

Facility Name & ID Number Lexington of Elmhurst

0037317 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,608	52	8,109	11,769	8
9	SNF/PED					9
10	ICF	20,600	16,543	1,770	38,913	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,208	16,595	9,879	50,682	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.57%

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 11/12/91

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 150 and days of care provided 8,007

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 Elmhurst # 0037317 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	323,625	30,613	12,423	366,661		366,661		366,661	1	
2	Food Purchase		217,570		217,570		217,570	(9,562)	208,008	2	
3	Housekeeping	211,656	29,119		240,775		240,775	153	240,928	3	
4	Laundry	64,671	15,119		79,790		79,790		79,790	4	
5	Heat and Other Utilities			211,490	211,490		211,490	3,589	215,079	5	
6	Maintenance	37,077		96,719	133,796		133,796	32,646	166,442	6	
7	Other (specify):* Mgmt. Alloc-Emp Ben							3,740	3,740	7	
8	TOTAL General Services	637,029	292,421	320,632	1,250,082		1,250,082	30,566	1,280,648	8	
	B. Health Care and Programs										
9	Medical Director			18,075	18,075		18,075		18,075	9	
10	Nursing and Medical Records	2,272,952	162,936	352,030	2,787,918		2,787,918	65,197	2,853,115	10	
10a	Therapy			626,351	626,351		626,351		626,351	10a	
11	Activities	168,997	19,220	7,713	195,930		195,930		195,930	11	
12	Social Services	46,435		6,006	52,441		52,441		52,441	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* Mgmt. Alloc-Emp Ben							7,980	7,980	15	
16	TOTAL Health Care and Programs	2,488,384	182,156	1,010,175	3,680,715		3,680,715	73,177	3,753,892	16	
	C. General Administration										
17	Administrative	98,056		778,351	876,407		876,407	(710,018)	166,389	17	
18	Directors Fees									18	
19	Professional Services			98,217	98,217		98,217	5,649	103,866	19	
20	Dues, Fees, Subscriptions & Promotions			21,029	21,029		21,029	986	22,015	20	
21	Clerical & General Office Expenses	209,557	27,814	18,896	256,267		256,267	226,891	483,158	21	
22	Employee Benefits & Payroll Taxes			520,830	520,830		520,830	9,533	530,363	22	
23	Inservice Training & Education			562	562		562		562	23	
24	Travel and Seminar			7,057	7,057		7,057	2,551	9,608	24	
25	Other Admin. Staff Transportation			319	319		319	8,213	8,532	25	
26	Insurance-Prop.Liab.Malpractice			213,221	213,221		213,221	2,509	215,730	26	
27	Other (specify):* Mgmt. Alloc-Emp Ben							35,698	35,698	27	
28	TOTAL General Administration	307,613	27,814	1,658,482	1,993,909		1,993,909	(417,988)	1,575,921	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,433,026	502,391	2,989,289	6,924,706		6,924,706	(314,245)	6,610,461	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 Elmhurst

#0037317

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			62,041	62,041		62,041	139,251	201,292			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,793	28,793		28,793	236,055	264,848			32
33	Real Estate Taxes							59,667	59,667			33
34	Rent-Facility & Grounds			837,870	837,870		837,870	(835,050)	2,820			34
35	Rent-Equipment & Vehicles			7,711	7,711		7,711	3,306	11,017			35
36	Other (specify):*											36
37	TOTAL Ownership			936,415	936,415		936,415	(396,771)	539,644			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		265,771	4,732	270,503		270,503		270,503			39
40	Barber and Beauty Shops			22,668	22,668		22,668		22,668			40
41	Coffee and Gift Shops			2,457	2,457		2,457		2,457			41
42	Provider Participation Fee			82,122	82,122		82,122		82,122			42
43	Other (specify):* Nonallowable Cost			71,028	71,028		71,028	(71,028)				43
44	TOTAL Special Cost Centers		265,771	183,007	448,778		448,778	(71,028)	377,750			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,433,026	768,162	4,108,711	8,309,899		8,309,899	(782,044)	7,527,855			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(29)	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				8
9	Non-Straightline Depreciation	1,692	30		9
10	Interest and Other Investment Income	(121)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,201)	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	(3,320)	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	(26,755)	43		24
25	Fund Raising, Advertising and Promotional	(9,342)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,457)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Refer to Sch 5A	(19,676)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (74,159)		\$	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)	(707,885)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (707,885)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (782,044)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/06 - 12/31/06

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

<u>Description</u>	<u>Amount</u>	<u>Reference</u>
Nonallowable collections	(4,354)	19
Disallow out of period legal fees	(113)	19
Nonallowable Chamber of Commerce dues	-	20
Disallow radiology	(10,654)	43
Disallow laboratory	(3,864)	43
Disallow personal item replacement	(509)	43
Disallow trust fees	(50)	43
Meals and Entertainment	(132)	43
Total	<u>(19,676)</u>	

See Accountants' Compilation Report

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Elmhurst# 0037317

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	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	(29)	0	0	0	0	0	0	0	0	0	0	(29)	2
3	Housekeeping	0	0	153	0	0	0	0	0	0	0	0	153	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,589	0	0	0	0	0	0	0	0	3,589	5
6	Maintenance	0	0	32,646	0	0	0	0	0	0	0	0	32,646	6
7	Other (specify):*	0	0	3,740	0	0	0	0	0	0	0	0	3,740	7
8	TOTAL General Services	(29)	0	40,128	0	0	0	0	0	0	0	0	40,099	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	2,134	63,063	0	0	0	0	0	0	0	65,197	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	7,980	0	0	0	0	0	0	0	7,980	15
16	TOTAL Health Care and Programs	0	0	2,134	71,043	0	0	0	0	0	0	0	73,177	16
	C. General Administration													
17	Administrative	0	0	68,333	(778,351)	0	0	0	0	0	0	0	(710,018)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	280	9,836	0	0	0	0	0	0	0	0	10,116	19
20	Fees, Subscriptions & Promotions	0	0	986	0	0	0	0	0	0	0	0	986	20
21	Clerical & General Office Expenses	0	57	223,230	3,604	0	0	0	0	0	0	0	226,891	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	2,551	0	0	0	0	0	0	0	2,551	24
25	Other Admin. Staff Transportation	0	0	0	10,406	0	0	0	0	0	0	0	10,406	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,509	0	0	0	0	0	0	0	2,509	26
27	Other (specify):*	0	0	0	35,698	0	0	0	0	0	0	0	35,698	27
28	TOTAL General Administration	0	337	302,385	(723,583)	0	0	0	0	0	0	0	(420,861)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29)	337	344,647	(652,540)	0	0	0	0	0	0	0	(307,585)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Elmhurst# 0037317

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	1,692	115,753	0	21,806	0	0	0	0	0	0	0	139,251	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(121)	223,784	0	12,392	0	0	0	0	0	0	0	236,055	32
33	Real Estate Taxes	0	57,870	0	1,797	0	0	0	0	0	0	0	59,667	33
34	Rent-Facility & Grounds	0	(837,870)	0	2,820	0	0	0	0	0	0	0	(835,050)	34
35	Rent-Equipment & Vehicles	0	0	0	1,113	0	0	0	0	0	0	0	1,113	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,571	(440,463)	0	39,928	0	(398,964)	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):*	(56,025)	74	0	132	0	0	0	0	0	0	0	(55,819)	43
44	TOTAL Special Cost Centers	(56,025)	74	0	132	0	(55,819)	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(54,483)	(440,052)	344,647	(612,480)	0	(762,368)	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 Elmhurst		
				II Ltd. Ptsp.	Elmhurst	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	34 Rental expense	\$ 837,870	Sambell of Elmhurst II Limited Partnership	**	\$	\$ (837,870)	1
2	V	19 Professional fees		Sambell of Elmhurst II Limited Partnership	**	280	280	2
3	V	21 Office supplies		Sambell of Elmhurst II Limited Partnership	**	57	57	3
4	V	30 Depreciation		Sambell of Elmhurst II Limited Partnership	**	115,753	115,753	4
5	V	32 Interest expense		Sambell of Elmhurst II Limited Partnership	**	221,355	221,355	5
6	V	32 Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	2,429	2,429	6
7	V	33 Property taxes		Sambell of Elmhurst II Limited Partnership	**	57,870	57,870	7
8	V	43 State replacement tax		Sambell of Elmhurst II Limited Partnership	**	24	24	8
9	V	43 Trust fees		Sambell of Elmhurst II Limited Partnership	**	50	50	9
10	V							10
11	V			** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				11
12	V			of Sambell of Elmhurst II Limited Partnership				12
13	V							13
14	Total		\$ 837,870			\$ 397,818	\$ * (440,052)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.

Provider # 0037317

1/1/06 - 12/31/05

Schedule B

VII. Related Parties

Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	16.66%
John Samatas Discretionary Trust	16.67%
Cynthia Thiem Discretionary Trust	16.67%
David S. Bell Revocable Trust	12.50%
Jeffrey J. Bell Revocable Trust	12.50%
Lawrence W. Bell Revocable Trust	12.50%
David S. Bell 2001 Trust	4.16%
Jeffrey J. Bell 2001 Trust	4.17%
Lawrence W. Bell 2001 Trust	4.17%

<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 Chicago Ridge, Inc.	Chicago Ridge
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

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.	**	\$ 153	\$	153	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	2,907		2,907	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	91		91	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	591		591	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	29,559		29,559	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	2,987		2,987	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	100		100	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	3,740		3,740	22	
23	V	10 Medical consultant		Royal Management Corp.	**	2,134		2,134	23	
24	V	17 Management allocation - salaries		Royal Management Corp.	**	68,333		68,333	24	
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	5,565		5,565	25	
26	V	19 Professional fees		Royal Management Corp.	**	4,271		4,271	26	
27	V	20 Dues & subscriptions		Royal Management Corp.	**	583		583	27	
28	V	20 Advertising - help wanted		Royal Management Corp.	**	403		403	28	
29	V	21 Management allocation - salaries		Royal Management Corp.	**	213,778		213,778	29	
30	V	21 Bank charges		Royal Management Corp.	**	285		285	30	
31	V	21 Office supplies & printing		Royal Management Corp.	**	6,816		6,816	31	
32	V	21 Postage		Royal Management Corp.	**	2,351		2,351	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 Elmhurst, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 344,647	\$ *	344,647	39	

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

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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.	**	\$ 3,604	\$ 3,604
16	V	24 Travel & seminar		Royal Management Corp.	**	2,551	2,551
17	V	25 Auto expense		Royal Management Corp.	**	10,406	10,406
18	V	26 Insurance general		Royal Management Corp.	**	2,509	2,509
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	35,698	35,698
20	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,365	3,365
21	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	4,664	4,664
22	V	30 Depreciation - equipment		Royal Management Corp.	**	13,777	13,777
23	V	32 Interest		Royal Management Corp.	**	12,370	12,370
24	V	32 Amortization of mortgage costs		Royal Management Corp.	**	22	22
25	V	33 Property taxes		Royal Management Corp.	**	1,797	1,797
26	V	34 Rent expense		Royal Management Corp.	**	2,820	2,820
27	V	35 Equipment rental		Royal Management Corp.	**	1,113	1,113
28	V	43 Travel & entertainment		Royal Management Corp.	**	132	132
29	V	17 Management fees	778,351	Royal Management Corp.	**		(778,351)
30	V	10 Management allocation-salaries		Royal Management Corp.	**	63,063	63,063
31	V	15 Management allocation-employee benefits		Royal Management Corp.	**	7,980	7,980
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 778,351			\$ 165,871	\$ * (612,480)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	16.66%	See Schedule C	2.9	7%	Salary	\$ 23,088	L 17, C 7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	16.67%	See Schedule C	2.9	7%	Salary	16,491	L 17, C 7	2
3	Cynthia Thiem	Owner/officer	Administrative	16.67%	See Schedule C	2.9	7%	Salary	16,491	L 17, C 7	3
4	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	2.9	7%	Salary	12,263	L 17, C 7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00%	See Schedule C	1.5	4%	Salary	2,783	L 21, C 7	5
6	Jeremy Samatas	Corporate Director	Quality Assurance	0.00%	See Schedule C	2.9	7%	Salary	6,698	L 10, C 7	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	\$ 77,814		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 Elmhurst

0037317 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	744,965	10	\$ 2,086	\$ 54,750	\$ 153	1
2	5	Utilities - gas & electric	Bed Days	744,965	10	39,549	54,750	2,907	2
3	5	Utilities - water & sewer	Bed Days	744,965	10	1,244	54,750	91	3
4	5	Utilities - maintenance office	Bed Days	744,965	10	8,043	54,750	591	4
5	6	Management allocation - salaries	Bed Days	744,965	10	402,200	402,200	29,559	5
6	6	Repairs & maintenance	Bed Days	744,965	10	40,648	54,750	2,987	6
7	6	Scavenger & exterminating	Bed Days	744,965	10	1,366	54,750	100	7
8	7	Management allocation - employee	Bed Days	744,965	10	50,893	54,750	3,740	8
9	10	Medical consultant	Bed Days	744,965	10	29,034	54,750	2,134	9
10	17	Management allocation - salaries	Bed Days	744,965	10	929,789	929,789	68,333	10
11	19	Computer consultant & supplies	Bed Days	744,965	10	75,717	54,750	5,565	11
12	19	Professional fees	Bed Days	744,965	10	58,113	54,750	4,271	12
13	20	Dues & subscriptions	Bed Days	744,965	10	7,935	54,750	583	13
14	20	Advertising - help wanted	Bed Days	744,965	10	5,488	54,750	403	14
15	21	Management allocation - salaries	Bed Days	744,965	10	2,908,810	2,908,810	213,778	15
16	21	Bank charges	Bed Days	744,965	10	3,883	54,750	285	16
17	21	Office supplies & printing	Bed Days	744,965	10	92,737	54,750	6,816	17
18	21	Postage	Bed Days	744,965	10	31,985	54,750	2,351	18
19	21	Telephone	Bed Days	744,965	10	49,035	54,750	3,604	19
20	24	Travel and seminar	Bed Days	744,965	10	34,717	54,750	2,551	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,773,272	\$ 4,240,799	\$ 350,802	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	744,965	10	\$ 141,593	\$ 54,750	\$ 10,406	1
2	26	Insurance general	Bed Days	744,965	10	34,142	54,750	2,509	2
3	27	Management allocation - employee	Bed Days	744,965	10	485,728	54,750	35,698	3
4	30	Depreciation - vehicles	Bed Days	744,965	10	45,792	54,750	3,365	4
5	30	Depreciation - leasehold improv.	Bed Days	744,965	10	63,466	54,750	4,664	5
6	30	Depreciation - equipment	Bed Days	744,965	10	187,456	54,750	13,777	6
7	32	Interest	Bed Days	744,965	10	168,318	54,750	12,370	7
8	32	Amortization of mortgage costs	Bed Days	744,965	10	299	54,750	22	8
9	33	Property taxes	Bed Days	744,965	10	24,448	54,750	1,797	9
10	34	Rent expense	Bed Days	744,965	10	38,371	54,750	2,820	10
11	35	Equipment rental	Bed Days	744,965	10	15,142	54,750	1,113	11
12	43	Travel & entertainment	Bed Days	744,965	10	1,795	54,750	132	12
13	10	Management allocation-salaries	Bed Days	744,965	10	858,074	858,074	63,063	13
14	15	Management allocation-employee	Bed Days	744,965	10	108,579	54,750	7,980	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,173,203	\$ 858,074	\$ 159,716	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Lexington Financial Services						\$	\$			\$	1						
2	II, L.L.C.	X		Mortgage	\$32,361.00	12/29/98	4,256,000	3,202,311	1/2008	0.0675	221,355	2						
3												3						
4												4						
5												5						
	Working Capital																	
6	LaSalle Bank, N.A.		X	Line of Credit	Varies	4/6/02	500,000	350,000	5/31/07	Prime	28,793	6						
7												7						
8												8						
9	TOTAL Facility Related				\$32,361.00		\$ 4,756,000	\$ 3,552,311			\$ 250,148	9						
	B. Non-Facility Related*																	
10								Amortization of loan cost			2,429	10						
11								Interest income offset			(121)	11						
12												12						
13								Allocated from management company			12,392	13						
14	TOTAL Non-Facility Related						\$	\$			\$ 14,700	14						
15	TOTALS (line 9+line14)						\$ 4,756,000	\$ 3,552,311			\$ 264,848	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.		\$	64,800	1
	Allocation from Management Co.		1,797	
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	\$	57,779	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(5,224)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	63,700	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.)		\$	1,191	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.		\$	59,667	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	65,080	8
	2002	69,897	9
	2003	65,659	10
	2004	62,824	11
	2005	57,779	12
Est. 06 taxes payable in 07		61,766	
Est. 06 tax with 3% increase:		63,619	
Use:		63,700	

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 of Elmhurst COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0037317

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>06-14-317-008</u>	<u>Land and building</u>	\$ <u>57,778.78</u>	\$ <u>57,778.78</u>
2. <u>Royal Management Corp. (Samvest of Lomard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land and building</u>	\$ <u>32,334.00</u>	\$ <u>1,797.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>90,112.78</u>	\$ <u>59,575.78</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 Elmhurst

0037317 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 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).

Lexington Square Life Care of Elmhurst, Inc.: Retirement Community; 342 units

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>55,000</u>	<u>1991</u>	<u>\$ 1,277,670</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>11,841</u>	<u>2</u>
3	TOTALS	55,000		\$ 1,289,511	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	138	1991	1991	\$ 4,110,586	\$	35	\$ 117,445	\$ 117,445	\$ 1,776,142	4
5	10	1995	1995	73,302	2,095	35	2,095		24,412	5
6	2	2001	2001							6
7										7
8										8
Improvement Type**										
9	Building Improvement		1992	693	20	35	20		283	9
10	Land Improvement		1995	7,500	500	15	500		5,667	10
11	Fan Coil Units		1996	4,903	140	35	140		1,471	11
12	Patio		1996	2,322	155	15	155		1,625	12
13	Basement rehab		1997	17,151	1,715	10	1,715		16,151	13
14	Baseboards		1997	3,129	313	10	313		2,894	14
15	Wiring		1998	3,090	309	10	309		2,627	15
16	Lobby Tile		1999	19,354	1,935	10	1,935		15,322	16
17	Patio		1999	4,196	280	15	280		1,958	17
18	Automatic Door		2000	1,300	130	10	130		845	18
19	Wallpaper		2000	6,853	685	10	685		4,455	19
20	Patio		2000	1,242	83	15	83		538	20
21	Storage closet for HVAC		2000	3,745	250	15	250		1,623	21
22	Fire pump system		2001	4,140	414	10	414		2,277	22
23	Door releases		2001	4,420	442	10	442		2,431	23
24	Infrared curtains for elevators		2001	3,000	300	10	300		1,650	24
25	Parking lot		2002	2,532	253	10	253		1,266	25
26	Kitchen tile and plumbing		2002	9,661	966	10	966		4,509	26
27	Elevator upgrade		2002	2,595	519	5	519		2,293	27
28	Facility Rehab-Painting/wallpaper/carpeting		2003	175,251	17,523	10	17,523		68,640	28
29	Facility Rehab-Floor tile/room upgrade		2003	38,140	1,907	20	1,907		7,469	29
30	Facility Rehab-Carpeting		2003	7,860	786	10	786		3,013	30
31	Parking lot		2004	1,999	400	5	400		933	31
32	Roof		2004	15,000	750	20	750		1,813	32
33	Landscaping		2005	5,396	270	20	270		405	33
34	Paint for building		2005	9,000	900	10	900		1,125	34
35	Roof		2005	14,300	715	20	715		834	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 Elmhurst

0037317

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HVAC upgrade	2005	\$ 3,230	\$ 162	20	\$ 162	\$	\$ 269	37
38	Sprinkler system	2005	1,060	53	20	53		66	38
39	Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		2,645	39
40	Window treatment	2005	1,931	193	10	193		322	40
41	Cubicle curtains	2005	820	164	5	164		219	41
42	Countertop	2005	845	169	5	169		282	42
43	HVAC	2006	3,793	16	20	16		16	43
44	Automatic Door Lock	2006	2,784		20				44
45	Storeroom Door Lock	2006	1,904	16	20	16		16	45
46	Service Door	2006	2,545		20				46
47	Landscaping Enhancement-Patio	2006	2,340	65	15	65		65	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61	Land improvements - management company	2002	18,663		15	1,163	1,163	6,117	61
62	Building - management company	2002	145,197		40	3,393	3,393	17,847	62
63	HVAC, electrical, security system - management company	2003	1,439		30	93	93	337	63
64	Key card system - management company	2004	226		20	11	11	27	64
65	VAV TX controls - management company	2005	69		20	3	3	6	65
66	Interior Signs- management company	2006	50		5	1	1	1	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,767,158	\$ 36,973		\$ 159,082	\$ 122,109	\$ 1,982,906	70

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	\$ 163,148	\$ 21,508	\$ 21,508	\$	3-10	\$ 80,702	71
72	Current Year Purchases	87,837	3,562	3,562		3-10	3,562	72
73	Fully Depreciated Assets	62,613					62,611	73
74	Allocated from Management Company	132,185		13,775	13,775		64,518	74
75	TOTALS	\$ 445,783	\$ 25,070	\$ 38,845	\$ 13,775		\$ 211,393	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			38,430		3,365	3,365		26,288	79
80	TOTALS			\$ 38,430	\$	\$ 3,365	\$ 3,365		\$ 26,288	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)	\$ 6,540,882	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 62,043	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 201,292	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 139,249	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,220,587	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	Therapy room rehabilitation	\$ 978	92
93	PT Therapy Room	570	93
94	Construct. In Progress -Renovation	119,711	94
95		\$ 121,259	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	<u>Allocated from management company</u>			<u>2,820</u>			6
7	TOTAL			\$ 2,820			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: \$ 8,824 Description: Copier-\$3,933; Postage machine-\$179; Fax machine-\$3,599; Allocated from Man Co. \$1,113

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20	<u>Allocated from management company</u>			<u>2,193</u>	20
21	TOTAL		\$	\$ 2,193	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	\$	3,287	\$ 253,024	\$	3,287	\$ 253,024	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		800	52,371		800	52,371	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		7,544	320,956		7,544	320,956	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescripts				265,771		265,771	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Schedule D</u>	L39,C3				4,732			4,732	13
14	TOTAL			\$	11,631	\$ 631,083	\$ 265,771	11,631	\$ 896,854	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

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/05 - 12/31/05

Schedule D

XIV. Special Services

Service	Schedule & Line Reference	Outside Practitioner (other than consultant)		Total Units	Total Cost
		Units	Cost		
Wound therapy	L39, C3		1,635	0	1,635
Ambulance	L39, C3		1,084	0	1,084
Dentist	L39, C3		2,013	0	2,013
		-	4,732	-	4,732

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 768,597	\$ 775,643	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 739,099)	1,473,357	1,473,357	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,833	95,833	6
7	Other Prepaid Expenses	870	870	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	2,735	41,043	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,341,392	\$ 2,386,746	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,429	7,429	12
13	Land		1,289,511	13
14	Buildings, at Historical Cost		4,109,750	14
15	Leasehold Improvements, at Historical Cost	491,764	657,408	15
16	Equipment, at Historical Cost	312,771	484,213	16
17	Accumulated Depreciation (book methods)	(329,304)	(2,220,587)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec CIP	1,548	121,259	22
23	Other(specify): Mortgage Costs		29,156	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 484,208	\$ 4,478,139	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,825,600	\$ 6,864,885	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 208,129	\$ 208,129	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,000	350,000	29
30	Accrued Salaries Payable	211,251	211,251	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,276	13,276	31
32	Accrued Real Estate Taxes(Sch.IX-B)		63,700	32
33	Accrued Interest Payable		18,013	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	296,681	268,517	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,079,337	\$ 1,132,886	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		3,202,311	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)	\$	\$ 3,202,311	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,079,337	\$ 4,335,197	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,746,263	\$ 2,529,688	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,825,600	\$ 6,864,885	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/06 - 12/31/06

Schedule 17A

XV. Balance Sheet
A. Current Assets

9. Other Current Assets

Description	After	
	Operating	Consolidation
Due To/From Employees	91	91
Escrow Real Estate Tax	0	38308
Due from Ins Carrier	1313	1313
Due to Republic Constructio	1331	1331
Total line 36	<u>2,735</u>	<u>41,043</u>

C. Current Liabilities

36. Other Current Liabilities

Description	After	
	Operating	Consolidation
Due to Royal	12,431	12,431
Bond Withholding	145	145
401K Withholding	3,822	3,822
Accrued 401K	9,050	9,050
Due from square Elmhurst	726	726
Accrued Expenses	177,996	177,996
Accrued Royl Genl Mgmt	13,001	13,001
Accrued Rent	28,164	-
Advance Biweekly Part A	51,346	51,346
Total line 36	<u>296,681</u>	<u>268,517</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,441,527	1
2	Restatements (describe):		2
3	Post Closing Journal Entries	(1,760)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,439,767	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,518,496	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	(1,212,000)	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)	\$ 306,496	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)	\$ 1,746,263	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	\$ 9,376,425	1
2	Discounts and Allowances for all Levels	(1,191,265)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,185,160	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,129,088	6
7	Oxygen	847	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,129,935	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	3,482	12
13	Barber and Beauty Care	26,267	13
14	Non-Patient Meals	29	14
15	Telephone, Television and Radio	8	15
16	Rental of Facility Space		16
17	Sale of Drugs	347,008	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,847	19
20	Radiology and X-Ray	15,406	20
21	Other Medical Services	103,781	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 511,828	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	121	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 121	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Investment Income</u>	1,351	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,351	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,828,395	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,250,082	31
32	Health Care	3,680,715	32
33	General Administration	1,993,909	33
	B. Capital Expense		
34	Ownership	936,415	34
	C. Ancillary Expense		
35	Special Cost Centers	366,656	35
36	Provider Participation Fee	82,122	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,309,899	40
41	Income before Income Taxes (line 30 minus line 40)**	1,518,496	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,518,496	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 tax payer

*** 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 Elmhurst

0037317

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,969	2,047	\$ 94,960	\$ 46.39	1
2	Assistant Director of Nursing	1,163	1,183	41,253	34.87	2
3	Registered Nurses	23,472	25,279	791,690	31.32	3
4	Licensed Practical Nurses	14,039	15,123	380,591	25.17	4
5	CNAs & Orderlies	72,428	77,856	887,209	11.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,632	6,067	77,249	12.73	8
9	Activity Director					9
10	Activity Assistants	16,149	17,377	168,997	9.73	10
11	Social Service Workers	2,465	2,615	46,435	17.76	11
12	Dietician	2,003	2,100	29,331	13.97	12
13	Food Service Supervisor	2,100	2,180	35,017	16.06	13
14	Head Cook	1,914	2,180	28,239	12.95	14
15	Cook Helpers/Assistants	12,936	13,696	119,761	8.74	15
16	Dishwashers	14,053	15,018	111,277	7.41	16
17	Maintenance Workers	2,119	2,282	37,077	16.25	17
18	Housekeepers	26,353	28,112	211,656	7.53	18
19	Laundry	9,076	9,543	64,671	6.78	19
20	Administrator	1,846	1,918	98,056	51.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,443	15,229	209,557	13.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	224,160	239,805	\$ 3,433,026 *	\$ 14.32	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	199	\$ 12,423	L1,C3	35
36	Medical Director	Monthly	18,075	L9,C3	36
37	Medical Records Consultant	32	2,004	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	144	6,929	L11,C3	44
45	Social Service Consultant	96	4,810	L12,C3	45
46	Other(specify)				46
47	Psychosocial	23	1,196	L12,C3	47
48	MDS	467	24,284	L10,C3	48
49	TOTAL (lines 35 - 48)	961	\$ 72,121		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,121	\$ 227,733	L10,C3	50
51	Licensed Practical Nurses	2,148	73,827	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,269	\$ 301,560		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Delnaz Vazifdar</u>	<u>Administrator</u>	<u>0%</u>	\$ <u>19,035</u>	<u>Workers' Compensation Insurance</u>	\$ <u>37,382</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
<u>Jennifer Conniff</u>	<u>Administrator</u>	<u>0%</u>	<u>79,021</u>	<u>Unemployment Compensation Insurance</u>	<u>108,568</u>	<u>Advertising: Employee Recruitment</u>	<u>10,055</u>	
				<u>FICA Taxes</u>	<u>252,555</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>89,648</u>	(Indicate # of checks performed <u>53</u>)	<u>530</u>	
				<u>Employee Meals</u>	<u>9,533</u>	<u>Patient Background Checks</u>	<u>347</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>1,745</u>	
				<u>401 (K)</u>	<u>9,050</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>3,239</u>	
				<u>Life Insurance</u>	<u>4,358</u>			
				<u>Other Employee Benefits</u>	<u>19,269</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>98,056</u>	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>530,363</u>	
(List each licensed administrator separately.)				(agree to Sch. V, line 20, col. 8)			\$ <u>22,015</u>	
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
<u>Management Fees (eliminated in column 7)</u>			\$ <u>778,351</u>				<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>778,351</u>	TOTAL			\$	
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	<u>7,057</u>
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount
<u>Grabowski Law Center, LLC</u>	<u>Collections</u>	\$ <u>4,354</u>					<u>Out-of-State Travel</u>	\$
<u>Altschuler, Melvoin & Glasser LLP</u>	<u>Accounting</u>	<u>15,351</u>						
<u>RSM McGladrey</u>	<u>Accounting</u>	<u>9,141</u>						
<u>Aronberg Glodgehn Davis & Garmis</u>	<u>401 (K)</u>	<u>103</u>					<u>In-State Travel</u>	
<u>Cassidy Schlade & Gloor</u>	<u>Legal</u>	<u>18,154</u>						
<u>Gilson, Labus & Silverman</u>	<u>Accounting</u>	<u>435</u>						
<u>ING</u>	<u>401 (K)</u>	<u>540</u>						
<u>James Samatas, Atty. At Law</u>	<u>Legal</u>	<u>100</u>					<u>Seminar Expense</u>	<u>7,057</u>
<u>Personnel Planners</u>	<u>U/C Consulting</u>	<u>2,550</u>						
<u>Royal Management Operations</u>	<u>Other professional Services</u>	<u>11,033</u>					<u>Allocated from management company</u>	<u>2,551</u>
<u>See Attached Schedule 21C</u>		<u>36,455</u>					<u>Entertainment Expense</u>	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>98,217</u>	TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>9,608</u>

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Elmhurst, Inc.

Provider # 0037317

1/1/06 - 12/31/06

Schedule F

XIX. Support Schedules

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Sachnoff & Weaver	Legal	5,657
Scott & Krause	Legal	542
Serpico, Novelle, Pertrosino	Legal	7,792
Systematic Mgmt Systems	Billing Service	4,117
National Datacare Corporation	Computer Consulting	1,435
Information Controls, Inc.	Computer Consulting	968
AAOD	Computer Consulting	2,010
eHealth Solutions	Computer Consulting	2,400
AdminaStar Federal	Computer Consulting	363
Lintech	Computer Consulting	2,994
Action Computer Service	Computer Consulting	259
Microsoft	Computer Consulting	2,833
Krakau	Computer Consulting	348
Gigatrend	Computer Consulting	215
Visual Click	Computer Consulting	120
CDW	Computer Consulting	980
Lanac	Computer Consulting	1,432
Royal/Shaker Advertising	Computer Consulting	1,990
Total, Other Professional Services		<u>36,455</u>

Total, Agrees to Schedule V, Line 19, Column 3 98,217

Allocated from management co.

RSM McGladrey	Accounting	150
Altschuler, Melvoin a	Accounting	330
ING	401 (k) Administration	138
Aronberg, Goldgehn.	Accounting	6
Pension Administrat	401 (k) Administration	807
Personnel Planners	U/C Consulting	10
Tax Caps	Real Estate Tax savings Co	121
Gene Whitehorn	Medicaid Reim Specialist	2,667
James Samatas	Legal	42
Lintech	Computer Consulting	5,565
		<u>9,836</u>

Allocated from building partnership

James Samatas Filing and recording fees 280

Nonallowable legal fees

Grabowski Law Center, LLC Legal-collection fees (4,354)
 Sachnoff & Weaver Legal (113)

Total, Agrees to Schedule V, Line 19, Column 8 103,866

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 Elmhurst# 0037317Report Period Beginning: 01/01/2006Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,194 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. \$ 82,122
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. \$ 9,533 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 29
- (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