



Facility Name & ID Number Lexington of Orland Park

# 0041855 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	270	Skilled (SNF)	270	98,550	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	270	TOTALS	270	98,550	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,621	619	11,017	17,257	8
9	SNF/PED					9
10	ICF	61,235	5,227	3,502	69,964	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,856	5,846	14,519	87,221	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.50%

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 07/08/96

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 270 and days of care provided 10,877

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 Orland Park      #      0041855      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	343,895	46,859	16,239	406,993		406,993	406,993			1
2	Food Purchase		371,049		371,049		371,049	(15,957)	355,092		2
3	Housekeeping	352,578	43,928		396,506		396,506	275	396,781		3
4	Laundry	50,311	24,289		74,600		74,600	4	74,604		4
5	Heat and Other Utilities			253,627	253,627		253,627	6,461	260,088		5
6	Maintenance	53,813		114,386	168,199		168,199	58,763	226,962		6
7	Other (specify):* <b>Allocated Benefits</b>							6,734	6,734		7
8	<b>TOTAL General Services</b>	800,597	486,125	384,252	1,670,974		1,670,974	56,280	1,727,254		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			65,650	65,650		65,650		65,650		9
10	Nursing and Medical Records	4,346,563	260,564	14,029	4,621,156		4,621,156	117,353	4,738,509		10
10a	Therapy			1,020,442	1,020,442		1,020,442		1,020,442		10a
11	Activities	271,839	27,497	6,858	306,194		306,194		306,194		11
12	Social Services	78,185		13,400	91,585		91,585		91,585		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Allocated Benefits</b>							14,363	14,363		15
16	<b>TOTAL Health Care and Programs</b>	4,696,587	288,061	1,120,379	6,105,027		6,105,027	131,716	6,236,743		16
	<b>C. General Administration</b>										
17	Administrative	152,798		1,312,236	1,465,034		1,465,034	(1,189,237)	275,797		17
18	Directors Fees										18
19	Professional Services			263,784	263,784		263,784	4,776	268,560		19
20	Dues, Fees, Subscriptions & Promotions			42,246	42,246		42,246	1,779	44,025		20
21	Clerical & General Office Expenses	387,961	34,869	31,859	454,689		454,689	408,488	863,177		21
22	Employee Benefits & Payroll Taxes			908,461	908,461		908,461	15,665	924,126		22
23	Inservice Training & Education			10,670	10,670		10,670		10,670		23
24	Travel and Seminar			20,416	20,416		20,416	4,592	25,008		24
25	Other Admin. Staff Transportation			1,567	1,567		1,567	16,309	17,876		25
26	Insurance-Prop.Liab.Malpractice			252,589	252,589		252,589	4,518	257,107		26
27	Other (specify):* <b>Allocated Benefits</b>							64,256	64,256		27
28	<b>TOTAL General Administration</b>	540,759	34,869	2,843,828	3,419,456		3,419,456	(668,854)	2,750,602		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,037,943	809,055	4,348,459	11,195,457		11,195,457	(480,858)	10,714,599		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Orland Park

#0041855

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

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			47,447	47,447		47,447	283,048	330,495			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,311	75,311		75,311	504,092	579,403			32
33	Real Estate Taxes							496,585	496,585			33
34	Rent-Facility & Grounds			1,933,353	1,933,353		1,933,353	(1,928,278)	5,075			34
35	Rent-Equipment & Vehicles			51,009	51,009		51,009	4,425	55,434			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,107,120	2,107,120		2,107,120	(640,128)	1,466,992			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		367,314	9,918	377,232		377,232		377,232			39
40	Barber and Beauty Shops			34,064	34,064		34,064		34,064			40
41	Coffee and Gift Shops			7,350	7,350		7,350		7,350			41
42	Provider Participation Fee			147,828	147,828		147,828		147,828			42
43	Other (specify):* <b>Nonallowable Cost</b>			173,211	173,211		173,211	(173,211)				43
44	<b>TOTAL Special Cost Centers</b>		367,314	372,371	739,685		739,685	(173,211)	566,474			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,037,943	1,176,369	6,827,950	14,042,262		14,042,262	(1,294,197)	12,748,065			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 Orland Park

# 0041855

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	(292)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,760)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	4	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(156)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(976)	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	(2)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,208)	43		24
25	Fund Raising, Advertising and Promotional	(13,079)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Page 5A</u>	47,038			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (98,431)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,195,766)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,195,766)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,294,197)		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 Orland Park

ID# 0041855

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Laboratory	\$ (6,466)	43	1
2	Disallow Radiology	(19,688)	43	2
3	Non-allowable collection fees	(7,627)	19	3
4	Non-allowable out of period legal fees	(5,420)	19	4
5	Non-allowable personal item replacement	(2,033)	43	5
6	Non-allowable meals and entertainment	(237)	43	6
7	Non-allowable trust fees	(75)	43	7
8	Fair value of interest rate swap	88,584	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	47,038		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Lexington of Orland Park

# 0041855

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(292)	0	0	0	0	0	0	0	0	0	0	(292)	2
3	Housekeeping	0	0	275	0	0	0	0	0	0	0	0	275	3
4	Laundry	4	0	0	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	0	6,461	0	0	0	0	0	0	0	0	6,461	5
6	Maintenance	0	0	58,763	0	0	0	0	0	0	0	0	58,763	6
7	Other (specify):*	0	0	6,734	0	0	0	0	0	0	0	0	6,734	7
8	<b>TOTAL General Services</b>	<b>(288)</b>	<b>0</b>	<b>72,233</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>71,945</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	3,840	113,513	0	0	0	0	0	0	0	117,353	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	14,364	0	0	0	0	0	0	0	14,364	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>3,840</b>	<b>127,877</b>	<b>0</b>	<b>131,717</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	0	122,999	(1,312,236)	0	0	0	0	0	0	0	(1,189,237)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,047)	118	17,705	0	0	0	0	0	0	0	0	4,776	19
20	Fees, Subscriptions & Promotions	0	0	1,779	0	0	0	0	0	0	0	0	1,779	20
21	Clerical & General Office Expenses	0	191	401,809	6,488	0	0	0	0	0	0	0	408,488	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	4,592	0	0	0	0	0	0	0	4,592	24
25	Other Admin. Staff Transportation	0	0	0	18,729	0	0	0	0	0	0	0	18,729	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	4,518	0	0	0	0	0	0	0	4,518	26
27	Other (specify):*	0	0	0	64,256	0	0	0	0	0	0	0	64,256	27
28	<b>TOTAL General Administration</b>	<b>(13,047)</b>	<b>309</b>	<b>544,292</b>	<b>(1,213,653)</b>	<b>0</b>	<b>(682,099)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(13,335)</b>	<b>309</b>	<b>620,365</b>	<b>(1,085,776)</b>	<b>0</b>	<b>(478,437)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Orland Park

# 0041855

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	0	243,794	0	39,254	0	0	0	0	0	0	0	283,048	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(156)	481,942	0	22,306	0	0	0	0	0	0	0	504,092	32
33	Real Estate Taxes	0	493,353	0	3,232	0	0	0	0	0	0	0	496,585	33
34	Rent-Facility & Grounds	0	(1,933,353)	0	5,075	0	0	0	0	0	0	0	(1,928,278)	34
35	Rent-Equipment & Vehicles	0	0	0	2,005	0	0	0	0	0	0	0	2,005	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(156)</b>	<b>(714,264)</b>	<b>0</b>	<b>71,872</b>	<b>0</b>	<b>(642,548)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	53,347	(88,509)	0	237	0	0	0	0	0	0	0	(34,925)	43
44	<b>TOTAL Special Cost Centers</b>	<b>53,347</b>	<b>(88,509)</b>	<b>0</b>	<b>237</b>	<b>0</b>	<b>(34,925)</b>	<b>44</b>						
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>39,856</b>	<b>(802,464)</b>	<b>620,365</b>	<b>(1,013,667)</b>	<b>0</b>	<b>(1,155,910)</b>	<b>45</b>						

Facility Name & ID Number Lexington of Orland Park

# 0041855

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

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas Discretionary Trust	30.00%			Lexington Health Care		
John Samatas Discretionary Trust	30.00%	See attached Schedule B		Systems of Orland		
Cynthia Thiem Discretionary Trust	30.00%			Park Ltd. Ptsp.	Orland Park	Real estate ptsp.
Dean Sweitzer	10.00%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional fees	\$	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	\$ 118	\$ 118	1
2	V	21 Clerical & Office Expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	191	191	2
3	V	30 Depreciation		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	243,794	243,794	3
4	V	32 Interest expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	475,389	475,389	4
5	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	6,553	6,553	5
6	V	33 Property taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	493,353	493,353	6
7	V	34 Rental Expense	1,933,353	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**		(1,933,353)	7
8	V	43 Trust fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	75	75	8
9	V	43 Unrealized gain on fair value of interest rate swap		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	(88,584)	(88,584)	9
10	V							10
11	V							11
12	V			**The owners of Lexington Health Care Center of Orland Park, Inc. own 100%				12
13	V			of Lexington Health Care Systems of Orland Park Ltd Ptsp.				13
14	Total		\$ 1,933,353			\$ 1,130,889	\$ * (802,464)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Orland Park, Inc.**

**Provider # 0041855**

**1/1/06 - 12/31/06**

**Schedule B**

VII. Related Parties

Related Nursing Homes

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

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington of Orland Park# 0041855Report 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	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 275	\$ 275	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	5,231	5,231	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	166	166	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,064	1,064	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	53,206	53,206	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,375	5,375	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	182	182	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	6,734	6,734	22	
23	V	10 Medical consultant		Royal Management Corp.	**	3,840	3,840	23	
24	V	17 Management allocation - salaries		Royal Management Corp.	**	122,999	122,999	24	
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	10,015	10,015	25	
26	V	19 Professional fees		Royal Management Corp.	**	7,690	7,690	26	
27	V	20 Dues & subscriptions		Royal Management Corp.	**	1,055	1,055	27	
28	V	20 Advertising - help wanted		Royal Management Corp.	**	724	724	28	
29	V	21 Management allocation - salaries		Royal Management Corp.	**	384,801	384,801	29	
30	V	21 Bank charges		Royal Management Corp.	**	511	511	30	
31	V	21 Office supplies & printing		Royal Management Corp.	**	12,266	12,266	31	
32	V	21 Postage		Royal Management Corp.	**	4,231	4,231	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 Orland Park, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 620,365	\$ * 620,365	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park# 0041855Report 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.	**	\$ 6,488	\$ 6,488	15
16	V	24	Travel & seminar		Royal Management Corp.	**	4,592	4,592	16
17	V	25	Auto expense		Royal Management Corp.	**	18,729	18,729	17
18	V	26	Insurance general		Royal Management Corp.	**	4,518	4,518	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	64,256	64,256	19
20	V	30	Depreciation - vehicles		Royal Management Corp.	**	6,059	6,059	20
21	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	8,398	8,398	21
22	V	30	Depreciation - equipment		Royal Management Corp.	**	24,797	24,797	22
23	V	32	Interest		Royal Management Corp.	**	22,266	22,266	23
24	V	32	Amortization of mortgage costs		Royal Management Corp.	**	40	40	24
25	V	33	Property taxes		Royal Management Corp.	**	3,232	3,232	25
26	V	34	Rent expense		Royal Management Corp.	**	5,075	5,075	26
27	V	35	Equipment rental		Royal Management Corp.	**	2,005	2,005	27
28	V	43	Travel & entertainment		Royal Management Corp.	**	237	237	28
29	V	17	Management fees	1,312,236	Royal Management Corp.	**		(1,312,236)	29
30	V	10	Management allocation salaries		Royal Management Corp.	**	113,513	113,513	30
31	V	15	Management allocation - employee benefits		Royal Management Corp.	**	14,364	14,364	31
32	V								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 Orland Park, Inc. own 100% of Royal Management Corp.						38
39	Total			\$ 1,312,236			\$ 298,569	\$ * (1,013,667)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 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	30.00%	See Schedule C	5.3	13%	Salary	\$ 41,559	L17, C7	1	
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00%	See Schedule C	5.3	13%	Salary	29,683	L17, C7	2	
3	Cynthia Thiem	Owner/officer	Administrative	30.00%	See Schedule C	5.3	13%	Salary	29,683	L17, C7	3	
4	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5.3	13%	Salary	22,074	L17, C7	4	
5	Daniel Thiem	Staff Accountant	Accounting	0.00%	See Schedule C	0.8	2%	Salary	5,010	L21, C7	5	
6	Jeremy Samatas	Corporate Director	Quality Assurance	0.00%	See Schedule C	5.3	13%	Salary	12,056	L10, C7	6	
7	Dean Sweitzer	Owner*	Administrative	10.00%	100,990	5.3	13%	Salary	15,439	L21, C7	7	
8											8	
9											9	
10		* Dean Sweitzer is an owner only in Lexington Health Care Center of Orland Park, Inc. He is an employee										10
11		of Royal Management Corp. and provides administrative services to Royal Management Corp. His compensation										11
12		has been allocated to all 10 Lexington facilities.										12
13								TOTAL	\$ 155,504		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 Orland Park

# 0041855 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	744,965	10	\$ 2,086		98,550	\$ 275	1
2	5	Utilities - gas & electric	744,965	10	39,549		98,550	5,231	2
3	5	Utilities - water & sewer	744,965	10	1,244		98,550	166	3
4	5	Utilities - maintenance office	744,965	10	8,043		98,550	1,064	4
5	6	Management allocation - salaries	744,965	10	402,200	402,200	98,550	53,206	5
6	6	Repairs & maintenance	744,965	10	40,648		98,550	5,375	6
7	6	Scavenger & exterminating	744,965	10	1,366		98,550	182	7
8	7	Management allocation - employe	744,965	10	50,893		98,550	6,734	8
9	10	Medical consultant	744,965	10	29,034		98,550	3,840	9
10	17	Management allocation - salaries	744,965	10	929,789	929,789	98,550	122,999	10
11	19	Computer consultant & supplies	744,965	10	75,717		98,550	10,015	11
12	19	Professional fees	744,965	10	58,113		98,550	7,690	12
13	20	Dues & subscriptions	744,965	10	7,935		98,550	1,055	13
14	20	Advertising - help wanted	744,965	10	5,488		98,550	724	14
15	21	Management allocation - salaries	744,965	10	2,908,810	2,908,810	98,550	384,801	15
16	21	Bank charges	744,965	10	3,883		98,550	511	16
17	21	Office supplies & printing	744,965	10	92,737		98,550	12,266	17
18	21	Postage	744,965	10	31,985		98,550	4,231	18
19	21	Telephone	744,965	10	49,035		98,550	6,488	19
20	24	Travel and seminar	744,965	10	34,717		98,550	4,592	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,773,272	\$ 4,240,799		\$ 631,445	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

# 0041855 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	744,965	10	\$ 141,593	\$	98,550	\$ 18,729	1
2	26	Insurance general	744,965	10	34,142		98,550	4,518	2
3	27	Management allocation - employe	744,965	10	485,728		98,550	64,256	3
4	30	Depreciation - vehicles	744,965	10	45,792		98,550	6,059	4
5	30	Depreciation - leasehold improv.	744,965	10	63,466		98,550	8,398	5
6	30	Depreciation - equipment	744,965	10	187,456		98,550	24,797	6
7	32	Interest	744,965	10	168,318		98,550	22,266	7
8	32	Amortization of mortgage costs	744,965	10	299		98,550	40	8
9	33	Property taxes	744,965	10	24,448		98,550	3,232	9
10	34	Rent expense	744,965	10	38,371		98,550	5,075	10
11	35	Equipment rental	744,965	10	15,142		98,550	2,005	11
12	43	Travel & entertainment	744,965	10	1,795		98,550	237	12
13	10	Management allocation salaries	744,965	10	858,074	858,074	98,550	113,513	13
14	15	Management allocation - employe	744,965	10	108,579		98,550	14,364	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		\$ 287,489	25

SEE ACCOUNTANTS' COMPILATION REPORT

**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		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 Services						\$	\$		\$	1						
2	L.L.C.	X		Mortgage	Varies	12/29/98	9,000,000	7,559,163	02/01/2026	Variable	475,429	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	LaSalle Bank N.A.		X	Line of credit	Varies	04/06/02	1,650,000	625,000	5/31/2007	Prime	75,311	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 10,650,000	\$ 8,184,163			\$ 550,740	9					
<b>B. Non-Facility Related*</b>																	
10										Amortization of loan costs	6,553	10					
11										Interest income offset	(156)	11					
12										Allocated from management company	22,266	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 28,663	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 10,650,000	\$ 8,184,163			\$ 579,403	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.)

Facility Name & ID Number Lexington of Orland Park# 0041855 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>501,000</b>	1
		Allocated from management company		3,232	
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>491,839</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(5,929)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>507,000</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>16,117</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>** 1998, 1999, 2003</b> <b>TOTAL REFUND \$ 20,603 For ** Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>(20,603)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>496,585</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2001	<u>455,748</u>	<u>8</u>			
2002	<u>435,909</u>	<u>9</u>			
2003	<u>448,025</u>	<u>10</u>			
2004	<u>486,436</u>	<u>11</u>			
2005	<u>491,839</u>	<u>12</u>			
<b>2005 tax bill paid</b>	<b>491,839</b>				
<b>Est. tax with 3% increase:</b>	<b>506,594</b>				
<b>Use:</b>	<b>507,000</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:

- Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
- 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,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lexington of Orland Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

CONTACT PERSON REGARDING THIS REPORT Sue Rojek

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

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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>27-10-100-099-0000</u>	<u>Land &amp; Building</u>	<u>\$ 491,838.96</u>	<u>\$ 491,838.96</u>
2. _____	_____	\$ _____	\$ _____
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>	_____	<u>\$ 126,705.00</u>	<u>\$ 2,683.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ <u>618,543.96</u></b>	<b>\$ <u>494,521.96</u></b>

B. **Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 Orland Park

# 0041855 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block & 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).

NA

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>152,460</u>	<u>1995</u>	<u>\$ 776,408</u>	<u>1</u>
2	<u>Allocated from Management Company</u>		<u>2002</u>	<u>21,315</u>	<u>2</u>
3	<b>TOTALS</b>	<b>152,460</b>		<b>\$ 797,723</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park# 0041855

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	250		1996	1996	\$ 8,455,949	\$	40	\$ 240,180	\$ 240,180	\$ 2,221,544	4
5	10		1998	1998	63,790	1,595	40	1,595		12,758	5
6	10		2001	2001							6
7											7
8											8
	<b>Improvement Type**</b>										
9	Electrical wiring		1996		2,304	58	40	58		586	9
10	Paving		1997		11,589		40	773	773	7,340	10
11	Additional building costs		1996		113,337		40	2,833	2,833	28,330	11
12	Wiring		1998		3,932	393	10	393		3,342	12
13	Additional building costs - 10 bed addition		1999		1,808	45	40	45		362	13
14	Seal/restrip parking lot		1999		3,450	230	15	230		1,725	14
15	Wiring		1999		1,798	45	40	45		337	15
16	Roof repairs		2000		23,201	1,547	15	1,547		10,054	16
17	Electrical wiring		2000		5,732	164	35	164		1,065	17
18	Ceiling mount curtain rod hardware		2000		6,952	199	35	199		1,291	18
19	Automatic door closer/sensors		2000		3,624	242	15	242		1,570	19
20	Seal and restripe parking lot		2001		2,277	228	10	228		1,252	20
21	HVAC control		2001		2,548	255	10	255		1,401	21
22	Infrared curtains for elevator doors		2001		4,500	450	10	450		2,475	22
23	Fire alarm panel		2002		5,120	512	10	512		2,304	23
24	Parking lot lights		2002		9,975	998	10	998		4,489	24
25	Chiller room compressor		2002		8,879	1,776	5	1,776		7,991	25
26	Carpeting		2002		7,037	1,408	5	1,408		6,334	26
27	Pave and seal parking lot		2005		4,180	209	20	209		279	27
28	HVAC		2005		6,143	307	20	307		333	28
29	Electrical wiring		2005		3,637	182	20	182		212	29
30	Kitchen rehab		2005		6,360	318	20	318		556	30
31	Elevator rehab		2005		8,948	447	20	447		746	31
32	Lounge, lobby, and reception area rehab		2005		27,663	1,383	20	1,383		1,614	32
33	Landscaping enhancements		2006		5,795	129	15	129		129	33
34	HVAC		2006		9,300	39	20	39		39	34
35	LHI-therapy room rehab LL TCU/main therapy		2006		33,184	553	20	553		553	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 Orland Park

# 0041855

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	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53	Land improvements - management company	2002	33,594	15	2,096	2,096	11,011	53
54	Building - management company	2002	261,353	40	6,110	6,110	32,125	54
55	HVAC, electrical, security system - management company	2003	2,592	30	181	181	607	55
56	Key card system - management company	2004	407	20	11	11	49	56
57	VAV TX controls - management company	2005	124	20	3	3	11	57
58	Interior Signs - Management Company	2006	90		1	1	1	58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 9,141,173	\$ 13,712	\$ 265,900	\$ 252,188	\$ 2,364,815	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 260,624	\$ 30,423	\$ 30,423	\$	5-10	\$ 173,700	71
72	Current Year Purchases	65,420	3,316	3,316		5-10	3,316	72
73	Fully Depreciated Assets	53,777				5-10	53,777	73
74	Allocated from management co.	253,076		24,797	24,797		113,133	74
75	TOTALS	\$ 632,897	\$ 33,739	\$ 58,536	\$ 24,797		\$ 343,926	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 co.			69,174		6,059	6,059		47,319	79
80	TOTALS			\$ 69,174	\$	\$ 6,059	\$ 6,059		\$ 47,319	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)	\$ 10,640,967	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 47,451	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 330,495	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 283,044	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,756,060	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	1st Floor Remodel	\$ 126,266	92
93	Therapy room renovation	978	93
94	Basement renovation	20,192	94
95		\$ 147,436	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



**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	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)	
<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	\$	5,766	\$ 403,593	\$	5,766	\$ 403,593	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,531	82,503		1,531	82,503	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		10,199	533,913		10,199	533,913	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				367,314		367,314	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Wound Care Other (specify): <u>dentist/diagnostics ma</u>	L39, C3 L39, C3				5,207 4,711			5,207 4,711	13
14	TOTAL			\$	17,496	\$ 1,029,927	\$ 367,314	17,496	\$ 1,397,241	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 Orland Park# 0041855Report 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 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 377,660	\$ 380,715	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>1,749,699</u> )	2,929,222	2,929,222	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	207,144	207,144	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,000	1,000	8
9	Other(specify): <u>Due from ins. Carrier</u>	1,461	1,461	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,516,487	\$ 3,519,542	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	90,908	90,908	12
13	Land		797,723	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	262,137	571,887	15
16	Equipment, at Historical Cost	394,965	702,071	16
17	Accumulated Depreciation (book methods)	(294,601)	(2,756,060)	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 (spe <u>Construction in progr</u> )	147,436	147,436	22
23	Other(specify): <u>Unamortized mortgage costs</u>		113,200	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 600,845	\$ 8,236,451	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,117,332	\$ 11,755,993	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 255,887	\$ 255,887	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	625,000	625,000	29
30	Accrued Salaries Payable	332,665	332,665	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,079	16,079	31
32	Accrued Real Estate Taxes(Sch.IX-B)		507,000	32
33	Accrued Interest Payable		24,860	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>	389,781	389,781	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,619,412	\$ 2,151,272	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		7,559,163	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Interest rate swap liability</u>	28,024	91,357	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 28,024	\$ 7,650,520	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,647,436	\$ 9,801,792	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,469,896	\$ 1,954,201	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,117,332	\$ 11,755,993	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington Health Care Center of Orland Park, Inc.  
Provider # 0041855  
1/1/06 - 12/31/06

Schedule 17a

XV. Balance Sheet  
C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due from royal	20,948	20,948
Due from -	1,900	1,900
Bond Withholding	870	870
401k withholding	4,762	4,762
Accrued 401k	12,774	12,774
Due to - Lexington Financial	503	503
Due to - Republic construction	17,585	17,585
Accrued expenses	327,294	327,294
Accrued royl genl mgmt fees	4,319	4,319
Accrued wage assignment	(1,174)	(1,174)
Total line 36	<u>389,781</u>	<u>389,781</u>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,525,629	1
2	Restatements (describe):		2
3	Post closing adjustments	334,705	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,860,334	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	909,562	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	(300,000)	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)	\$ 609,562	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,469,896	24 *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park

# 0041855

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 19,292,858	1
2	Discounts and Allowances for all Levels	(6,953,219)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,339,639	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,872,409	6
7	Oxygen	210	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,872,619	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	9,193	12
13	Barber and Beauty Care	40,612	13
14	Non-Patient Meals	292	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	366,509	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,962	19
20	Radiology and X-Ray	19,846	20
21	Other Medical Services	240,657	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 702,071	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	156	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 156	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Investment income	5,868	28
28a	Rental & Inter-facility help income	31,471	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 37,339	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,951,824	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,670,974	31
32	Health Care	6,105,027	32
33	General Administration	3,419,456	33
<b>B. Capital Expense</b>			
34	Ownership	2,107,120	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	591,857	35
36	Provider Participation Fee	147,828	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,042,262	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	909,562	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 909,562	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 Orland Park

# 0041855

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	1,962	2,172	\$ 110,857	\$ 51.04	1
2	Assistant Director of Nursing	6,792	7,359	243,399	33.08	2
3	Registered Nurses	27,397	29,454	944,739	32.08	3
4	Licensed Practical Nurses	46,255	50,267	1,318,060	26.22	4
5	CNAs & Orderlies	132,563	142,468	1,577,640	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,668	11,496	133,302	11.60	8
9	Activity Director	3,520	3,698	54,023	14.61	9
10	Activity Assistants	21,991	23,633	217,816	9.22	10
11	Social Service Workers	3,447	3,783	78,185	20.67	11
12	Dietician	1,961	2,089	29,387	14.07	12
13	Food Service Supervisor	2,041	2,170	36,127	16.65	13
14	Head Cook	2,017	2,170	27,727	12.78	14
15	Cook Helpers/Assistants	13,479	14,656	119,376	8.15	15
16	Dishwashers	18,068	19,416	131,278	6.76	16
17	Maintenance Workers	4,098	4,398	53,813	12.24	17
18	Housekeepers	44,395	47,934	352,578	7.36	18
19	Laundry	6,755	7,344	50,311	6.85	19
20	Administrator	1,498	1,749	152,798	87.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,283	25,978	387,961	14.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,292	1,364	18,566	13.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	374,482	403,598	\$ 6,037,943 *	\$ 14.96	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	298	\$ 16,239	L1, C3	35
36	Medical Director	Monthly	65,650	L9, C3	36
37	Medical Records Consultant	33	2,032	L10, C3	37
38	Nurse Consultant	83	5,910	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	120	5,801	L11, C3	44
45	Social Service Consultant	104	5,210	L12, C3	45
46	Other(specify) <u>Psychosocial</u>	158	8,190	L12, C3	46
47	<u>Rehabcare</u>	Monthly	775	L10, C3	47
48	<u>MDS</u>	56	2,912	L10, C3	48
49	TOTAL (lines 35 - 48)	852	\$ 115,119		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Lexington Health Care Center of Orland Park, Inc.

FYE: 12/31/06

Medicaid Cost Report Workpapers

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Provider Number - 0041855

**Schedule F**

XIX. Support Schedules

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
RSM McGladrey	Accounting	6,779
Sachnoff & Weaver	Legal	135,000
Systematic Management System	Billing Services	7,910
Scott & Krause	Legal	1,083
Covad Communications	Computer Consulting	570
National Data Care Group	Computer Consulting	3,593
Information Controls, Inc.	Computer Consulting	1,402
AAOD	Computer Consulting	2,010
eHealth Solutions	Computer Consulting	2,800
Adminastar	Computer Consulting	363
Krakau Business	Computer Consulting	696
Action Computer Service	Computer Consulting	433
Microsoft	Computer Consulting	3,036
Gigatrend	Computer Consulting	215
Visual Click	Computer Consulting	120
CDW	Computer Consulting	899
Lanac	Computer Consulting	2,349
Lintech	Computer Consulting	2,994
Royal Shaker Advertising	Computer Consulting	1,990
Total, Other Professional Services		<u>174,242</u>
Plus Professional Services from page 21		89,542
Total Professional Services:		<u>263,784</u>

Allocated from management co.

James Samatas		76
AM&G		596
RSM McGladrey		270
ING Administration Fee		248
Aronberg, Goldgehn, Davis		10
Pension Administrators		1,454
Personnel Planners		16
Tax Caps		218
Gene Whitehorn		4,800
Lintech		10,015

Allocated from building partnership

James Samatas	Filing and recording fees	118
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Non-allowable legal

Grabowski Law Center, LLC (collections)		(7,627)
Cassiday, Schade, & Gloor (Out of period fees)		(5,045)
Sachnoff & Weaver		(373)

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

268,560

**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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Orland Park

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 66,588 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. \$ 147,828  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 15,665 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 292
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**