

Facility Name & ID Number Lexington of Schaumburg

0036095 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	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,913	463	8,895	14,271	8
9	SNF/PED					9
10	ICF	49,430	6,297	2,869	58,596	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,343	6,760	11,764	72,867	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.12%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 4/1/90

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

YES Date New Construction NO

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

YES NO If YES, enter number of beds certified 224 and days of care provided 8,146

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 Schaumburg # 0036095 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	349,096	31,744	15,435	396,275		396,275		396,275		1
2	Food Purchase		303,938		303,938		303,938	(13,650)	290,288		2
3	Housekeeping	315,072	39,976		355,048		355,048	229	355,277		3
4	Laundry	74,989	21,302		96,291		96,291	280	96,571		4
5	Heat and Other Utilities			220,116	220,116		220,116	5,360	225,476		5
6	Maintenance	35,793		127,733	163,526		163,526	48,752	212,278		6
7	Other (specify):* Allocated Benefits							5,586	5,586		7
8	TOTAL General Services	774,950	396,960	363,284	1,535,194		1,535,194	46,557	1,581,751		8
	B. Health Care and Programs										
9	Medical Director			39,000	39,000		39,000		39,000		9
10	Nursing and Medical Records	4,248,633	230,345	82,433	4,561,411		4,561,411	97,360	4,658,771		10
10a	Therapy			750,379	750,379		750,379		750,379		10a
11	Activities	228,900	25,928	5,799	260,627		260,627		260,627		11
12	Social Services	62,264		6,461	68,725		68,725		68,725		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Allocated Benefits							11,917	11,917		15
16	TOTAL Health Care and Programs	4,539,797	256,273	884,072	5,680,142		5,680,142	109,277	5,789,419		16
	C. General Administration										
17	Administrative	109,917		1,089,009	1,198,926		1,198,926	(986,965)	211,961		17
18	Directors Fees										18
19	Professional Services			73,128	73,128		73,128	14,583	87,711		19
20	Dues, Fees, Subscriptions & Promotions			26,245	26,245		26,245	1,473	27,718		20
21	Clerical & General Office Expenses	264,220	27,314	32,027	323,561		323,561	338,386	661,947		21
22	Employee Benefits & Payroll Taxes			866,371	866,371		866,371	13,618	879,989		22
23	Inservice Training & Education			1,076	1,076		1,076		1,076		23
24	Travel and Seminar			10,955	10,955		10,955	3,810	14,765		24
25	Other Admin. Staff Transportation			1,457	1,457		1,457	13,532	14,989		25
26	Insurance-Prop.Liab.Malpractice			229,747	229,747		229,747	3,747	233,494		26
27	Other (specify):* Allocated Benefits							53,308	53,308		27
28	TOTAL General Administration	374,137	27,314	2,330,015	2,731,466		2,731,466	(544,508)	2,186,958		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,688,884	680,547	3,577,371	9,946,802		9,946,802	(388,674)	9,558,128		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 Schaumburg

#0036095

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			98,479	98,479		98,479	204,117	302,596			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,523	69,523		69,523	367,385	436,908			32
33	Real Estate Taxes							418,153	418,153			33
34	Rent-Facility & Grounds			1,615,470	1,615,470		1,615,470	(1,611,259)	4,211			34
35	Rent-Equipment & Vehicles			9,194	9,194		9,194	3,670	12,864			35
36	Other (specify):*											36
37	TOTAL Ownership			1,792,666	1,792,666		1,792,666	(617,934)	1,174,732			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		279,017		279,017		279,017		279,017			39
40	Barber and Beauty Shops			26,070	26,070		26,070		26,070			40
41	Coffee and Gift Shops			6,885	6,885		6,885		6,885			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable Cost			111,784	111,784		111,784	(111,784)				43
44	TOTAL Special Cost Centers		279,017	267,379	546,396		546,396	(111,784)	434,612			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,688,884	959,564	5,637,416	12,285,864		12,285,864	(1,118,392)	11,167,472			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(32)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,690)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	280	4		8
9	Non-Straightline Depreciation	(6,451)	30		9
10	Interest and Other Investment Income	(34)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,001)	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	(198)	43		19
20	Contributions	(485)	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	(66,722)	43		24
25	Fund Raising, Advertising and Promotional	(14,111)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(251)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	38,126			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,569)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,062,823)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,062,823)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,118,392)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Schaumburg

ID# 0036095

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Laboratory	\$ (4,475)	43	1
2	Radiology	(11,712)	43	2
3	Personal Item Replacement	(1,025)	43	3
4	Collections	(7,335)	43	4
5	Offset Miscellaneous Income	(487)	21	5
6	Out of period legal	(385)	19	6
7	Fair value of interest rate swap	63,595	43	7
8	Trust Fees	(50)	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
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	38,126		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Schaumburg# 0036095

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(32)	0	0	0	0	0	0	0	0	0	0	(32)	2
3	Housekeeping	0	0	229	0	0	0	0	0	0	0	0	229	3
4	Laundry	280	0	0	0	0	0	0	0	0	0	0	280	4
5	Heat and Other Utilities	0	0	5,360	0	0	0	0	0	0	0	0	5,360	5
6	Maintenance	0	0	48,752	0	0	0	0	0	0	0	0	48,752	6
7	Other (specify):*	0	0	5,586	0	0	0	0	0	0	0	0	5,586	7
8	TOTAL General Services	248	0	59,927	0	0	0	0	0	0	0	0	60,175	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	3,186	94,174	0	0	0	0	0	0	0	97,360	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	11,917	0	0	0	0	0	0	0	11,917	15
16	TOTAL Health Care and Programs	0	0	3,186	106,091	0	109,277	16						
	C. General Administration													
17	Administrative	0	0	102,044	(1,089,009)	0	0	0	0	0	0	0	(986,965)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(385)	280	14,688	0	0	0	0	0	0	0	0	14,583	19
20	Fees, Subscriptions & Promotions	0	0	1,473	0	0	0	0	0	0	0	0	1,473	20
21	Clerical & General Office Expenses	(487)	135	333,356	5,382	0	0	0	0	0	0	0	338,386	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	3,810	0	0	0	0	0	0	0	3,810	24
25	Other Admin. Staff Transportation	0	0	0	15,540	0	0	0	0	0	0	0	15,540	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,747	0	0	0	0	0	0	0	3,747	26
27	Other (specify):*	0	0	0	53,308	0	0	0	0	0	0	0	53,308	27
28	TOTAL General Administration	(872)	415	451,561	(1,007,222)	0	(556,118)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(624)	415	514,674	(901,131)	0	(386,666)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Schaumburg# 0036095

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	(6,451)	178,004	0	32,564	0	0	0	0	0	0	0	204,117	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34)	348,913	0	18,506	0	0	0	0	0	0	0	367,385	32
33	Real Estate Taxes	0	415,470	0	2,683	0	0	0	0	0	0	0	418,153	33
34	Rent-Facility & Grounds	0	(1,615,470)	0	4,211	0	0	0	0	0	0	0	(1,611,259)	34
35	Rent-Equipment & Vehicles	0	0	0	1,662	0	0	0	0	0	0	0	1,662	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,485)	(673,083)	0	59,626	0	(619,942)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(48,460)	(63,521)	0	197	0	0	0	0	0	0	0	(111,784)	43
44	TOTAL Special Cost Centers	(48,460)	(63,521)	0	197	0	(111,784)	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(55,569)	(736,189)	514,674	(841,308)	0	(1,118,392)	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Schaumburg		
				Ltd. Ptsp.	Schaumburg	Real estate ptsp.
				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	\$	Sambell of Schaumburg Limited Partnership	**	\$ 280	\$	280	1	
2	V	21 Office supplies		Sambell of Schaumburg Limited Partnership	**	135		135	2	
3	V	30 Depreciation		Sambell of Schaumburg Limited Partnership	**	178,004		178,004	3	
4	V	32 Amortization of mortgage costs		Sambell of Schaumburg Limited Partnership	**	6,902		6,902	4	
5	V	32 Interest expense		Sambell of Schaumburg Limited Partnership	**	342,011		342,011	5	
6	V	33 Property taxes		Sambell of Schaumburg Limited Partnership	**	415,470		415,470	6	
7	V	34 Rental expense	1,615,470	Sambell of Schaumburg Limited Partnership	**			(1,615,470)	7	
8	V	43 State replacement tax		Sambell of Schaumburg Limited Partnership	**	24		24	8	
9	V	43 Trust fees		Sambell of Schaumburg Limited Partnership	**	50		50	9	
10	V	43 Unrealized gain on fair value of an interest rate swap		Sambell of Schaumburg Limited Partnership	**	(63,595)		(63,595)	10	
11	V			Sambell of Schaumburg Limited Partnership	**				11	
12	V								12	
13	V	**The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Sambell of Schaumburg Limited Partnership.								13
14	Total		\$ 1,615,470			\$ 879,281	\$ *	(736,189)	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Schaumburg, Inc.

Provider # 0036095

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%

Related Nursing Homes

City

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 Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 229	\$	229	15	
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,340		4,340	16	
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	137		137	17	
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	883		883	18	
19	V	6 Management allocation - salaries		Royal Management Corp.	**	44,141		44,141	19	
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,461		4,461	20	
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	150		150	21	
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,586		5,586	22	
23	V	10 Medical consultant		Royal Management Corp.	**	3,186		3,186	23	
24	V	17 Management allocation - salaries		Royal Management Corp.	**	102,044		102,044	24	
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	8,310		8,310	25	
26	V	19 Professional fees		Royal Management Corp.	**	6,378		6,378	26	
27	V	20 Dues & subscriptions		Royal Management Corp.	**	871		871	27	
28	V	20 Advertising - help wanted		Royal Management Corp.	**	602		602	28	
29	V	21 Management allocation - salaries		Royal Management Corp.	**	319,242		319,242	29	
30	V	21 Bank charges		Royal Management Corp.	**	426		426	30	
31	V	21 Office supplies & printing		Royal Management Corp.	**	10,178		10,178	31	
32	V	21 Postage		Royal Management Corp.	**	3,510		3,510	32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V	** Certain owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Royal Management Corp.								38
39	Total		\$			\$ 514,674	\$ *	514,674	39	

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 5,382	\$	5,382	15
16	V	24 Travel & seminar		Royal Management Corp.	**	3,810		3,810	16
17	V	25 Auto expense		Royal Management Corp.	**	15,540		15,540	17
18	V	26 Insurance general		Royal Management Corp.	**	3,747		3,747	18
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	53,308		53,308	19
20	V	30 Depreciation - vehicles		Royal Management Corp.	**	5,026		5,026	20
21	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	6,965		6,965	21
22	V	30 Depreciation - equipment		Royal Management Corp.	**	20,573		20,573	22
23	V	32 Interest		Royal Management Corp.	**	18,473		18,473	23
24	V	32 Amortization of mortgage costs		Royal Management Corp.	**	33		33	24
25	V	33 Property taxes		Royal Management Corp.	**	2,683		2,683	25
26	V	34 Rent expense		Royal Management Corp.	**	4,211		4,211	26
27	V	35 Equipment rental		Royal Management Corp.	**	1,662		1,662	27
28	V	17 Management fees	1,089,009	Royal Management Corp.	**			(1,089,009)	28
29	V	43 Travel & Entertainment		Royal Management Corp.	**	197		197	29
30	V	10 Management allocation - salaries		Royal Management Corp.	**	94,174		94,174	30
31	V	15 Management allocation - employee benefits		Royal Management Corp.	**	11,917		11,917	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,089,009			\$ 247,701	\$ *	(841,308)	39

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

Facility Name & ID Number

Lexington of Schaumburg

0036095

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	4.4	11.00	Salary	\$ 34,478	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33%	See Schedule C	4.4	11.00	Salary	24,627	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34%	See Schedule C	4.4	11.00	Salary	24,627	L17, C7	3
4	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	4.4	11.00	Salary	18,312	L17, C7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00%	See Schedule C	2.2	5.50	Salary	4,158	L21, C7	5
6	Jeremy Samatas	Corporate Director	Quality Assurance	0.00%	See Schedule C	4.4	11.00	Salary	10,006	L10, C7	6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 116,208		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping supplies	Bed Days	744,965	10	\$ 2,086	\$ 81,760	\$ 229	1	
2	5	Utilities - gas & electric	Bed Days	744,965	10	39,549	81,760	4,340	2	
3	5	Utilities - water & sewer	Bed Days	744,965	10	1,244	81,760	137	3	
4	5	Utilities - maintenance office	Bed Days	744,965	10	8,043	81,760	883	4	
5	6	Management allocation - salaries	Bed Days	744,965	10	402,200	402,200	81,760	44,141	5
6	6	Repairs & maintenance	Bed Days	744,965	10	40,648	81,760	4,461	6	
7	6	Scavenger & exterminating	Bed Days	744,965	10	1,366	81,760	150	7	
8	7	Management allocation - employee	Bed Days	744,965	10	50,893	81,760	5,586	8	
9	10	Medical consultant	Bed Days	744,965	10	29,034	81,760	3,186	9	
10	17	Management allocation - salaries	Bed Days	744,965	10	929,789	929,789	81,760	102,044	10
11	19	Computer consultant & supplies	Bed Days	744,965	10	75,717	81,760	8,310	11	
12	19	Professional fees	Bed Days	744,965	10	58,113	81,760	6,378	12	
13	20	Dues & subscriptions	Bed Days	744,965	10	7,935	81,760	871	13	
14	20	Advertising - help wanted	Bed Days	744,965	10	5,488	81,760	602	14	
15	21	Management allocation - salaries	Bed Days	744,965	10	2,908,810	2,908,810	81,760	319,242	15
16	21	Bank charges	Bed Days	744,965	10	3,883	81,760	426	16	
17	21	Office supplies & printing	Bed Days	744,965	10	92,737	81,760	10,178	17	
18	21	Postage	Bed Days	744,965	10	31,985	81,760	3,510	18	
19	21	Telephone	Bed Days	744,965	10	49,035	81,760	5,382	19	
20	24	Travel and seminar	Bed Days	744,965	10	34,717	81,760	3,810	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,773,272	\$ 4,240,799	\$ 523,866	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg

0036095 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	744,965	10	\$ 141,593	\$ 81,760	\$ 15,540	1
2	26	Insurance general	Bed Days	744,965	10	34,142	81,760	3,747	2
3	27	Management allocation - employee	Bed Days	744,965	10	485,728	81,760	53,308	3
4	30	Depreciation - vehicles	Bed Days	744,965	10	45,792	81,760	5,026	4
5	30	Depreciation - leasehold improv.	Bed Days	744,965	10	63,466	81,760	6,965	5
6	30	Depreciation - equipment	Bed Days	744,965	10	187,456	81,760	20,573	6
7	32	Interest	Bed Days	744,965	10	168,318	81,760	18,473	7
8	32	Amortization of mortgage costs	Bed Days	744,965	10	299	81,760	33	8
9	33	Property taxes	Bed Days	744,965	10	24,448	81,760	2,683	9
10	34	Rent expense	Bed Days	744,965	10	38,371	81,760	4,211	10
11	35	Equipment rental	Bed Days	744,965	10	15,142	81,760	1,662	11
12	43	Travel & Entertainment	Bed Days	744,965	10	1,795	81,760	197	12
13	10	Management allocation-salaries	Bed Days	744,965	10	858,074	858,074	94,174	13
14	15	Management allocation-benefits	Bed Days	744,965	10	108,579	81,760	11,917	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,173,203	\$ 858,074	\$ 238,509	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Schaumburg

0036095

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	2	3	4	5	6	7	8	9	10	Reporting Period Interest Expense											
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
													YES	NO				Original	Balance		
A. Directly Facility Related																					
Long-Term																					
1	Lexington Financial	X		Mortgage	Varies	4/25/01	\$ 6,200,000	\$ 5,452,500	2/1/2026	Variable	\$ 342,011	1									
2	Services, L.L.C											2									
3												3									
4												4									
5												5									
Working Capital																					
6	LaSalle Bank N.A.		X	Working Capital	Varies	4/6/02	1,350,000	475,000	5/31/07	Prime	69,523	6									
7												7									
8												8									
9	TOTAL Facility Related						\$ 7,550,000	\$ 5,927,500			\$ 411,534	9									
B. Non-Facility Related*																					
10										Amortization of loan costs	6,902	10									
11										Interest Income Offset	(34)	11									
12										Allocated from management company	18,506	12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$ 25,374	14									
15	TOTALS (line 9+line14)						\$ 7,550,000	\$ 5,927,500			\$ 436,908	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.)

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 Schaumburg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036095

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4796

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>07-27-201-039-000</u>	<u>Land & Building</u>	\$ <u>386,810.39</u>	\$ <u>386,810.39</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>126,705.00</u>	\$ <u>2,683.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>513,515.39</u>	\$ <u>389,493.39</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Lexington of Schaumburg

0036095

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,541 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>230,000</u>	<u>1988</u>	<u>\$ 211,532</u>	<u>1</u>
2	<u>Allocated from Management Company</u>		<u>2002</u>	<u>17,683</u>	<u>2</u>
3	TOTALS	230,000		\$ 229,215	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg# 0036095

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	215	1990	1990	\$ 5,865,346	\$	35	\$ 167,581	\$ 167,581	\$ 2,854,155	4
5	9	1995	1995	146,217	4,178	35	4,178		48,043	5
6										6
7										7
8										8
	Improvement Type**									
9	Building improvements		1991	3,521		10			3,491	9
10	Building improvements		1992	859	25	35	25		357	10
11	Land improvements		1992	5,764		20	288	288	4,178	11
12	Land improvements		1992	5,000		20	250	250	3,375	12
13	Building improvements		1993	12,368		10			12,368	13
14	Fan coil units in offices		1996	5,149	147	35	147		1,545	14
15	Basement rehab		1997	14,697	1,470	10	1,470		14,452	15
16	Brick		1997	1,500	43	35	43		404	16
17	Dining room rehab		1997	6,422	642	10	642		5,994	17
18	Parking lot repave and restripe		1998	2,777	278	10	278		2,360	18
19	Wiring		1998	3,667	367	10	367		3,117	19
20	Retile 2nd and 3rd floor corridors		1998	10,100	1,010	10	1,010		8,585	20
21	Plumbing for HVAC		1998	2,263		5			2,263	21
22	Lobby-floor tile		1999	7,478	748	10	748		5,858	22
23	Wallpaper-labor		1999	9,705	970	10	970		7,521	23
24	New patio		1999	19,039	1,269	15	1,269		9,202	24
25	New pay phone/wiring		1999	2,975	298	10	298		2,157	25
26	Roof repairs		2000	9,625	963	10	963		6,256	26
27	Water heater		2000	6,688	669	10	669		4,347	27
28	Automatic door		2000	1,300	130	10	130		845	28
29	Rehab project - paint resident rooms, carpet hallways, and tile		2000	52,760	5,276	10	5,276		34,294	29
30	Water heater and storage tanks		2001	12,102	1,210	10	1,210		7,261	30
31	Garbage area		2001	4,788	479	20	479		2,633	31
32										32
33										33
34										34
35										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 Schaumburg# 0036095

Report Period Beginning:

01/01/2006 Ending: 12/31/2006**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Roof	2002	\$ 25,600	\$ 2,560	10	\$ 2,560	\$	\$ 11,094	37
38	Facility rehab - paint resident rooms, carpet hallways, and tile	2002	327,253	16,363	20	16,363		88,187	38
39	Elevator electronic curtain	2002	4,500	450	10	450		2,026	39
40	Elevator upgrade	2002	5,471	547	10	547		2,462	40
41	Painting and decorating	2003	13,477	1,348	10	1,348		4,043	41
42	Electrical improvements	2003	844	42	20	42		130	42
43	Repave parking lot	2004	28,840	721	40	721		1,742	43
44	Dining room remodel - paint	2004	11,387	569	20	569		1,518	44
45	Landscaping	2005	593	30	20	30		42	45
46	HVAC upgrade	2005	17,734	887	20	887		961	46
47	Generator upgrade	2005	19,650	983	20	983		1,966	47
48	Window replacement	2005	3,899	195	20	195		260	48
49	Flooring replacement	2005	1,483	74	20	74		99	49
50	Lobby, lounge and reception rehab	2005	27,180	1,359	20	1,359		1,360	50
51	Therapy room rehab	2005	35,135	1,757	20	1,757		2,050	51
52	Create first floor therapy room	2005	32,045	1,602	20	1,602		2,937	52
53	Create transitional care unit	2005	29,170	1,458	20	1,458		1,580	53
54	Basement renovation	2005	5,996	300	20	300		301	54
55	Countertops	2005	845	169	5	169		282	55
56	Interior signs	2005	4,412	882	5	882		1,029	56
57	Window treatments	2005	912	182	5	182		258	57
58	Wall covering	2005	439	87	5	88	1	110	58
59	Panel Brick Replacement	2006	17,387	145	20	145		145	59
60	Landscaping Enhancement	2006	7,608	127	15	127		127	60
61	HVAC	2006	12,232	51	20	51		51	61
62	Sink	2006	2,331	78	20	78		78	62
63	TCU Units	2006	16,379	205	20	205		205	63
64	Employee lunch room rehab	2006	8,127	203	20	203		203	64
65	Dining room rehab	2006	2,357	59	20	59		59	65
66	Basement renovation	2006	9,465	158	20	158		158	66
67	Oxygen room rehab	2006	2,662	44	20	44		44	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,887,523	\$ 53,807		\$ 221,927	\$ 168,120	\$ 3,170,568	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,887,523	\$ 53,807		\$ 221,927	\$ 168,120	\$ 3,170,568	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17	Land improvements - management company	2002	27,870		15	1,737	1,737	9,135	17
18	Building - management company	2002	216,828		40	5,070	5,070	26,652	18
19	HVAC, electrical, security system - management company	2003	2,149		30	138	138	503	19
20	Key card system - management company	2004	338		20	17	17	41	20
21	VAV TX controls - management company	2005	103		20	5	5	9	21
22	Interior Signs - management company	2006	75		5	1	1	1	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,134,886	\$ 53,807		\$ 228,895	\$ 175,088	\$ 3,206,909	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 383,534	\$ 43,769	\$ 47,199	\$ 3,430	5-10	\$ 190,850	71
72	Current Year Purchases	102,652	903	903		5	903	72
73	Fully Depreciated Assets	72,105					72,105	73
74	Allocated from management company	197,395		20,573	20,573		96,347	74
75	TOTALS	\$ 755,686	\$ 44,672	\$ 68,675	\$ 24,003		\$ 360,205	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management company			57,389		5,026	5,026		39,257	79
80	TOTALS			\$ 57,389	\$	\$ 5,026	\$ 5,026		\$ 39,257	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,177,176	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 98,479	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 302,596	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 204,117	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,606,371	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		<u>Allocated from management company</u>			<u>4,211</u>			6
7	TOTAL				\$ <u>4,211</u>			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: \$ \$ 10,856 Description: Copier- \$9,014; Mailing System \$ 180; Management Allocation \$1,662

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocation from Management Company</u>			<u>2,008</u>	20
21	TOTAL		\$	\$ <u>2,008</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	3,768	\$ 261,118	\$	3,768	\$ 261,118	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		956	60,177		956	60,177	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		9,544	429,084		9,544	429,084	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				279,017		279,017	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	14,268	\$ 750,379	\$ 279,017	14,268	\$ 1,029,396	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 Schaumburg
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0036095
 As of 12/31/2006

Report Period Beginning: 01/01/2006
 (last day of reporting year)

Ending: 12/31/2006

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,735	\$ 14,735	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 905,080)	1,938,643	1,963,585	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,744	56,744	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	164	164	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,010,286	\$ 2,035,228	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	37,630	37,630	12
13	Land		229,215	13
14	Buildings, at Historical Cost		5,865,346	14
15	Leasehold Improvements, at Historical Cost	999,028	1,269,540	15
16	Equipment, at Historical Cost	558,291	813,075	16
17	Accumulated Depreciation (book methods)	(560,349)	(3,606,371)	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): Mortgage Costs		134,011	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,034,600	\$ 4,742,446	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,044,886	\$ 6,777,674	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 287,500	\$ 287,500	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	475,000	475,000	29
30	Accrued Salaries Payable	285,399	285,399	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,252	8,252	31
32	Accrued Real Estate Taxes(Sch.IX-B)		398,400	32
33	Accrued Interest Payable		17,884	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	661,840	435,539	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,717,991	\$ 1,907,974	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		5,452,500	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest rate swap liability		45,683	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,498,183	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,717,991	\$ 7,406,157	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,326,895	\$ (628,483)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,044,886	\$ 6,777,674	48

Lexington of Schaumburg
Provider # 0036095
1/1/06 - 12/31/06

Schedule 17A

XV. Balance Sheet

A. Current Assets

9. Other Current Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Loans Receivable-Employee	83	83
Federal Income Tax	81	81
	<u>164</u>	<u>164</u>

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to related parties	21,454	22,825
Bond withholding	1,179	1,179
401(k) withholding	11,349	11,349
Accrued rent	227,672	
Accrued 401(k)	29,977	29,977
Accrued expenses	251,666	251,666
Biweekly advance	118,543	118,543
Total line 36	<u>661,840</u>	<u>435,539</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,361,785	1
2	Restatements (describe):		2
3	Post closing adjustments	58,465	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,420,250	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	86,645	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	(180,000)	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)	\$ (93,355)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,326,895	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg# 0036095Report Period Beginning: 01/01/2006Ending: 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,399,513	1
2	Discounts and Allowances for all Levels	(6,152,413)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,247,100	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,350,049	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,350,049	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	10,851	12
13	Barber and Beauty Care	30,270	13
14	Non-Patient Meals	322	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	566,794	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,333	19
20	Radiology and X-Ray	18,020	20
21	Other Medical Services	117,311	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 770,901	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,369	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,369	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	487	28
28a	<u>Rental Income</u>	1,603	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,090	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,372,509	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,535,194	31
32	Health Care	5,680,142	32
33	General Administration	2,731,466	33
	B. Capital Expense		
34	Ownership	1,792,666	34
	C. Ancillary Expense		
35	Special Cost Centers	423,756	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,285,864	40
41	Income before Income Taxes (line 30 minus line 40)**	86,645	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 86,645	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 Schaumburg

0036095

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	2,018	2,160	\$ 116,205	\$ 53.80	1
2	Assistant Director of Nursing	3,097	3,301	109,452	33.16	2
3	Registered Nurses	57,788	62,681	2,041,002	32.56	3
4	Licensed Practical Nurses	7,457	8,169	235,537	28.83	4
5	CNAs & Orderlies	115,779	124,288	1,502,898	12.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,878	15,943	221,837	13.91	8
9	Activity Director	2,046	2,167	36,860	17.01	9
10	Activity Assistants	17,442	18,705	192,040	10.27	10
11	Social Service Workers	3,128	3,308	62,264	18.82	11
12	Dietician	2,005	2,166	31,487	14.54	12
13	Food Service Supervisor	1,925	2,045	34,507	16.87	13
14	Head Cook	1,853	2,008	24,142	12.02	14
15	Cook Helpers/Assistants	11,781	12,723	115,528	9.08	15
16	Dishwashers	18,719	20,321	143,432	7.06	16
17	Maintenance Workers	2,092	2,248	35,793	15.92	17
18	Housekeepers	38,534	41,829	315,072	7.53	18
19	Laundry	9,745	10,612	74,989	7.07	19
20	Administrator	2,019	2,188	109,917	50.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,995	17,157	264,220	15.40	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	1,470	1,576	21,702	13.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	329,771	355,595	\$ 5,688,884 *	\$ 16.00	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	267	\$ 15,435	L1, C3	35
36	Medical Director	Monthly	39,000	L9, C3	36
37	Medical Records Consultant	26	1,647	L10, C3	37
38	Nurse Consultant	Monthly	1,664	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	115	5,566	L11, C3	44
45	Social Service Consultant	51	5,073	L12, C3	45
46	Other(specify) <u>MDS Consultant</u>	333	18,716	L10, C3	46
47	<u>Psychosocial Consultant</u>	14	1,388	L12, C3	47
48	<u>Medical Consultant</u>		3,186	L10, C3	48
49	TOTAL (lines 35 - 48)	806	\$ 94,075		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lake Zurich, Inc.
Provider # 0039768
1/1/06 - 12/31/06

Schedule 21C

XIX. Support Schedules
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
RSM McGladrey	Accounting	6,533
Sachnoff & Weaver	Legal	2,379
Scott & Krause	Legal	542
Systematic Management Systems	Billing Service	11,004
National Data Care Corp	Computer Services	2,114
Information Controls	Computer Services	1,185
AAOD	Computer Services	2,010
Ehealth	Computer Services	2,400
Adminastar	Computer Services	363
Krakau	Computer Services	696
Action Computer Service	Computer Services	324
Microsoft	Computer Services	2,801
Gigatrend	Computer Services	215
Visual Click	Computer Services	120
CDW	Computer Services	754
Lanac	Computer Services	1,964
Lintech	Computer Services	2,994
Royal/Shaker Advertising	Computer Services	1,990
CARF	Consulting/Health	1,372
		<u>41,760</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u><u>73,128</u></u>

Allocated from management co.

Altschuler, Melvoin & Glasser LLP	Accounting	2,725
RSM McGladrey	Accounting	224
ING	Accounting	205
Aronberg, Goldgehn, Davis	Accounting	9
Pension Administrators	401 (k) Administration	1,205
Personnel Planners	U/C Consulting	15
Gene Whitehorn	Medicaid Billing Consultant	1,992
Various	Computer Consulting	8,313
Allocated from building partnership		
James Samatas	Legal	280
Nonallowable legal fees		
Scott & Krause	Legal	(385)
Total, Agrees to Schedule V, Line 19, Column 8		<u><u>87,711</u></u>

See Accountants' Compilation Report

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg# 0036095Report 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. \$ 57,176 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 122,640
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,618 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 32
- (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