	0	0	0	0	0	0	0	(1,003,598)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,179)	136	14,688	0	0	0	0	0	0	0	0	13,645	19
20	Fees, Subscriptions & Promotions	(625)	0	1,473	0	0	0	0	0	0	0	0	848	20
21	Clerical & General Office Expenses	(1,325)	0	338,738	0	0	0	0	0	0	0	0	337,413	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	3,810	0	0	0	0	0	0	0	0	3,810	24
25	Other Admin. Staff Transportation	0	0	15,540	0	0	0	0	0	0	0	0	15,540	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,747	0	0	0	0	0	0	0	0	3,747	26
27	Other (specify):*	0	0	0	53,308	0	0	0	0	0	0	0	53,308	27
28	TOTAL General Administration	(3,129)	136	480,040	(1,052,334)	0	(575,287)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,244)	136	543,153	(946,243)	0	(406,198)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center of Lombard, Inc. # 0028660 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	110,682	0	32,564	0	0	0	0	0	0	0	143,246	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,150)	108,132	0	18,506	0	0	0	0	0	0	0	124,488	32
33	Real Estate Taxes	0	134,335	0	2,683	0	0	0	0	0	0	0	137,018	33
34	Rent-Facility & Grounds	0	(1,334,335)	0	4,211	0	0	0	0	0	0	0	(1,330,124)	34
35	Rent-Equipment & Vehicles	0	0	0	1,662	0	0	0	0	0	0	0	1,662	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,150)	(981,186)	0	59,626	0	(923,710)	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):*	(121,913)	14,681	0	197	0	0	0	0	0	0	0	(107,035)	43
44	TOTAL Special Cost Centers	(121,913)	14,681	0	197	0	(107,035)	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(127,307)	(966,369)	543,153	(886,420)	0	(1,436,943)	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
James Samatas	33.33%	See Attached Schedule B	See Attached Schedule B	Lexington Health		
John Samatas	33.33%			Care Systems of		
Cynthia Thiem	33.34%			Lombard Ltd. Ptsp.	Lombard	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental expense	\$ 1,334,335	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	\$	\$ (1,334,335)	1
2	V	19 Professional fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	136	136	2
3	V	30 Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	110,682	110,682	3
4	V	32 Interest expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	105,678	105,678	4
5	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	2,454	2,454	5
6	V	33 Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	134,335	134,335	6
7	V	43 State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	14,231	14,231	7
8	V	43 Trust fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	450	450	8
9	V							9
10	V							10
11	V			** - The owners of Lexington Health Care Center of Lombard, Inc. own				11
12	V			100% of Lexington Health Care Systems of Lombard Limited Partnership				12
13	V							13
14	Total		\$ 1,334,335			\$ 367,966	\$ * (966,369)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.

Provider # 0028660

1/1/06 - 12/31/06

Schedule B

VII. Related Parties

Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

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.	**	\$ 229	\$	229	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,340		4,340	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	137		137	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	883		883	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	44,141		44,141	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,461		4,461	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	150		150	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,586		5,586	22	
23	V	10 Medical consultant		Royal Management Corp.	**	3,186		3,186	23	
24	V	17 Management allocation - salaries		Royal Management Corp.	**	102,044		102,044	24	
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	8,310		8,310	25	
26	V	19 Professional fees		Royal Management Corp.	**	6,378		6,378	26	
27	V	20 Dues & subscriptions		Royal Management Corp.	**	871		871	27	
28	V	20 Advertising - help wanted		Royal Management Corp.	**	602		602	28	
29	V	21 Management allocation - salaries		Royal Management Corp.	**	319,242		319,242	29	
30	V	21 Bank charges		Royal Management Corp.	**	426		426	30	
31	V	21 Office supplies & printing		Royal Management Corp.	**	10,178		10,178	31	
32	V	21 Postage		Royal Management Corp.	**	3,510		3,510	32	
33	V	21 Telephone		Royal Management Corp.	**	5,382		5,382	33	
34	V	24 Travel & seminar		Royal Management Corp.	**	3,810		3,810	34	
35	V	25 Auto expense		Royal Management Corp.	**	15,540		15,540	35	
36	V	26 Insurance general		Royal Management Corp.	**	3,747		3,747	36	
37	V								37	
38	V	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 543,153	\$ *	543,153	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	27 Management allocation - employee h	\$	Royal Management Corp.	**	\$ 53,308	\$ 53,308
16	V	30 Depreciation - vehicles		Royal Management Corp.	**	5,026	5,026
17	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	6,965	6,965
18	V	30 Depreciation - equipment		Royal Management Corp.	**	20,573	20,573
19	V	32 Interest		Royal Management Corp.	**	18,473	18,473
20	V	32 Amortization of mortgage costs		Royal Management Corp.	**	33	33
21	V	33 Property taxes		Royal Management Corp.	**	2,683	2,683
22	V	34 Rent expense		Royal Management Corp.	**	4,211	4,211
23	V	35 Equipment rental		Royal Management Corp.	**	1,662	1,662
24	V	43 Travel & entertainment		Royal Management Corp.	**	197	197
25	V	17 Management fees	1,105,642	Royal Management Corp.	**		(1,105,642)
26	V	10 Management allocation - salaries		Royal Management Corp.	**	94,174	94,174
27	V	15 Management allocation - benefits		Royal Management Corp.	**	11,917	11,917
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 Lombard, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 1,105,642			\$ 219,222	\$ * (886,420)

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

Facility Name & ID Number Lexington Health Care Center of Lombard, IL # 0028660 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	0.33	See Schedule C	4.4	11.00	Salary	\$ 34,478	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	0.33	See Schedule C	4.4	11.00	Salary	24,627	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	0.33	See Schedule C	4.4	11.00	Salary	24,627	L17, C7	3
4	Jason Samatas	VP of Operations	Administrative	0.00	See Schedule C	4.4	11.00	Salary	18,312	L17, C7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule C	2.2	5.50	Salary	4,158	L21, C7	5
6	Jeremy Samatas	Corporate Director	Quality Assurance	0.00	See Schedule C	4.4	11.00	Salary	10,006	L10, C7	6
7											7
8											8
9						All individuals work in excess of 40 hours per week.					9
10											10
11											11
12											12
13								TOTAL	\$ 116,208		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 of Lombard, Inc.# 0028660

Report Period Beginning:

01/01/06Ending: 12/31/06

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	\$ 81,760	\$ 229	1	
2	5	Utilities - gas & electric	Bed Days	744,965	10	39,549	81,760	4,340	2	
3	5	Utilities - water & sewer	Bed Days	744,965	10	1,244	81,760	137	3	
4	5	Utilities - maintenance office	Bed Days	744,965	10	8,043	81,760	883	4	
5	6	Management allocation - salaries	Bed Days	744,965	10	402,200	402,200	81,760	44,141	5
6	6	Repairs & maintenance	Bed Days	744,965	10	40,648	81,760	4,461	6	
7	6	Scavenger & exterminating	Bed Days	744,965	10	1,366	81,760	150	7	
8	7	Management allocation - employee	Bed Days	744,965	10	50,893	81,760	5,586	8	
9	10	Medical consultant	Bed Days	744,965	10	29,034	81,760	3,186	9	
10	17	Management allocation - salaries	Bed Days	744,965	10	929,789	929,789	81,760	102,044	10
11	19	Computer consultant & supplies	Bed Days	744,965	10	75,717	81,760	8,310	11	
12	19	Professional fees	Bed Days	744,965	10	58,113	81,760	6,378	12	
13	20	Dues & subscriptions	Bed Days	744,965	10	7,935	81,760	871	13	
14	20	Advertising - help wanted	Bed Days	744,965	10	5,488	81,760	602	14	
15	21	Management allocation - salaries	Bed Days	744,965	10	2,908,810	2,908,810	81,760	319,242	15
16	21	Bank charges	Bed Days	744,965	10	3,883	81,760	426	16	
17	21	Office supplies & printing	Bed Days	744,965	10	92,737	81,760	10,178	17	
18	21	Postage	Bed Days	744,965	10	31,985	81,760	3,510	18	
19	21	Telephone	Bed Days	744,965	10	49,035	81,760	5,382	19	
20	24	Travel and seminar	Bed Days	744,965	10	34,717	81,760	3,810	20	
21	25	Auto expense	Bed Days	744,965	10	141,593	81,760	15,540	21	
22	26	Insurance general	Bed Days	744,965	10	34,142	81,760	3,747	22	
23	27	Management allocation - employee	Bed Days	744,965	10	485,728	81,760	53,308	23	
24	30	Depreciation - vehicles	Bed Days	744,965	10	45,792	81,760	5,026	24	
25	TOTALS					\$ 5,480,527	\$ 4,240,799	\$ 601,487	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center of Lombard, Inc. # 0028660 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	30	Depreciation - leasehold improv.	Bed Days	744,965	10	\$ 63,466	\$ 81,760	\$ 6,965	1
2	30	Depreciation - equipment	Bed Days	744,965	10	187,456	81,760	20,573	2
3	32	Interest	Bed Days	744,965	10	168,318	81,760	18,473	3
4	32	Amortization of mortgage costs	Bed Days	744,965	10	299	81,760	33	4
5	33	Property taxes	Bed Days	744,965	10	24,448	81,760	2,683	5
6	34	Rent expense	Bed Days	744,965	10	38,371	81,760	4,211	6
7	35	Equipment rental	Bed Days	744,965	10	15,142	81,760	1,662	7
8	43	Travel and entertainment	Bed Days	744,965	10	1,795	81,760	197	8
9	10	Management allocation - salaries	Bed Days	744,965	10	858,074	858,074	94,174	9
10	15	Management allocation - benefits	Bed Days	744,965	10	108,579	81,760	11,917	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					\$ 1,465,948	\$ 858,074	\$ 160,888	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center of Lombard, I # 0028660 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	GMAC		X	Mortgage	\$39,766.00	4/11/94	\$ 3,978,766	\$ 1,036,049	4/11/09	0.0875	\$ 101,411	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	LaSalle Bank, N.A.		X	Line of Credit	Varies	04/06/02	750,000	615,000	5/31/07	Prime	42,437	6						
7												7						
8												8						
9	TOTAL Facility Related				\$39,766.00		\$ 4,728,766	\$ 1,651,049			\$ 143,848	9						
B. Non-Facility Related*																		
10										Interest income offset	2,150	10						
11										Amortization of mortgage costs	2,454	11						
12										Allocation from management compay	18,473	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 23,077	14						
15	TOTALS (line 9+line14)						\$ 4,728,766	\$ 1,651,049			\$ 166,925	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.

\$ **144,000** 1

Allocation from Management Co.

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 \$ **131,207** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(10,110)** 3

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **144,400** 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.)

\$ **2,728** 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 \$ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **137,018** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	137,587	8
	2002	141,180	9
	2003	141,173	10
	2004	140,451	11
	2005	131,207	12

2005 taxes paid: **131,207**

Est. taxes w/ 10% increase: **144,328**

Use: **144,400**

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 of Lombard, Inc. COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0028660

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>06-19-307-002</u>	<u>Building and Land</u>	\$ <u>131,207.00</u>	\$ <u>131,207.00</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. _____	_____	\$ <u>126,204.00</u>	\$ <u>2,683.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>257,411.00</u>	\$ <u>133,890.00</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 of Lombard, Inc.

0028660

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,770 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).

Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square feet

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>30,000</u>	<u>1984</u>	<u>\$ 616,761</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>17,683</u>	<u>2</u>
3	TOTALS	30,000		\$ 634,444	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center of Lombard, Inc.

0028660

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	215	1984	1984	\$ 3,661,473	\$	35	\$ 104,614	\$ 104,614	\$ 2,325,469	4
5	9	1995	1995	284,156	8,119	35	8,119		93,365	5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvements		1990	96,217		10			96,217	9
10	Building Improvements		1991	71,493		10			71,493	10
11	Building Improvements		1994	20,200		10			20,200	11
12	Building Improvements		1995	14,535	415	35	415		4,776	12
13	Building Improvements - dishwasher hood		1996	2,748	137	10	137		2,748	13
14	Building Improvements - outside painting		1996	11,308	566	10	566		11,308	14
15	Building Improvements - dining room		1996	3,752	187	10	187		3,752	15
16	Leasehold Improvements		1992	16,299	466	35	466		6,753	16
17	Leasehold Improvements		1994	21,836		10			21,836	17
18	Leasehold Improvements - 2nd floor		1996	19,319		10			18,353	18
19	Leasehold Improvements - bathroom rehab		1996	9,216	154	10	154		8,909	19
20	Leasehold Improvements - fan coil repairs		1996	6,669	191	35	191		1,969	20
21	Land Improvements		1993	2,985	199	15	199		2,687	21
22	Land Improvements		1995	4,596	306	15	306		3,523	22
23	Capitalized Repairs		1986	1,730		10			1,730	23
24	Building Improvements - basement		1996	18,993	1,899	10	1,899		18,518	24
25	Leasehold Improvements - Corner Guards		1997	520	52	10	52		494	25
26	Leasehold Improvements - Corridor flooring		1997	10,381	1,038	10	1,038		9,861	26
27	BI: Kitchen Rehab		1998	2,494	249	10	249		2,120	27
28	Wiring for MDS project		1998	3,365	337	10	337		2,861	28
29	Install Fire Sprinklers in Mechanical Rms		1998	4,600	131	35	131		1,117	29
30	Tile for Lobby		1998	20,530	2,053	10	2,053		17,451	30
31	Walk in Freezers/Coolers		1998	3,182	91	35	91		773	31
32	Fire Wall Repairs		1998	12,410	355	35	355		3,014	32
33	Underground storage tank		1998	2,613		10			2,096	33
34	Repave parking lot		1999	7,625	508	15	508		3,812	34
35	Lounge Floor Tile		1999	2,964	296	10	296		2,223	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 of Lombard, Inc.

0028660

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	Rewire Building	1999	\$ 9,083	\$ 260	35	\$ 260	\$	\$ 1,946	37
38	Heat exchanger for water heater	1999	1,660		5			1,660	38
39	Compressor and tank for freezer	1999	2,924		5			2,924	39
40	Plumbing Improvements	2000	2,833	283	10	283		1,841	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		409	41
42	Water heater repairs	2000	3,831		5			3,831	42
43	Automatic door	2000	4,556	130	35	130		846	43
44	Install sprinklers	2001	6,082	608	10	608		3,396	44
45	Infrared curtains for elevator	2001	4,500	450	10	450		2,325	45
46	Elevator upgrade	2002	3,006	601	5	601		2,705	46
47	Condensor	2002	2,678	536	5	536		2,412	47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		5,243	48
49	Plumbing loop repairs	2003	6,125	613	10	613		1,889	49
50	Fire alarm panel/call system	2003	8,495	425	20	425		1,664	50
51	Facility Rehab - Painting	2003	6,872	687	10	687		2,222	51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		4,748	52
53	Nurse call system	2003	49,451	2,473	20	2,473		7,624	53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		1,000	54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		62,896	55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		55,265	56
57	Floor Tile	2003	58,720	2,936	20	2,936		11,744	57
58	Carpeting/cove base	2003	29,519	2,952	10	2,952		11,807	58
59	Water heater	2004	9,209	921	10	921		1,995	59
60	Kitchen sewer and dishroom	2004	31,232	1,562	20	1,562		3,253	60
61	Landscaping	2005	3,255	163	20	163		231	61
62	HVAC	2005	8,028	401	20	401		468	62
63	Kitchen sewer, dishroom and ceiling	2005	22,924	1,146	20	1,146		1,815	63
64	Lobby and reception redecorating - painting/wallpaper	2005	37,999	1,900	20	1,900		3,167	64
65	Rehab therapy room - electrical, carpet, tile	2005	66,393	3,320	20	3,320		5,533	65
66	Rehab 1st floor therapy room - electrical, carpet, tile	2005	39,341	1,967	20	1,967		3,278	66
67	Wallpaper, tile, electrical for transitional unit	2005	22,946	1,147	20	1,147		2,008	67
68	Window treatments	2005	8,053	403	20	403		638	68
69	Tile, flooring, and wallpaper	2005	57,699	2,885	20	2,885		4,568	69
70	TOTAL (lines 4 thru 69)		\$ 5,504,061	\$ 79,393		\$ 184,007	\$ 104,614	\$ 2,976,779	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 of Lombard, Inc.

0028660

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 5,504,061	\$ 79,393		\$ 184,007	\$ 104,614	\$ 2,976,779	1
2	Countertops	2005	846	169	5	169		282	2
3	Curtains and blinders	2005	4,672	935	5	935		1,271	3
4	Mini scroll	2005	527	105	5	105		132	4
5	Medical Records Storage/Office Room	2006	5,901	25	40	25		25	5
6	Office Remodel	2006	5,537		40				6
7	Piping	2006	4,510	100	15	100		100	7
8	HVAC	2006	7,985		40				8
9	Emergency A/C	2006	9,385		40				9
10	Adm Office-HVAC	2006	6,421	67	40	67		67	10
11	Sink installation	2006	2,561	48	40	48		48	11
12	Land Improvements Patio	2006	23,736	527	15	527		527	12
13									13
14									14
15									15
16									16
17									17
18	Land improvements - management company	2002	27,870		15	815	815	9,135	18
19	Building - management company	2002	216,828		40	6,338	6,338	26,652	19
20	HVAC, electrical, security system - management company	2003	2,149		30	63	63	503	20
21	Key card system - management company	2004	338		20	9	9	41	21
22	VAV TX controls - management company	2005	103		20	4	4	9	22
23	Building improvements - management company	2006	75		20	1	1	1	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)		\$ 5,823,505	\$ 81,369		\$ 193,213	\$ 111,844	\$ 3,015,572	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	\$ 382,972	\$ 71,268	\$ 71,268	\$	3-10	\$ 112,345	71
72	Current Year Purchases	97,895	5,231	5,231		5-7	5,231	72
73	Fully Depreciated Assets	94,022					94,022	73
74	Allocated from management company	197,395		20,573	20,573		96,347	74
75	TOTALS	\$ 772,284	\$ 76,499	\$ 97,072	\$ 20,573		\$ 307,945	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			57,389		5,026	5,026		39,257	79
80	TOTALS			\$ 57,389	\$	\$ 5,026	\$ 5,026		\$ 39,257	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)	\$ 7,287,622	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 157,868	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 295,311	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 137,443	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,362,774	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		\$	92
93			93
94			94
95		\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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 management company				4,211			6
7	TOTAL				\$ 4,211			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: \$ 29,975 Description: Postage meter - \$179; Copier - \$5,617; Medical Equipment - \$22,517; Allocated from mgmt. co. - \$1,662

(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	Allocation from Management Company			2,008	20
21	TOTAL		\$ _____	\$ 2,008	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	\$	4,924	\$ 313,386	\$	4,924	\$ 313,386	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		905	58,470		905	58,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,606	373,831		8,606	373,831	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				316,296		316,296	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Wound therapy Other (specify): <u>Dentist</u>	L39, C3 L39, C3				186 975			186 975	13
14	TOTAL			\$	14,435	\$ 746,848	\$ 316,296	14,435	\$ 1,063,144	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 of Lombard, Inc.**

0028660

Report Period Beginning: **01/01/06**

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/06**

(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	\$ 103,989	\$ 108,298	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>557,800</u>)	2,569,304	2,569,304	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	140,293	140,293	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,511	5,511	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,819,097	\$ 2,823,406	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		634,444	13
14	Buildings, at Historical Cost		3,661,473	14
15	Leasehold Improvements, at Historical Cost	1,694,096	2,162,032	15
16	Equipment, at Historical Cost	734,787	829,673	16
17	Accumulated Depreciation (book methods)	(807,718)	(3,362,774)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>Unamortized loan costs</u>		5,729	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,621,165	\$ 3,930,577	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,440,262	\$ 6,753,983	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 175,303	\$ 175,303	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	615,000	615,000	29
30	Accrued Salaries Payable	350,796	350,796	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,332	8,332	31
32	Accrued Real Estate Taxes(Sch.IX-B)		144,400	32
33	Accrued Interest Payable		7,555	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached schedule 17A</u>	349,950	401,532	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,499,381	\$ 1,702,918	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,036,049	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)	\$	\$ 1,036,049	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,499,381	\$ 2,738,967	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,940,881	\$ 4,015,016	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,440,262	\$ 6,753,983	48

Lexington Health Care Center of Lombard, Inc.

Provider # 0028860

1/1/06 - 12/31/06

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Notes Payable	-	65,000
Bond Withholding	1,413	1,413
401k Withholding	4,504	4,504
Accrued 401k	21,040	21,040
Due to Royal (OPS)	15,160	15,160
Accrued expenses	240,511	240,511
Accrued Royl genl mgmt fees	5,953	5,953
Accrued Rent	13,418	-
Accrued Wage Assignment	298	298
Advance - biweekly Part A	47,653	47,653
Total line 36	<u>349,950</u>	<u>401,532</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,095,484	1
2	Restatements (describe):		2
3			3
4	Post closing adjustment	99,174	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,194,658	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,771,223	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	(2,025,000)	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)	\$ (253,777)	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)	\$ 2,940,881	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	\$ 16,058,093	1
2	Discounts and Allowances for all Levels	(5,266,788)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,791,305	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,360,617	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,360,617	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	3,614	12
13	Barber and Beauty Care	42,584	13
14	Non-Patient Meals	448	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	640,332	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,807	19
20	Radiology and X-Ray	18,530	20
21	Other Medical Services	136,644	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 875,959	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,150	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,150	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Service Availability Fee</u>	601,885	28
28a	<u>Miscellaneous Income</u>	770	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 602,655	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,632,686	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,589,398	31
32	Health Care	5,441,295	32
33	General Administration	2,681,441	33
	B. Capital Expense		
34	Ownership	1,557,150	34
	C. Ancillary Expense		
35	Special Cost Centers	469,539	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,861,463	40
41	Income before Income Taxes (line 30 minus line 40)**	1,771,223	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,771,223	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 of Lombard, Inc.

0028660

Report Period Beginning: 01/01/06

Ending:

12/31/06

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	1,635	1,928	\$ 110,252	\$ 57.18	1
2	Assistant Director of Nursing	4,795	5,145	183,025	35.57	2
3	Registered Nurses	48,159	51,869	1,624,525	31.32	3
4	Licensed Practical Nurses	18,158	20,113	526,213	26.16	4
5	CNAs & Orderlies	15,079	16,291	221,716	13.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	105,672	112,954	1,340,282	11.87	8
9	Activity Director	2,008	2,169	32,676	15.07	9
10	Activity Assistants	19,527	21,390	231,600	10.83	10
11	Social Service Workers	3,700	4,650	95,857	20.61	11
12	Dietician	1,813	1,925	31,806	16.52	12
13	Food Service Supervisor	1,965	2,166	34,086	15.74	13
14	Head Cook	2,238	2,358	43,117	18.29	14
15	Cook Helpers/Assistants	12,712	13,751	110,922	8.07	15
16	Dishwashers	18,773	20,007	135,345	6.76	16
17	Maintenance Workers	1,643	1,884	28,821	15.30	17
18	Housekeepers	41,968	44,885	331,506	7.39	18
19	Laundry	6,343	6,957	50,665	7.28	19
20	Administrator	2,055	2,176	132,029	60.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,676	13,988	229,098	16.38	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	1,321	1,464	20,151	13.76	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	322,240	348,070	\$ 5,513,692 *	\$ 15.84	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	245	\$ 13,541	L1, C3	35
36	Medical Director	Monthly	52,800	L9, C3	36
37	Medical Records Consultant	14	1,014	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>Psychosocial</u>	39	2,041	L10, C3	46
47	<u>Health & Safety Consultant</u>	17	1,135	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	523	\$ 83,166		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Nancy McDonald	Administrator	0%	\$ 132,029	Workers' Compensation Insurance	\$ 60,630	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	86,960	Advertising: Employee Recruitment	32,287		
				FICA Taxes	403,106	Health Care Worker Background Check			
				Employee Health Insurance	208,161	(Indicate # of checks performed <u>116</u>)	1,160		
				Employee Meals	13,792	Patient Background Checks <u>434</u>	4,340		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	2,315		
				401 (k) Contribution	21,040	Miscellaneous Dues & Subscriptions	268		
				Other Employee Benefits	32,721				
				Life Insurance	7,618				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 132,029	TOTAL (agree to Schedule V, line 22, col.8)		\$ 834,028	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 43,833
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount	
Management fees (eliminated in Column 7)			\$ 1,105,642	N/A			Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,105,642				Seminar Expense	20,747	
C. Professional Services				TOTAL		\$	Allocated from Management Company	3,810	
Vendor/Payee	Type		Amount				Entertainment Expense	()	
Altschuler, Melvoin & Glasser LLP	Accounting		\$ 22,176				(agree to Sch. V, line 24, col. 8)		
Aronberg Goldgehn Davis & Garism	401 (k) Consultant		103				TOTAL	\$ 24,557	
RSM McGladrey	Accounting		635						
Cassiday, Shade & Gloor	Legal		24,633						
Gilson Labus & Silverman	Accounting		435						
ING	401 (k) Consultant		960						
James Samatas	Legal		125						
Personnel Planners	U/C Consultant		1,650						
Sachnoff & Weaver	Legal		9,286						
Scott & Krause	Legal		542						
See attached Schedule F			29,549						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 90,094						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660
1/1/06 - 12/31/06

Schedule F

XIX. Support Schedules
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Grabowski Law Center	Legal-collection fees	2,042
Systematic Management System	Billing Services	7,649
XO Communications	Computer Consulting	323
National Data Care Corp	Computer Consulting	1,769
Information Controls, Inc.	Computer Consulting	1,185
AAOD	Computer Consulting	2,010
Ehealth	Computer Consulting	2,400
Adminastar	Computer Consulting	363
Krakau Business	Computer Consulting	696
Action Computer Service	Computer Consulting	324
Microsoft	Computer Consulting	2,833
Gigatrend	Computer Consulting	215
Visual Click	Computer Consulting	120
CDW	Computer Consulting	722
Lanac	Computer Consulting	1,915
Lintech	Computer Consulting	2,994
Royal/Shaker Advertising	Computer Consulting	1,990
		<u>29,549</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u><u>90,094</u></u>

Allocated from management co.

Altschuler, Melvoin & Glasser LLP	Accounting	2,235
RSM McGladrey	Accounting	224
ING	401 (k) Consultant	205
Aronberg Goldgehn Davis & Garisma	Accounting	9
Pension Administrators	401 (k) Consultant	1,205
Personnel Planners	U/C Consulting	15
Gene Whitehorn	Medicaid Billing Consultant	1,992
Various	Computer Consulting	9,702
Allocated from building partnership James Samatas	Filing and recording fees	100
Nonallowable legal fees Grabowski Law Center	Legal-collection fees	(2,042)
Total, Agrees to Schedule V, Line 19, Column 8		<u><u>103,739</u></u>

See accountants' compilation report

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

(See instructions.)

	1	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							N/A						
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 of Lombard, Inc.# 0028660Report Period Beginning: 01/01/06Ending: 31/06**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? 6 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,526 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. \$ 122,640
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 13,792 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 448
- (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