

Facility Name & ID Number Lexington of Chicago Ridge

0042739 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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,411	209	9,703	15,323	8
9	SNF/PED					9
10	ICF	51,504	7,257	2,054	60,815	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,915	7,466	11,757	76,138	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.12%

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 06/04/91

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

YES Date New construction NO

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

YES NO If YES, enter number

of beds certified 224 and days of care provided 9,371

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 of Chicago Ridge # 0042739 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	329,150	32,792	18,904	380,846		380,846		380,846		1
2	Food Purchase		330,413		330,413		330,413	(13,662)	316,751		2
3	Housekeeping	325,086	34,469		359,555		359,555	229	359,784		3
4	Laundry	71,108	20,983		92,091		92,091	257	92,348		4
5	Heat and Other Utilities			209,052	209,052		209,052	5,360	214,412		5
6	Maintenance	35,574		107,626	143,200		143,200	48,752	191,952		6
7	Other (specify):* Mgmt. Alloc-Emp Ben							5,586	5,586		7
8	TOTAL General Services	760,918	418,657	335,582	1,515,157		1,515,157	46,522	1,561,679		8
	B. Health Care and Programs										
9	Medical Director			43,200	43,200		43,200		43,200		9
10	Nursing and Medical Records	3,881,884	271,222	25,619	4,178,725		4,178,725	97,360	4,276,085		10
10a	Therapy			710,842	710,842		710,842		710,842		10a
11	Activities	270,546	30,337	6,152	307,035		307,035		307,035		11
12	Social Services	84,467		7,540	92,007		92,007		92,007		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt. Alloc-Emp Ben							11,917	11,917		15
16	TOTAL Health Care and Programs	4,236,897	301,559	793,353	5,331,809		5,331,809	109,277	5,441,086		16
	C. General Administration										
17	Administrative	127,935		1,097,687	1,225,622		1,225,622	(995,643)	229,979		17
18	Directors Fees										18
19	Professional Services			63,215	63,215		63,215	14,843	78,058		19
20	Dues, Fees, Subscriptions & Promotions			15,599	15,599		15,599	1,473	17,072		20
21	Clerical & General Office Expenses	248,835	27,540	22,506	298,881		298,881	338,927	637,808		21
22	Employee Benefits & Payroll Taxes			810,541	810,541		810,541	13,662	824,203		22
23	Inservice Training & Education			6,753	6,753		6,753		6,753		23
24	Travel and Seminar			6,221	6,221		6,221	3,810	10,031		24
25	Other Admin. Staff Transportation			1,551	1,551		1,551	13,532	15,083		25
26	Insurance-Prop.Liab.Malpractice			218,444	218,444		218,444	3,747	222,191		26
27	Other (specify):* Mgmt. Alloc-Emp Ben							53,309	53,309		27
28	TOTAL General Administration	376,770	27,540	2,242,517	2,646,827		2,646,827	(552,340)	2,094,487		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,374,585	747,756	3,371,452	9,493,793		9,493,793	(396,541)	9,097,252		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 of Chicago Ridge

#0042739

Report Period Beginning:

01/01/06

Ending:

12/31/06

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			91,101	91,101		91,101	180,109	271,210			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,383	53,383		53,383	309,499	362,882			32
33	Real Estate Taxes							495,605	495,605			33
34	Rent-Facility & Grounds			1,692,922	1,692,922		1,692,922	(1,688,711)	4,211			34
35	Rent-Equipment & Vehicles			64,548	64,548		64,548	3,670	68,218			35
36	Other (specify):*											36
37	TOTAL Ownership			1,901,954	1,901,954		1,901,954	(699,828)	1,202,126			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		312,533	4,893	317,426		317,426		317,426			39
40	Barber and Beauty Shops			21,949	21,949		21,949		21,949			40
41	Coffee and Gift Shops			6,241	6,241		6,241		6,241			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable Cost			173,262	173,262		173,262	(173,262)				43
44	TOTAL Special Cost Centers		312,533	328,985	641,518		641,518	(173,262)	468,256			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,374,585	1,060,289	5,602,391	12,037,265		12,037,265	(1,269,631)	10,767,634			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

0042739

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				4
5	Telephone, TV & Radio in Resident Rooms	(4,724)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	257	4		8
9	Non-Straightline Depreciation	592	30		9
10	Interest and Other Investment Income	(102)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(935)	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	(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	(99,035)	43		24
25	Fund Raising, Advertising and Promotional	(15,674)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,066)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See attached Sch 5A</u>	(47,199)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (174,386)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,095,245)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,095,245)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,269,631)		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 of Chicago Ridge

Provider #: 0042739

01/01/06 to 12/31/06

Schedule A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Disallow nonallowable radiology	(19,300)	43
Disallow nonallowable laboratory	(18,907)	43
Nonallowable personal replacement costs	(304)	43
Nonallowable collection fees	(6,843)	43
Disallow out of period legal fees	(125)	19
Disallow shareholder's interest	(1,447)	32
Disallow Trust Fees	(76)	43
Entertainment and Meals	<u>(197)</u>	43
Total	<u><u>(47,199)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Chicago Ridge

ID# 0042739

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			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			24
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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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	229	0	0	0	0	0	0	0	0	229	3
4	Laundry	257	0	0	0	0	0	0	0	0	0	0	257	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	257	0	59,927	0	0	0	0	0	0	0	0	60,184	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	(1,097,687)	0	0	0	0	0	0	0	(995,643)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	280	14,688	0	0	0	0	0	0	0	0	14,968	19
20	Fees, Subscriptions & Promotions	0	0	1,473	0	0	0	0	0	0	0	0	1,473	20
21	Clerical & General Office Expenses	0	189	333,356	5,382	0	0	0	0	0	0	0	338,927	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	3,810	0	0	0	0	0	0	0	3,810	24
25	Other Admin. Staff Transportation	0	0	0	15,540	0	0	0	0	0	0	0	15,540	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,747	0	0	0	0	0	0	0	3,747	26
27	Other (specify):*	0	0	0	53,309	0	0	0	0	0	0	0	53,309	27
28	TOTAL General Administration	0	469	451,561	(1,015,899)	0	(563,869)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	257	469	514,674	(909,808)	0	(394,408)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	592	146,953	0	32,564	0	0	0	0	0	0	0	180,109	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(102)	292,542	0	18,506	0	0	0	0	0	0	0	310,946	32
33	Real Estate Taxes	0	492,922	0	2,683	0	0	0	0	0	0	0	495,605	33
34	Rent-Facility & Grounds	0	(1,692,922)	0	4,211	0	0	0	0	0	0	0	(1,688,711)	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	490	(760,505)	0	59,626	0	(700,389)	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):*	(127,934)	102	0	197	0	0	0	0	0	0	0	(127,635)	43
44	TOTAL Special Cost Centers	(127,934)	102	0	197	0	(127,635)	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(127,187)	(759,934)	514,674	(849,985)	0	(1,222,432)	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 Chicago Rdige		
				Limited Partnership Chicago Ridge		Real estate ptsp.
				Royal Mgmt. Corp. Lombard		Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C. Lombard		Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional fees	\$	Sambell of Chicago Ridge Limited Partnership	**	\$ 280	\$ 280	1
2	V	21 Office expense		Sambell of Chicago Ridge Limited Partnership	**	189	189	2
3	V	30 Depreciation		Sambell of Chicago Ridge Limited Partnership	**	146,953	146,953	3
4	V	32 Interest expense		Sambell of Chicago Ridge Limited Partnership	**	289,333	289,333	4
5	V	32 Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	3,209	3,209	5
6	V	33 Real estate tax		Sambell of Chicago Ridge Limited Partnership	**	492,922	492,922	6
7	V	34 Rental expense	1,692,922	Sambell of Chicago Ridge Limited Partnership	**		(1,692,922)	7
8	V	43 State replacement tax		Sambell of Chicago Ridge Limited Partnership	**	26	26	8
9	V	43 Trust fees		Sambell of Chicago Ridge Limited Partnership	**	76	76	9
10	V							10
11	V			** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%				11
12	V			of Sambell of Chicago Ridge Limited Partnership				12
13	V							13
14	Total		\$ 1,692,922			\$ 932,988	\$ * (759,934)	14

* 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	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								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 514,674	\$ *	514,674	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.	**	\$ 5,382	\$ 5,382 15
16	V	24 Travel & seminar		Royal Management Corp.	**	3,810	3,810 16
17	V	25 Auto expense		Royal Management Corp.	**	15,540	15,540 17
18	V	26 Insurance general		Royal Management Corp.	**	3,747	3,747 18
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	53,309	53,309 19
20	V	30 Depreciation - vehicles		Royal Management Corp.	**	5,026	5,026 20
21	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	6,965	6,965 21
22	V	30 Depreciation - equipment		Royal Management Corp.	**	20,573	20,573 22
23	V	32 Interest		Royal Management Corp.	**	18,473	18,473 23
24	V	32 Amortization of mortgage costs		Royal Management Corp.	**	33	33 24
25	V	33 Property taxes		Royal Management Corp.	**	2,683	2,683 25
26	V	34 Rent expense		Royal Management Corp.	**	4,211	4,211 26
27	V	35 Equipment rental		Royal Management Corp.	**	1,662	1,662 27
28	V	43 Travel & entertainment		Royal Management Corp.	**	197	197 28
29	V	17 Management fees	1,097,687	Royal Management Corp.	**		(1,097,687) 29
30	V	10 Management Allocation-Salaries		Royal Management Corp.	**	94,174	94,174 30
31	V	15 Management Allocation Employee Benefits		Royal Management Corp.	**	11,917	11,917 31
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 1,097,687			\$ 247,702	\$ * (849,985) 39

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

Lexington Health Care Center of Chicago Ridge, Inc.

Provider # 0036996

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%

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 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	22.33%	See Schedule C	4.4	11%	Salary	\$ 34,478	L17, C7	1	
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33%	See Schedule C	4.4	11%	Salary	24,627	L17, C7	2	
3	Cynthia Thiem	Owner/Officer	Administrative	22.34%	See Schedule C	4.4	11%	Salary	24,627	L17, C7	3	
4	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	4.4	11%	Salary	18,312	L17, C7	4	
5	Daniel Thiem	Staff Accountant	Accounting	0.00%	See Schedule C	2.2	5.5%	Salary	4,158	L21, C7	5	
6	Jeremy Samatas	Corporate Director	Quality Assurance	0.00%	See Schedule C	4.4	11%	Salary	10,006	L10, C7	6	
7											7	
8					All individuals work in excess of 40 hours per week.							8
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 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 of Chicago Ridge

0042739

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	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									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,773,272	\$ 4,240,799	\$ 523,866	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

0042739

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	25	Auto expense	Bed Days	744,965	10	\$ 141,593	\$ 81,760	\$ 15,540	1
2	26	Insurance general	Bed Days	744,965	10	34,142	81,760	3,747	2
3	27	Management allocation - employee	Bed Days	744,965	10	485,729	81,760	53,309	3
4	30	Depreciation - vehicles	Bed Days	744,965	10	45,792	81,760	5,026	4
5	30	Depreciation - leasehold improv.	Bed Days	744,965	10	63,466	81,760	6,965	5
6	30	Depreciation - equipment	Bed Days	744,965	10	187,456	81,760	20,573	6
7	32	Interest	Bed Days	744,965	10	168,318	81,760	18,473	7
8	32	Amortization of mortgage costs	Bed Days	744,965	10	299	81,760	33	8
9	33	Property taxes	Bed Days	744,965	10	24,448	81,760	2,683	9
10	34	Rent expense	Bed Days	744,965	10	38,371	81,760	4,211	10
11	35	Equipment rental	Bed Days	744,965	10	15,142	81,760	1,662	11
12	43	Travel & entertainment	Bed Days	744,965	10	1,795	81,760	197	12
13	10	Management allocation-salaries	Bed Days	744,965	10	858,074	858,074	94,174	13
14	15	Management allocation - employee	Bed Days	744,965	10	108,580	81,760	11,917	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,173,205	\$ 858,074	\$ 238,510	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Chicago Ridge

0042739

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**					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 II, L.L.C	X		Mortgage	\$42,300.00	12/29/98	5,563,000	4,185,727	1/1/08	0.0675	289,333	2					
3												3					
4												4					
5												5					
	Working Capital																
6	LaSalle Bank N.A.		X	Working Capital	Varies	4/6/02	1,000,000	440,000	5/31/07	Prime	51,936	6					
7	Shareholder	X									1,447	7					
8												8					
9	TOTAL Facility Related				\$42,300.00		\$ 6,563,000	\$ 4,625,727			\$ 342,716	9					
	B. Non-Facility Related*																
10											3,209	10					
11											(102)	11					
12											18,506	12					
13											(1,447)	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 20,166	14					
15	TOTALS (line 9+line14)						\$ 6,563,000	\$ 4,625,727			\$ 362,882	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.		\$	568,200	1
	Allocation from management company		2,683	
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	\$	516,365	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(49,152)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	531,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	13,205	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 \$ <u>48</u> For <u>1999</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(48)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	495,605	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	499,417	8
	2002	551,245	9
	2003	534,109	10
	2004	551,783	11
	2005	516,365	12
Estimated taxes payable 07:		516,365	
Estimated tax increase with 3%:		531,856	
Use:		531,600	

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.

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 of Chicago Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042739

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>24-18-200-030-0000</u>	<u>Land & Building</u>	\$ <u>500,857.72</u>	\$ <u>500,857.72</u>
2. <u>24-07-311-012-0000</u>	<u>Land & Building</u>	\$ <u>15,507.12</u>	\$ <u>15,507.12</u>
3. <u>Royal Management Corp (Samvest of Lombard II)</u>		\$ _____	\$ _____
4. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>32,334.00</u>	\$ <u>2,683.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>548,698.84</u>	\$ <u>519,047.84</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 of Chicago Ridge

0042739

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>31,000</u>	<u>1989</u>	<u>\$ 505,000</u>	<u>1</u>
2	<u>Allocation from management company</u>			<u>17,683</u>	<u>2</u>
3	TOTALS	31,000		\$ 522,683	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

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		1991	1991	\$ 5,143,342	\$	35	\$ 146,953	\$ 146,953	\$ 2,290,013	4
5	9		1995	1995	97,352	2,781	35	2,781		31,987	5
6											6
7											7
8											8
	Improvement Type**										
9		Leasehold Improvements		1993	2,694	77	35	77		1,040	9
10		Leasehold Improvements		1994	6,581	188	35	188		2,350	10
11		Dishwasher hood		1996	2,480	124	10	124		2,480	11
12		Lobby repairs		1996	8,698	434	10	434		8,698	12
13		Basement rehab		1997	24,477	2,448	10	2,448		24,070	13
14		Wiring		1998	3,428	343	10	343		2,915	14
15		Handrails		1998	895	60	15	60		509	15
16		Resurface & restripe parking lot		1998	4,450	445	10	445		3,783	16
17		Fire wall		1998	2,169	62	35	62		527	17
18		Foyer floor tile		1999	32,379	3,238	10	3,238		25,364	18
19		Wallpapering / painting / decorating		1999	8,833	883	10	883		6,404	19
20		Rebuild garage area		1999	1,762	50	35	50		361	20
21		Roof repairs		2000	6,240	624	10	624		4,056	21
22		Electrical wiring		2000	3,986	114	35	114		741	22
23		Electrical wiring		2000	2,536	72	35	72		469	23
24		Kitchen rehab		2000	6,623	221	35	221		1,436	24
25		Automatic doors		2000	1,300	130	10	130		845	25
26		Elevator eye sensors		2000	4,500	300	15	300		1,950	26
27		Resurface & restripe parking lot		2001	3,319	332	10	332		1,826	27
28		Door releases		2001	5,200	520	10	520		2,860	28
29		Carpeting		2001	10,022	1,002	10	1,002		5,511	29
30		Roof repairs		2002	25,600	1,280	20	1,280		6,187	30
31		Elevator upgrade		2002	9,866	986	10	986		4,520	31
32		Painting/decorating/carpet/wallpaper		2003	38,165	1,908	20	1,908		7,632	32
33		Rehab/new office		2003	26,733	1,337	20	1,337		5,348	33
34		Facility rehab - construction costs, painting & decorating		2003	257,174	12,859	20	12,859		45,006	34
35		Facility rehab - electrical		2003	12,840	642	20	642		2,247	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

0042739

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	Facility rehab - carpeting	2003	\$ 7,800	\$ 780	10	\$ 780	\$	\$ 2,730	37
38	Facility rehab - floor tile	2003	3,547	177	20	177		620	38
39	Kickplates/Door protectors	2004	4,095	410	10	410		1,093	39
40	Kitchen Fire Protection Upgrade	2004	1,428	143	10	143		381	40
41	Parking Lot - Paving and Sealcoating	2005	4,375	219	20	219		292	41
42	Kitchen Rehab	2005	19,228	961	20	961		1,121	42
43	Lobby/Lounge Reception Area	2005	36,503	1,825	20	1,825		2,890	43
44	Sidewalk - Raise and Support	2005	1,330	67	20	67		84	44
45	Lower Level Therapy Rehab	2005	52,525	2,626	20	2,626		3,496	45
46	Transitional Unit	2005	1,019	51	20	51		55	46
47	Basement Renovation	2005	3,753	188	20	188		219	47
48	Landscaping Enhancement	2006	6,463	108	15	108		108	48
49	Lhi-Hvac	2006	4,333	18	20	18		18	49
50	Rehab Common Areas	2006	7,661	192	20	192		192	50
51	Modular Units attached to wall	2006	10,316	172	20	172		172	51
52	Cubical Curtains	2006	1,578	263	5	263		263	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,919,598	\$ 41,660		\$ 188,613	\$ 146,953	\$ 2,504,869	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,919,598	\$ 41,660		\$ 188,613	\$ 146,953	\$ 2,504,869	1
2									2
3									3
4									4
5									5
6	Land improvements - management company	2002	27,870		15	1,737	1,737	9,135	6
7	Building - management company	2002	216,828		40	5,067	5,067	26,652	7
8	HVAC, electrical, security system - management company	2003	2,149		30	138	138	503	8
9	Key card system - management company	2004	338		20	17	17	41	9
10	VAV TX controls - management company	2005	103		20	5	5	9	10
11	Interior Signs- management company	2006	75		5	1	1	1	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,166,961	\$ 41,660		\$ 195,578	\$ 153,918	\$ 2,541,210	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	\$ 348,895	\$	\$ 46,787	\$ 46,787	5-10	\$ 177,699	71
72	Current Year Purchases	84,954		2,654	2,654	5-10	2,654	72
73	Fully Depreciated Assets	109,737					109,737	73
74	Allocation from Mgmt. Co.	197,395		21,165	21,165		96,347	74
75	TOTALS	\$ 740,981	\$	\$ 70,606	\$ 70,606		\$ 386,437	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	Allocation from Mgmt. Co.			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)	\$ 7,488,014	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 271,210	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 229,550	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,966,904	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	Parking Lot	\$ 11,774	92
93	First Floor Therapy	185	93
94			94
95		\$ 11,959	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	Home office allocation			4,211			5
6							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: \$ 66,210 Description: Copier \$8,976, Medical Equip. \$45,614, Oxygen Equip \$9,958, home office allocation \$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			N/A		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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A,C3	hrs	\$	4,213	\$ 345,623	\$	4,213	\$ 345,623	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		911	52,487		911	52,487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		8,323	312,732		8,323	312,732	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				312,533		312,533	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): Wound Therapy	L39,C3 L39,C3				4,858 35			4,858 35	13
14	TOTAL			\$	13,447	\$ 715,735	\$ 312,533	13,447	\$ 1,028,268	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

0042739

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	\$ 207,686	\$ 217,724	1
2	Cash-Patient Deposits	38,781	38,781	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 974,500)	1,921,343	1,921,343	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	128,926	128,926	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,888	1,888	8
9	Other(specify): See Sch 17A	5,297	139,333	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,303,921	\$ 2,447,995	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,711	9,711	12
13	Land		522,683	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	776,256	1,023,619	15
16	Equipment, at Historical Cost	540,536	798,370	16
17	Accumulated Depreciation (book methods)	(501,896)	(2,966,904)	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) Other LT Assets	11,959	11,959	22
23	Other(specify): Mortgage Cost		38,501	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 836,566	\$ 4,581,281	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,140,487	\$ 7,029,276	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 170,687	\$ 170,687	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,781	38,781	28
29	Short-Term Notes Payable	440,000	440,000	29
30	Accrued Salaries Payable	418,409	418,409	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,115	4,115	31
32	Accrued Real Estate Taxes(Sch.IX-B)		531,600	32
33	Accrued Interest Payable		23,545	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	860,379	452,819	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,932,371	\$ 2,079,956	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		4,185,727	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)	\$	\$ 4,185,727	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,932,371	\$ 6,265,683	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,208,116	\$ 763,593	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,140,487	\$ 7,029,276	48

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/06 - 12/31/06

Schedule E

XV. Balance Sheet

A. Current Assets

9. Other Current Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Loans Receivable	1,016	1,016
Due from Ins Carrier	4,281	4,281
Escrow-Real Estate Tax	-	134,036
	<hr/>	<hr/>
Total line 36	<u>5,297</u>	<u>139,333</u>

XV. Balance Sheet

C Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due from Royal	18416	18416
State Income Tax Withheld	28	28
Bond Withholding	1772	1772
401K Withholding	15453	15453
Accrued 401K	39132	39132
Accrued Expenses	218,187	218187
Accrued Royal General Mgmt	4,708	4708
Accrued Rent	407,560	0
Advance-Biweekly Part A	155,123	155123
	<hr/>	<hr/>
Total line 36	<u>860,379</u>	<u>452,819</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,084,923	1
2	Restatements (describe):		2
3			3
4	<u>Post closing AJE's</u>	138,211	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,223,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	551,982	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	(567,000)	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)	\$ (15,018)	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)	\$ 1,208,116	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	\$ 17,002,001	1
2	Discounts and Allowances for all Levels	(6,460,448)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,541,553	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,263,695	6
7	Oxygen	2,310	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,266,005	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	9,551	12
13	Barber and Beauty Care	25,743	13
14	Non-Patient Meals	103	14
15	Telephone, Television and Radio	7	15
16	Rental of Facility Space		16
17	Sale of Drugs	503,328	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,540	19
20	Radiology and X-Ray	20,738	20
21	Other Medical Services	179,811	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 779,821	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	102	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 102	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Investment Income</u>	1,766	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,766	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,589,247	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,515,157	31
32	Health Care	5,331,809	32
33	General Administration	2,646,827	33
	B. Capital Expense		
34	Ownership	1,901,954	34
	C. Ancillary Expense		
35	Special Cost Centers	518,878	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)*	\$ 12,037,265	40
41	Income before Income Taxes (line 30 minus line 40)**	551,982	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 551,982	43

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

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

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

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

Facility Name & ID Number Lexington of Chicago Ridge

0042739

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	2,003	2,163	\$ 120,305	\$ 55.62	1
2	Assistant Director of Nursing	4,123	4,444	155,370	34.96	2
3	Registered Nurses	57,584	62,513	1,969,290	31.50	3
4	Licensed Practical Nurses	5,022	5,517	135,783	24.61	4
5	CNAs & Orderlies	105,574	113,935	1,294,608	11.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,792	12,876	191,468	14.87	8
9	Activity Director	2,003	2,100	36,136	17.21	9
10	Activity Assistants	21,213	22,744	234,410	10.31	10
11	Social Service Workers	3,879	4,161	84,467	20.30	11
12	Dietician	1,636	1,907	29,275	15.35	12
13	Food Service Supervisor	1,470	1,688	23,025	13.64	13
14	Head Cook	1,968	2,134	27,737	13.00	14
15	Cook Helpers/Assistants	11,877	13,154	113,198	8.61	15
16	Dishwashers	18,595	19,815	135,915	6.86	16
17	Maintenance Workers	2,280	2,405	35,574	14.79	17
18	Housekeepers	38,197	41,786	325,086	7.78	18
19	Laundry	8,452	9,385	71,108	7.58	19
20	Administrator	1,954	2,069	127,935	61.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,680	15,729	248,835	15.82	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	956	1,112	15,060	13.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	315,258	341,637	\$ 5,374,585 *	\$ 15.73	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	312	\$ 18,904	L1,C3	35
36	Medical Director	Monthly	43,200	L9,C3	36
37	Medical Records Consultant	23	1,509	L10,C3	37
38	Nurse Consultant	8	416	L10,C3	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	108	5,237	L11,C3	44
45	Social Service Consultant	96	4,810	L12,C3	45
46	Other(specify) <u>Psychosocial</u>	53	2,730	L12,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	600	\$ 79,206		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	479	\$ 21,294	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	479	\$ 21,294		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			
<u>Marichu Bueno</u>	<u>Administrator</u>	<u>0%</u>	\$ <u>127,935</u>	<u>Workers' Compensation Insurance</u>	\$ <u>58,855</u>	<u>IDPH License Fee</u>	\$			
				<u>Unemployment Compensation Insurance</u>	<u>63,817</u>	<u>Advertising: Employee Recruitment</u>	<u>7,658</u>			
				<u>FICA Taxes</u>	<u>395,190</u>	<u>Health Care Worker Background Check</u>	<u>1,300</u>			
				<u>Employee Health Insurance</u>	<u>199,656</u>	(Indicate # of checks performed <u>130</u>)				
				<u>Employee Meals</u>	<u>13,662</u>	<u>Patient Background Checks</u>	<u>2,700</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>3,390</u>			
				<u>401 (k)</u>	<u>39,132</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>551</u>			
				<u>Life Insurance</u>	<u>8,714</u>					
				<u>Other Employee Benefits</u>	<u>45,177</u>					
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>127,935</u>	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>824,203</u>	TOTAL (agree to Sch. V, line 20, col. 8)		\$ <u>17,072</u>
(List each licensed administrator separately.)								<u>Allocation from management company</u>		<u>1,473</u>
B. Administrative - Other								<u>Less: Public Relations Expense</u>		()
Description			Amount					<u>Non-allowable advertising</u>		()
<u>Management Fees (eliminated in column 7)</u>			\$ <u>1,097,687</u>					<u>Yellow page advertising</u>		()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>1,097,687</u>							
(Attach a copy of any management service agreement)										
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		
<u>Altschler, Melvoin & Glasser LLP</u>	<u>Accounting</u>		\$ <u>13,796</u>			\$	<u>Out-of-State Travel</u>	\$		
<u>RSM McGladrey, Inc.</u>	<u>Accounting</u>		<u>6,941</u>							
<u>Aronberg Goldgehn Davis & Garmis</u>	<u>401 K</u>		<u>103</u>				<u>In-State Travel</u>			
<u>Cassiday, Shade & Gloor</u>	<u>Legal</u>		<u>377</u>							
<u>Scott & Krause</u>	<u>Legal</u>		<u>542</u>				<u>Seminar Expense</u>	<u>6,221</u>		
<u>Gilson Labus & Silverman</u>	<u>Accounting</u>		<u>435</u>							
<u>ING</u>	<u>401 K</u>		<u>1,335</u>				<u>Allocation from management company</u>	<u>3,810</u>		
<u>James Samatas, Atty.AT Law</u>	<u>Legal</u>		<u>100</u>				<u>Entertainment Expense</u>	()		
<u>Personnel Planners</u>	<u>Consulting</u>		<u>1,560</u>				(agree to Sch. V, line 24, col. 8)			
<u>Sachnoff & Weaver</u>	<u>Legal</u>		<u>3,256</u>				TOTAL	\$ <u>10,031</u>		
<u>See attached schedule 21C</u>			<u>34,770</u>	TOTAL		\$				
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>63,215</u>							
(If total legal fees exceed \$5,000, attach copy of invoices.)										

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Chicago Ridge, Inc.
 Provider # 0042739
 1/1/06- 12/31/06

Schedule 21C

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Serpico, Novelle, Petrosino	Legal	1,220
Systematic Management Systems	Billing Services	11,983
Royal/Shaker Advertising	Computer Services	2,253
Covad Communications	Computer Services	360
National Datacare Corp	Computer Services	3,220
Information Controls	Computer Services	1,185
AAOD	Computer Services	2,010
Ehealth	Computer Services	2,400
Adminiastar	Computer Services	363
Krakau	Computer Services	696
Action Computer Service	Computer Services	324
Microsoft	Computer Services	2,744
Gigatrend	Computer Services	215
Visual Click	Computer Services	120
CDW	Computer Services	754
Lanac	Computer Services	1,931
Lintech	Computer Services	2,994
		<u>34,770</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u>63,215</u>
Allocated from management co.		
RSM McGladrey	Accounting	224
AM & G	Accounting	493
ING	401(k) Administration	205
Aronberg,Goldgehn,Davis	Accounting	9
Tax Caps	Real Estate Tax Savings Co.	181
ILIAC / Pension Administrators	401 (k) Administration	1,205
Personnel Planners	U/C Consulting	15
Gene Whitehorn	Medicaid Billing Consultant	3,983
Lintech	Computer Consulting	8,310
James Samats	Legal	63
Allocated from building partnership		
James Samatas (FR PAGE C/1)	Filing and recording fees	280
Disallow out of period legal fees	Serpico, Novelle, Petrosino & Rascia, Ltd.	Out of period fees (125)
		<u>78,058</u>

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

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													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739Report Period Beginning: 01/01/06Ending: 12/31/06**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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 64,599 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.
- (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. \$ 13,662 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? N/A
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