



Facility Name & ID Number Lexington of LaGrange

# 0038083 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	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,600	1,843	17,182	21,625	8
9	SNF/PED					9
10	ICF	9,923	7,802	917	18,642	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,523	9,645	18,099	40,267	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.71%

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 7/31/92

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 119 and days of care provided 17,075

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 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
	<b>A. General Services</b>										
1	Dietary	261,691	18,424	12,336	292,451		292,451		292,451		1
2	Food Purchase		156,314		156,314		156,314	(8,344)	147,970		2
3	Housekeeping	227,428	24,031		251,459		251,459	122	251,581		3
4	Laundry	40,641	12,200		52,841		52,841	830	53,671		4
5	Heat and Other Utilities			181,163	181,163		181,163	2,848	184,011		5
6	Maintenance	29,347		97,199	126,546		126,546	25,900	152,446		6
7	Other (specify):* <b>Mgmt Alloc Emp Ben</b>							2,967	2,967		7
8	<b>TOTAL General Services</b>	559,107	210,969	290,698	1,060,774		1,060,774	24,323	1,085,097		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			42,000	42,000		42,000		42,000		9
10	Nursing and Medical Records	2,436,269	139,901	215,412	2,791,582		2,791,582	51,723	2,843,305		10
10a	Therapy			1,048,277	1,048,277		1,048,277		1,048,277		10a
11	Activities	215,009	21,584	6,067	242,660		242,660		242,660		11
12	Social Services	54,342		4,560	58,902		58,902		58,902		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Mgmt Alloc Emp Ben</b>							6,331	6,331		15
16	<b>TOTAL Health Care and Programs</b>	2,705,620	161,485	1,316,316	4,183,421		4,183,421	58,054	4,241,475		16
	<b>C. General Administration</b>										
17	Administrative	112,630		664,318	776,948		776,948	(610,108)	166,840		17
18	Directors Fees										18
19	Professional Services			60,018	60,018		60,018	8,083	68,101		19
20	Dues, Fees, Subscriptions & Promotions			66,534	66,534		66,534	783	67,317		20
21	Clerical & General Office Expenses	165,606	24,635	22,599	212,840		212,840	180,450	393,290		21
22	Employee Benefits & Payroll Taxes			476,113	476,113		476,113	8,344	484,457		22
23	Inservice Training & Education			1,414	1,414		1,414		1,414		23
24	Travel and Seminar			5,815	5,815		5,815	2,024	7,839		24
25	Other Admin. Staff Transportation			12	12		12	7,189	7,201		25
26	Insurance-Prop.Liab.Malpractice			101,617	101,617		101,617	1,991	103,608		26
27	Other (specify):* <b>Mgmt Alloc Emp Ben</b>							28,320	28,320		27
28	<b>TOTAL General Administration</b>	278,236	24,635	1,398,440	1,701,311		1,701,311	(372,924)	1,328,387		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,542,963	397,089	3,005,454	6,945,506		6,945,506	(290,547)	6,654,959		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 LaGrange

#0038083

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	
	<b>D. Ownership</b>											
30	Depreciation			79,092	79,092		79,092	204,090	283,182			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,054	20,054		20,054	167,053	187,107			32
33	Real Estate Taxes							140,856	140,856			33
34	Rent-Facility & Grounds			799,431	799,431		799,431	(797,194)	2,237			34
35	Rent-Equipment & Vehicles			32,863	32,863		32,863	1,950	34,813			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			931,440	931,440		931,440	(283,245)	648,195			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		440,504	930	441,434		441,434		441,434			39
40	Barber and Beauty Shops			25,630	25,630		25,630		25,630			40
41	Coffee and Gift Shops			246	246		246		246			41
42	Provider Participation Fee			68,787	68,787		68,787		68,787			42
43	Other (specify):* <b>Nonallowable Cost</b>			91,348	91,348		91,348	(91,348)				43
44	<b>TOTAL Special Cost Centers</b>		440,504	186,941	627,445		627,445	(91,348)	536,097			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,542,963	837,593	4,123,835	8,504,391		8,504,391	(665,140)	7,839,251			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 LaGrange

# 0038083

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,831)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	830	4		8
9	Non-Straightline Depreciation	(10,249)	30		9
10	Interest and Other Investment Income	(65)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(620)	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	(9,475)	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	(38,172)	43		24
25	Fund Raising, Advertising and Promotional	(11,586)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,627)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Schedule 5A</u>	(230,548)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (304,343)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(360,797)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (360,797)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (665,140)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of LaGrange

ID# 0038083

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (7,183)	43	1
2	X-Rays - Part A	(9,750)	43	2
3	Non-Allowable Collection Fees	(8,647)	43	3
4	Miscellaneous Income Offset	364	21	4
5	Personal Item Replacement	(1,457)	43	5
6	Trust Fees	(75)	43	6
7	Meals & Entertainment	(105)	43	7
8	Non-Allowable Shareholder Interest	(203,695)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(230,548)		49

**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 LaGrange		
				Limited Partnership	LaGrange	Real Estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, LLC	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	\$ 799,431	Sambell of LaGrange Limited Partnership	**	\$	(799,431)	1
2	V	19 Professional fees		Sambell of LaGrange Limited Partnership	**	280	280	2
3	V	21 Office supplies		Sambell of LaGrange Limited Partnership	**	132	132	3
4	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	197,039	197,039	4
5	V	32 Interest expense		Sambell of LaGrange Limited Partnership	**	359,205	359,205	5
6	V	32 Amortization of mortgage costs		Sambell of LaGrange Limited Partnership	**	1,777	1,777	6
7	V	33 Property taxes		Sambell of LaGrange Limited Partnership	**	139,431	139,431	7
8	V	43 Trust fees		Sambell of LaGrange Limited Partnership	**	75	75	8
9	V							9
10	V							10
11	V			** The owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Sambell of LaGrange Limited Partnership				11
12	V							12
13	V							13
14	Total		\$ 799,431			\$ 697,939	\$ * (101,492)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Lagrange Inc.**  
**Provider # 0038083**  
**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 Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
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.	**	\$ 122	\$	122	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	2,306		2,306	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	73		73	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	469		469	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	23,450		23,450	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	2,370		2,370	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	80		80	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	2,967		2,967	22	
23	V	10 Medical consultant		Royal Management Corp.	**	1,693		1,693	23	
24	V	17 Management allocation - salaries		Royal Management Corp.	**	54,210		54,210	24	
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	4,415		4,415	25	
26	V	19 Professional fees		Royal Management Corp.	**	3,388		3,388	26	
27	V	20 Dues & subscriptions		Royal Management Corp.	**	463		463	27	
28	V	20 Advertising - help wanted		Royal Management Corp.	**	320		320	28	
29	V	21 Management allocation - salaries		Royal Management Corp.	**	169,597		169,597	29	
30	V	21 Bank charges		Royal Management Corp.	**	226		226	30	
31	V	21 Office supplies & printing		Royal Management Corp.	**	5,407		5,407	31	
32	V	21 Postage		Royal Management Corp.	**	1,865		1,865	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 LaGrange, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 273,421	\$ *	273,421	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 2,859	\$ 2,859 15	
16	V	24 Travel & seminar		Royal Management Corp.	**	2,024	2,024 16	
17	V	25 Auto expense		Royal Management Corp.	**	8,256	8,256 17	
18	V	26 Insurance general		Royal Management Corp.	**	1,991	1,991 18	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	28,320	28,320 19	
20	V	30 Depreciation - vehicles		Royal Management Corp.	**	2,670	2,670 20	
21	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	3,700	3,700 21	
22	V	30 Depreciation - equipment		Royal Management Corp.	**	10,930	10,930 22	
23	V	32 Interest		Royal Management Corp.	**	9,814	9,814 23	
24	V	32 Amortization of mortgage costs		Royal Management Corp.	**	17	17 24	
25	V	33 Property taxes		Royal Management Corp.	**	1,425	1,425 25	
26	V	34 Rent expense		Royal Management Corp.	**	2,237	2,237 26	
27	V	35 Equipment rental		Royal Management Corp.	**	883	883 27	
28	V	17 Management fees	664,318	Royal Management Corp.	**		(664,318) 28	
29	V	43 Meals & Entertainment		Royal Management Corp.	**	105	105 29	
30	V	10 Management allocation - salaries		Royal Management Corp.	**	50,030	50,030 30	
31	V	15 Management allocation - employee benefits		Royal Management Corp.	**	6,331	6,331 31	
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V	** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total		\$ 664,318			\$ 131,592	\$ * (532,726) 39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Lexington of LaGrange

# 0038083

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	2.4	6%	Salary	\$ 18,316	L 17, C 7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2.4	6%	Salary	13,083	L 17, C 7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2.4	6%	Salary	13,083	L 17, C 7	3
4	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	2.4	6%	Salary	9,728	L 17, C 7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00%	See Schedule C	1.2	3%	Salary	2,208	L 21, C 7	5
6	Jeremy Samatas	Corporate Director	Quality Assurance	0.00%	See Schedule C	2.4	6%	Salary	5,313	L 10, C 7	6
7											7
8											8
9											9
10						All individuals work in excess of 40 hours per week.					10
11											11
12											12
13								TOTAL	\$ 61,731		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 LaGrange

# 0038083

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	744,965	10	\$ 2,086	\$ 43,435	\$ 122	1
2	5	Utilities - gas & electric	Bed Days	744,965	10	39,549	43,435	2,306	2
3	5	Utilities - water & sewer	Bed Days	744,965	10	1,244	43,435	73	3
4	5	Utilities - maintenance office	Bed Days	744,965	10	8,043	43,435	469	4
5	6	Management allocation - salaries	Bed Days	744,965	10	402,200	402,200	23,450	5
6	6	Repairs & maintenance	Bed Days	744,965	10	40,648	43,435	2,370	6
7	6	Scavenger & exterminating	Bed Days	744,965	10	1,366	43,435	80	7
8	7	Management allocation - employee b	Bed Days	744,965	10	50,893	43,435	2,967	8
9	10	Medical consultant	Bed Days	744,965	10	29,034	43,435	1,693	9
10	17	Management allocation - salaries	Bed Days	744,965	10	929,789	929,789	54,210	10
11	19	Computer consultant & supplies	Bed Days	744,965	10	75,717	43,435	4,415	11
12	19	Professional fees	Bed Days	744,965	10	58,113	43,435	3,388	12
13	20	Dues & subscriptions	Bed Days	744,965	10	7,935	43,435	463	13
14	20	Advertising - help wanted	Bed Days	744,965	10	5,488	43,435	320	14
15	21	Management allocation - salaries	Bed Days	744,965	10	2,908,810	2,908,810	169,597	15
16	21	Bank charges	Bed Days	744,965	10	3,883	43,435	226	16
17	21	Office supplies & printing	Bed Days	744,965	10	92,737	43,435	5,407	17
18	21	Postage	Bed Days	744,965	10	31,985	43,435	1,865	18
19	21	Telephone	Bed Days	744,965	10	49,035	43,435	2,859	19
20	24	Travel & seminar	Bed Days	744,965	10	34,717	43,435	2,024	20
21	25	Auto expense	Bed Days	744,965	10	141,593	43,435	8,256	21
22	26	Insurance general	Bed Days	744,965	10	34,142	43,435	1,991	22
23	27	Management allocation - employee b	Bed Days	744,965	10	485,729	43,435	28,320	23
24	30	Depreciation - vehicles	Bed Days	744,965	10	45,792	43,435	2,670	24
25	TOTALS					\$ 5,480,528	\$ 4,240,799	\$ 319,541	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

# 0038083

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	30	Depreciation - leasehold improv.	Bed Days	744,965	10	\$ 63,466	\$ 43,435	\$ 3,700	1
2	30	Depreciation - equipment	Bed Days	744,965	10	187,456	43,435	10,930	2
3	32	Interest	Bed Days	744,965	10	168,318	43,435	9,814	3
4	32	Amortization of mortgage costs	Bed Days	744,965	10	299	43,435	17	4
5	33	Property taxes	Bed Days	744,965	10	24,448	43,435	1,425	5
6	34	Rent expense	Bed Days	744,965	10	38,371	43,435	2,237	6
7	35	Equipment rental	Bed Days	744,965	10	15,142	43,435	883	7
8	43	Meals & Entertainment	Bed Days	744,965	10	1,795	43,435	105	8
9	10	Management allocation-Salaries	Bed Days	744,965	10	858,074	858,074	50,030	9
10	15	Management Allocation - Employ	Bed Days	744,965	10	108,580	43,435	6,331	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,465,949	\$ 858,074	\$ 85,472	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Lexington of LaGrange

# 0038083

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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	Lexington Financial						\$	\$			\$	1						
2	Services II, LLC	X		Mortgage	\$22,735.00	12/29/98	2,990,000	2,249,744	12/29/2008	0.0675	155,510	2						
3												3						
4												4						
5												5						
	<b>Working Capital</b>																	
6	LaSalle Bank, N.A.		X	Line of Credit	Various	12/1/02	500,000	185,000	5/31/2007	Prime	20,054	6						
7	Partner Loans	X		Working Capital	Various	11/26/03	1,330,000	2,300,000	Demand	Prime + 1	203,695	7						
8												8						
9	<b>TOTAL Facility Related</b>				\$22,735.00		\$ 4,820,000	\$ 4,734,744			\$ 379,259	9						
	<b>B. Non-Facility Related*</b>																	
10										Amortization of loan costs	1,777	10						
11										Interest income offset	(65)	11						
12										Nonallowable partner loan interest	(203,695)	12						
13										Allocated from management company	9,831	13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (192,152)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 4,820,000	\$ 4,734,744			\$ 187,107	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.		\$	<b>300,000</b>	1
	Allocated from Management Company		<b>1,425</b>	
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	\$	<b>217,905</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(82,095)</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>224,400</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>14,283</b>	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. <b>TOTAL REFUND \$ 17,157 For 2003 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(17,157)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>140,856</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>220,342</b>	8
	2002	<b>198,271</b>	9
	2003	<b>205,441</b>	10
	2004	<b>217,366</b>	11
	2005	<b>217,905</b>	12
<b>Est 06 taxes payable 07:</b>		<b>217,905</b>	
<b>Est. 06 tax with 3% increase:</b>		<b>224,442</b>	
<b>Use:</b>		<b>224,400</b>	

<b>FOR BHF USE ONLY</b>			
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 LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Sue 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>18-08-207-017-000</u>	<u>Land &amp; Building</u>	\$ <u>116,135.28</u>	\$ <u>116,135.28</u>
2. <u>18-08-207-018-000</u>	<u>Land &amp; Building</u>	\$ <u>101,769.85</u>	\$ <u>101,769.85</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ <u>32,335.00</u>	\$ <u>1,425.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>250,240.13</u>	\$ <u>219,330.13</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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Lexington of LaGrange

# 0038083

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 50,072 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

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>40,000</u>	<u>1991</u>	<u>\$ 500,000</u>	<u>1</u>
2	<u>Allocated from Management Company</u>			<u>8,605</u>	<u>2</u>
3	<b>TOTALS</b>	<b>40,000</b>		<b>\$ 508,605</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of LaGrange

# 0038083

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	99	1992	1992	\$ 2,661,448	\$	35	\$ 76,124	\$ 76,124	\$ 1,103,718	4
5	10	1995	1995	79,363	661	10	661		79,363	5
6	10	2005	2005	2,321,014		21	110,524	110,524	165,787	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Land Improvements		1992	1,152		20	58	58	836	9
10	Building Improvements		1992	2,714		31			2,714	10
11	Building Improvements		1993	2,901		35	83	83	1,119	11
12	Leasehold Improvements		1994	6,402	107	10	107		6,402	12
13	Leasehold Improvements - Corner Guards		1996	2,195	37	10	37		2,122	13
14	Wiring		1998	3,378	338	10	338		2,871	14
15	Resurface & Restripe Parking Lot		1998	3,753	375	10	375		3,190	15
16	Lobby Tile		1998	19,488	1,949	10	1,949		15,915	16
17	Resurface & Restripe Parking Lot		2000	1,997	200	10	200		1,298	17
18	Automatic Door		2000	1,300	130	10	130		845	18
19	Kitchen Rehab		2001	1,441	144	10	144		793	19
20	Infrared curtains for elevator		2001	3,000	300	10	300		1,650	20
21	Dining room, resident rooms, and corridors renovations		2002	150,084	7,505	20	7,505		30,642	21
22	Elevator upgrade		2002	5,398	540	10	540		2,519	22
23	Air conditioner compressor		2003	9,218	922	10	922		3,149	23
24	Sidewalk and fencing		2005	46,701	2,335	20	2,335		2,724	24
25	HVAC		2005	8,141	407	20	407		441	25
26	Wiring		2005	4,506	225	20	225		282	26
27	Lobby, lounge and reception renovations		2005	24,362	1,218	20	1,218		1,624	27
28	1st floor new dining room, floors, ceilings, wallcoverings, doors		2005	326,862	16,343	20	16,343		16,343	28
29	Wallcoverings		2005	10,822	2,164	5	2,164		3,427	29
30	Medical records room rehab		2006	19,739		20				30
31	Activity/PT Room Rehab		2006	1,158		20				31
32	Land scape enhancement		2006	8,726	194	15	194		194	32
33	Roof		2006	29,700	660	15	660		660	33
34	HVAC		2006	3,254	54	20	54		54	34
35	Plumbing and sprinkler system		2006	20,725	1,036	20	1,036		1,036	35
36	Laundry combustion air		2006	16,814	631	20	631		631	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	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	Lobby/Lounge/Reception rehab	2006	\$ 14,033	\$ 702	10	\$ 702	\$	\$ 702	37
38	Cubicle curtains/drapery	2006	6,955	1,214	5	1,214		1,214	38
39	Cabinets/counters for 2nd FI library	2006	2,665	67	10	67		67	39
40	TCU rehab	2006	2,402	10	20	10		10	40
41	First floor remodel	2006	212,084		20				41
42	Kitchen rehab	2006	8,165	204	20	204		204	42
43	Bath fixtures-2nd floor	2006	2,076	173	10	173		173	43
44									44
45									45
46									46
47									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	13,562		15	923	923	4,445	61
62	Building - management company	2002	105,510		40	2,692	2,692	12,969	62
63	HVAC, electrical, security system - management company	2003	1,046		30	58	58	245	63
64	Key card system - management company	2004	164		20	24	24	20	64
65	VAV TX controls - management company	2005	50		20	4	4	5	65
66	Interior Signs-management company	2006	36		5				66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,166,504	\$ 40,845		\$ 231,335	\$ 190,490	\$ 1,472,403	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	\$ 214,757	\$ 23,728	\$ 23,728	\$	3-10	\$ 104,626	71
72	Current Year Purchases	206,611	14,519	14,519		5-7	14,519	72
73	Fully Depreciated Assets	69,705					69,705	73
74	Allocated from Management Company	96,054		10,930	10,930		46,884	74
75	TOTALS	\$ 587,127	\$ 38,247	\$ 49,177	\$ 10,930		\$ 235,734	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			27,926		2,670	2,670		19,103	79
80	TOTALS			\$ 27,926	\$	\$ 2,670	\$ 2,670		\$ 19,103	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)	\$ 7,290,162	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,092	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 283,182	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 204,090	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,727,240	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	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$ _____			3
4	Additions						4
5							5
6	Allocated from Management Company			2,237			6
7	TOTAL			\$ 2,237			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: \$ 33,746 Description: Postage meter - \$179; Copier - \$6,833; Medical Equipment - \$18,069; Oxygen - \$7,782; Mgmt Co - \$883

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20	Allocated from Management Company			1,067	20
21	TOTAL		\$ _____	\$ 1,067	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	7,602	\$ 456,107	\$	7,602	\$ 456,107	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		667	32,670		667	32,670	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		11,904	559,500		11,904	559,500	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				440,504		440,504	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>Wound Care</b>	L39, C3				930			930	13
14	<b>TOTAL</b>			\$	20,173	\$ 1,049,207	\$ 440,504	20,173	\$ 1,489,711	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 LaGrange** # **0038083** 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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 35,349	\$ 51,450	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>298,600</u> )	1,889,056	1,889,056	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	(21,348)	(21,348)	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,389	4,389	8
9	Other(specify): <u>Cobra &amp; Escrow</u>	2,126	171,395	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,909,572	\$ 2,094,942	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,219	5,219	12
13	Land		508,605	13
14	Buildings, at Historical Cost		2,656,897	14
15	Leasehold Improvements, at Historical Cost	1,064,359	3,509,607	15
16	Equipment, at Historical Cost	432,307	615,053	16
17	Accumulated Depreciation (book methods)	(353,910)	(1,727,240)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>Unamortized Loans</u>		21,315	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,147,975	\$ 5,589,456	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,057,547	\$ 7,684,398	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 258,291	\$ 258,291	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	185,000	2,485,000	29
30	Accrued Salaries Payable	205,414	205,414	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,899	4,899	31
32	Accrued Real Estate Taxes(Sch.IX-B)		224,400	32
33	Accrued Interest Payable		48,210	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See attached schedule 17A</u>	474,335	460,567	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,127,939	\$ 3,686,781	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		2,249,744	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 2,249,744	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,127,939	\$ 5,936,525	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,929,608	\$ 1,747,873	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,057,547	\$ 7,684,398	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington Health Care Center of Lagrange, Inc.  
 Provider # 0038083  
 1/1/06 - 12/31/06

**Schedule 17A**

XV. Balance Sheet  
 C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	After <u>Consolidation</u>
A/R - PA Audit Settlement	116,564	116,564
Due to Royal (OPS)	7,915	7,915
Due to / from Schaumburg	(2,981)	(2,981)
Bond withholding	299	299
401k withholding	7,982	7,982
Accrued 401k	16,141	16,141
Due to - Republic Construction	(14)	(14)
Accrued expenses	287,392	287,392
Accrued royl genl mgmt fees	13,728	13,728
Accrued rent	13,768	-
Accrued wage assignment	591	591
Advance - biweekly Part A	12,950	12,950
Total line 36	<u>474,335</u>	<u>460,567</u>

**See Accountants' Compilation Report**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>958,859</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post closing entries</b>	<b>90,071</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,048,930</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>880,678</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>880,678</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,929,608</b>	<b>24</b> *

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 9,289,682	1
2	Discounts and Allowances for all Levels	(3,044,019)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,245,663	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,100,522	6
7	Oxygen	770	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,101,292	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,689	13
14	Non-Patient Meals	7	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	854,049	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,246	19
20	Radiology and X-Ray	16,846	20
21	Other Medical Services	99,263	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,037,100	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,014	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,014	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,385,069	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,060,774	31
32	Health Care	4,183,421	32
33	General Administration	1,701,311	33
	<b>B. Capital Expense</b>		
34	Ownership	931,440	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	558,658	35
36	Provider Participation Fee	68,787	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,504,391	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	880,678	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 880,678	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 LaGrange

# 0038083

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	2,398	2,576	\$ 117,317	\$ 45.54	1
2	Assistant Director of Nursing	3,271	3,750	123,435	32.92	2
3	Registered Nurses	20,377	22,050	683,180	30.98	3
4	Licensed Practical Nurses	21,376	23,293	571,625	24.54	4
5	CNAs & Orderlies	68,607	73,384	817,745	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,164	8,984	122,967	13.69	8
9	Activity Director	2,827	2,835	47,029	16.59	9
10	Activity Assistants	15,497	16,431	167,980	10.22	10
11	Social Service Workers	2,038	2,583	54,342	21.04	11
12	Dietician	625	633	7,842	12.39	12
13	Food Service Supervisor	1,914	2,144	46,373	21.63	13
14	Head Cook	2,064	2,144	28,959	13.51	14
15	Cook Helpers/Assistants	11,779	12,782	105,812	8.28	15
16	Dishwashers	9,775	10,259	72,705	7.09	16
17	Maintenance Workers	1,895	2,198	29,347	13.35	17
18	Housekeepers	27,249	29,677	227,428	7.66	18
19	Laundry	5,304	5,766	40,641	7.05	19
20	Administrator	1,814	2,178	112,630	51.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,001	12,228	165,606	13.54	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)	217,975	235,895	\$ 3,542,963 *	\$ 15.02	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	238	\$ 12,336	L1, C3	35
36	Medical Director	Monthly	42,000	L9, C3	36
37	Medical Records Consultant	21	1,372	L10, C3	37
38	Nurse Consultant	Monthly	2,704	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	99	4,814	L11, C3	44
45	Social Service Consultant	52	2,610	L12, C3	45
46	Other(specify)				46
47	Psychosocial	38	1,950	L12, C3	47
48					48
49	TOTAL (lines 35 - 48)	448	\$ 70,185		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,927	\$ 95,957	L10, C3	50
51	Licensed Practical Nurses	2,533	112,835	L10, C3	51
52	Certified Nurse Assistants/Aides	8	144	L10, C3	52
53	TOTAL (lines 50 - 52)	4,468	\$ 208,936		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

# 0038083

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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		
Kathy Dyhouse	Administrator	0	\$ 98,483	Workers' Compensation Insurance	\$ 38,044	IDPH License Fee	\$		
Donna Miskowicz	Administrator	0	14,147	Unemployment Compensation Insurance	37,920	Advertising: Employee Recruitment	58,591		
				FICA Taxes	260,413	Health Care Worker Background Check (Indicate # of checks performed <u>43</u> )	430		
				Employee Health Insurance	97,260	Patient Background Checks	5,570		
				Employee Meals	8,344	Miscellaneous licenses & permits	1,740		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	203		
				401 (k) Contributions	16,141	Allocation from Management Co	783		
				Other Employee Benefits	19,839				
				Life Insurance	6,496				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 112,630	TOTAL (agree to Schedule V, line 22, col.8)		\$ 67,317			
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	
			\$	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	5,815	
							Allocation from Management Co	2,024	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		
C. Professional Services							TOTAL		\$ 7,839
Vendor/Payee	Type		Amount						
Altschuler, Melvoin And Glasser LLP	Accounting		\$ 17,201						
RSM McGladrey	Accounting		10,640						
Aronberg Goldgehn Davis & Garisma	401 (k)		103						
Chicago Legal Clinic	Legal		594						
Gibson, Labus & Silverman	Accounting		435						
ING	401 (k) Administration		585						
James Samatas	Legal		100						
Personnel Planners	U/C Consulting		1,470						
Sachnoff & Weaver	Legal		6,642						
Scott & Krause	Legal		542						
See attached Schedule F			21,706						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 60,018						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Lexington Health Care Center of LaGrange, Inc.

FYE: 12/31/06

Medicaid Cost Report Workpapers

C:\Client\SNF Medicaid\Royals\Lexington - Orland Park COST REPORTS ONLY\YX40318\_Orland Park\_1206\Orland Park MCD\_WP\_1206-.xls]Page 21

Provider Number - 0038083

**Schedule F**

XIX. Support Schedules

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Systematic Management System	Accounting	2,969
Advanced Answers on Demand, Inc.	Computer Consulting	2,010
National Datacare Corporation	Computer Consulting	1,085
AdminaStar	Computer Consulting	363
Information Controls, Inc.	Computer Consulting	968
eHealth Solutions	Computer Consulting	2,400
Action Computer Service	Computer Consulting	324
Microsoft	Computer Consulting	2,509
Covad Communications	Computer Consulting	494
Krakau Business	Computer Consulting	1,080
Gigatrend	Computer Consulting	215
Visual Click	Computer Consulting	120
CDW	Computer Consulting	754
Lanac	Computer Consulting	1,431
Lintech	Computer Consulting	2,994
Royal/Shaker Advertising	Computer Consulting	<u>1,990</u>

Total, Other Professional Services 21,706

Plus Professional Services from Page 21 38,312

Total Professional Services Col 3 60,018

Allocated from management co.

James Samatas	Legal	33
RSM McGladrey	Accounting	381
ING Administration Fee	Accounting	109
Aronberg, Goldgehn, Davis	Accounting	5
Pension Administrators	401(K) Administration	640
Personnel Planners	U/C Consulting	8
Tax Caps	RE Tax Savings Co	96
Gene Whitehorn	Medicaid Reim Specialist	2,116
Lintech	Computer Consulting	4,415

7,803

Allocated from building partnership

James Samatas	Filing and recording fees	280
---------------	---------------------------	-----

Total, Agrees to Schedule V, Line 19, Column 8 68,101

**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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												
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 LaGrange# 0038083Report 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. \$ 29,988 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. \$ 68,787  
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. \$ 8,344 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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