

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040923

Facility Name: Lexington of Wheeling

Address: 730 West Hintz Road Wheeling 60090
 Number City Zip Code

County: Cook

Telephone Number: (847) 537-7474 Fax # (847) 537-7599

HFS ID Number: 363885225001

Date of Initial License for Current Owners: 05/12/95

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
 Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	221	Skilled (SNF)	221	80,665	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	221	TOTALS	221	80,665	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	1,890	432	6,699	9,021	8
9	SNF/PED					9
10	ICF	41,172	7,419	2,138	50,729	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,062	7,851	8,837	59,750	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.07%

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)

N/A

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 05/12/95

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 221 and days of care provided 6,644

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 Wheeling # 0040923 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	313,035	30,550	12,807	356,392		356,392		356,392		1
2	Food Purchase		269,647		269,647		269,647	(13,085)	256,562		2
3	Housekeeping	285,305	31,605		316,910		316,910	226	317,136		3
4	Laundry	73,492	19,390		92,882		92,882	455	93,337		4
5	Heat and Other Utilities			196,058	196,058		196,058	5,288	201,346		5
6	Maintenance	32,699		112,438	145,137		145,137	48,099	193,236		6
7	Other (specify):* Mgmt. Co. Alloc Bene							5,511	5,511		7
8	TOTAL General Services	704,531	351,192	321,303	1,377,026		1,377,026	46,494	1,423,520		8
	B. Health Care and Programs										
9	Medical Director			28,000	28,000		28,000		28,000		9
10	Nursing and Medical Records	3,534,902	195,217	46,121	3,776,240		3,776,240	96,056	3,872,296		10
10a	Therapy			759,467	759,467		759,467		759,467		10a
11	Activities	216,175	22,184	6,069	244,428		244,428		244,428		11
12	Social Services	67,136		10,712	77,848		77,848		77,848		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt. Co. Alloc Bene							11,757	11,757		15
16	TOTAL Health Care and Programs	3,818,213	217,401	850,369	4,885,983		4,885,983	107,813	4,993,796		16
	C. General Administration										
17	Administrative	106,740		1,015,811	1,122,551		1,122,551	(915,133)	207,418		17
18	Directors Fees										18
19	Professional Services			116,517	116,517		116,517	7,793	124,310		19
20	Dues, Fees, Subscriptions & Promotions			66,493	66,493		66,493	979	67,472		20
21	Clerical & General Office Expenses	239,068	32,516	29,062	300,646		300,646	334,202	634,848		21
22	Employee Benefits & Payroll Taxes			701,936	701,936		701,936	12,737	714,673		22
23	Inservice Training & Education			3,220	3,220		3,220		3,220		23
24	Travel and Seminar			5,588	5,588		5,588	3,759	9,347		24
25	Other Admin. Staff Transportation			2,678	2,678		2,678	13,351	16,029		25
26	Insurance-Prop.Liab.Malpractice			196,037	196,037		196,037	3,697	199,734		26
27	Other (specify):* Mgmt. Co. Alloc Bene							52,595	52,595		27
28	TOTAL General Administration	345,808	32,516	2,137,342	2,515,666		2,515,666	(486,020)	2,029,646		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,868,552	601,109	3,309,014	8,778,675		8,778,675	(331,713)	8,446,962		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 Wheeling

#0040923

Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			45,262	45,262		45,262	203,297	248,559			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			140,812	140,812		140,812	265,424	406,236			32
33	Real Estate Taxes							447,476	447,476			33
34	Rent-Facility & Grounds			1,644,829	1,644,829		1,644,829	(1,640,674)	4,155			34
35	Rent-Equipment & Vehicles			45,263	45,263		45,263	3,621	48,884			35
36	Other (specify):*											36
37	TOTAL Ownership			1,876,166	1,876,166		1,876,166	(720,856)	1,155,310			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		231,647	6,807	238,454		238,454		238,454			39
40	Barber and Beauty Shops			20,028	20,028		20,028		20,028			40
41	Coffee and Gift Shops			2,266	2,266		2,266		2,266			41
42	Provider Participation Fee			120,996	120,996		120,996		120,996			42
43	Other (specify):* Nonallowable Cost			517,604	517,604		517,604	(517,604)				43
44	TOTAL Special Cost Centers		231,647	667,701	899,348		899,348	(517,604)	381,744			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,868,552	832,756	5,852,881	11,554,189		11,554,189	(1,570,173)	9,984,016			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 Wheeling

0040923

Report Period Beginning: 01/01/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(348)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,335)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	455	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(914)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(486,557)	43		24
25	Fund Raising, Advertising and Promotional	(10,515)	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 Schedule 5A</u>	(118,073)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (620,302)		\$	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)	(949,871)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (949,871)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,570,173)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/06-12/31/06

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

<u>Description</u>	<u>Amount</u>	<u>Reference</u>
Disallow nonallowable collection fees	(3,560)	19
Disallow out of period fees	(6,833)	19
Disallow trust fees	(75)	43
Disallow shareholder interest	(95,214)	32
Disallw travel & entetainment	(194)	43
Disallow Chamber of Commerece Dues	(474)	43
Nonallowable personal item replacement	(545)	43
Disallow radiology	(5,833)	43
Disallow laboratory	(5,340)	43
Penalties	(5)	43
Total	<u>(118,073)</u>	

See Accountants' Compilation Report

Lexington of Wheeling

ID# 0040923

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(348)	0	0	0	0	0	0	0	0	0	0	(348)	2
3	Housekeeping	0	0	226	0	0	0	0	0	0	0	0	226	3
4	Laundry	455	0	0	0	0	0	0	0	0	0	0	455	4
5	Heat and Other Utilities	0	0	5,288	0	0	0	0	0	0	0	0	5,288	5
6	Maintenance	0	0	48,099	0	0	0	0	0	0	0	0	48,099	6
7	Other (specify):*	0	0	5,511	0	0	0	0	0	0	0	0	5,511	7
8	TOTAL General Services	107	0	59,124	0	0	0	0	0	0	0	0	59,231	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	3,144	92,912	0	0	0	0	0	0	0	96,056	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	11,757	0	0	0	0	0	0	0	11,757	15
16	TOTAL Health Care and Programs	0	0	3,144	104,669	0	107,813	16						
	C. General Administration													
17	Administrative	0	0	100,678	(1,015,811)	0	0	0	0	0	0	0	(915,133)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	135	14,491	0	0	0	0	0	0	0	0	14,626	19
20	Fees, Subscriptions & Promotions	0	0	1,453	0	0	0	0	0	0	0	0	1,453	20
21	Clerical & General Office Expenses	0	0	334,202	0	0	0	0	0	0	0	0	334,202	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	3,759	0	0	0	0	0	0	0	0	3,759	24
25	Other Admin. Staff Transportation	0	0	15,332	0	0	0	0	0	0	0	0	15,332	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,697	0	0	0	0	0	0	0	0	3,697	26
27	Other (specify):*	0	0	0	52,595	0	0	0	0	0	0	0	52,595	27
28	TOTAL General Administration	0	135	473,612	(963,216)	0	(489,469)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	107	135	535,880	(858,547)	0	(322,425)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES 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)	
	D. Ownership													
30	Depreciation	0	171,169	0	32,128	0	0	0	0	0	0	0	203,297	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15)	342,395	0	18,258	0	0	0	0	0	0	0	360,638	32
33	Real Estate Taxes	0	444,829	0	2,647	0	0	0	0	0	0	0	447,476	33
34	Rent-Facility & Grounds	0	(1,644,829)	0	4,155	0	0	0	0	0	0	0	(1,640,674)	34
35	Rent-Equipment & Vehicles	0	0	0	1,640	0	0	0	0	0	0	0	1,640	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(15)	(686,436)	0	58,828	0	0	0	0	0	0	0	(627,623)	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):*	(502,321)	75	0	194	0	0	0	0	0	0	0	(502,052)	43
44	TOTAL Special Cost Centers	(502,321)	75	0	194	0	0	0	0	0	0	0	(502,052)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(502,229)	(686,226)	535,880	(799,525)	0	0	0	0	0	0	0	(1,452,100)	45

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	33.33%	See attached Schedule B		Lexington Health		
John Samatas Discretionary Trust	33.33%			Care Systems of		
Cynthia Thiem Discretionary Trust	33.33%			Wheeling Ltd. Ptsp.	Wheeling	Lessor
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C	Lombard	Finance Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V		\$			\$		1	
2	V	19 Professional fees		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	135	135	2	
3	V	30 Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	171,169	171,169	3	
4	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	3,653	3,653	4	
5	V	32 Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	338,742	338,742	5	
6	V	33 Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	444,829	444,829	6	
7	V	34 Rental expense	1,644,829	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,644,829)	7	
8	V	43 Trust fees		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	75	75	8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V	**The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Lexington Health Care Systems of Wheeling Ltd. Ptsp.							13
14	Total		\$ 1,644,829			\$ 958,603	\$ * (686,226)	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/06-12/31/06

Schedule 6B

VII. Related Parties
Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/06Ending: 12/31/06

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.	**	\$ 226	\$ 226	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,282	4,282	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	135	135	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	871	871	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	43,550	43,550	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	4,401	4,401	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	148	148	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,511	5,511	22
23	V	10 Medical consultant		Royal Management Corp.	**	3,144	3,144	23
24	V	17 Management allocation - salaries		Royal Management Corp.	**	100,678	100,678	24
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	8,199	8,199	25
26	V	19 Professional fees		Royal Management Corp.	**	6,292	6,292	26
27	V	20 Dues & subscriptions		Royal Management Corp.	**	859	859	27
28	V	20 Advertising - help wanted		Royal Management Corp.	**	594	594	28
29	V	21 Management allocation - salaries		Royal Management Corp.	**	314,967	314,967	29
30	V	21 Bank charges		Royal Management Corp.	**	420	420	30
31	V	21 Office supplies & printing		Royal Management Corp.	**	10,042	10,042	31
32	V	21 Postage		Royal Management Corp.	**	3,463	3,463	32
33	V	21 Telephone		Royal Management Corp.	**	5,310	5,310	33
34	V	24 Travel & seminar		Royal Management Corp.	**	3,759	3,759	34
35	V	25 Auto expense		Royal Management Corp.	**	15,332	15,332	35
36	V	26 Insurance general		Royal Management Corp.	**	3,697	3,697	36
37	V							37
38	V	** Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.						38
39	Total		\$			\$ 535,880	\$ * 535,880	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Management allocation - employee ben	\$	Royal Management Corp.	**	\$ 52,595	\$ 52,595	15
16	V	30 Depreciation - vehicles		Royal Management Corp.	**	4,958	4,958	16
17	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	6,872	6,872	17
18	V	30 Depreciation - equipment		Royal Management Corp.	**	20,298	20,298	18
19	V	32 Interest		Royal Management Corp.	**	18,226	18,226	19
20	V	32 Amortization of mortgage costs		Royal Management Corp.	**	32	32	20
21	V	33 Property taxes		Royal Management Corp.	**	2,647	2,647	21
22	V	34 Rent expense		Royal Management Corp.	**	4,155	4,155	22
23	V	35 Equipment rental		Royal Management Corp.	**	1,640	1,640	23
24	V	17 Management Fees	1,015,811	Royal Management Corp.	**		(1,015,811)	24
25	V	43 Meals & Entertainment		Royal Management Corp.	**	194	194	25
26	V	10 Management allocation - salaries		Royal Management Corp.	**	92,912	92,912	26
27	V	15 Management allocation - employee benefits		Royal Management Corp.	**	11,757	11,757	27
28	V							28
29	V							29
30	V							30
31	V							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 Wheeling, Inc. own 100% of Royal Management Corp.						38
39	Total		\$ 1,015,811			\$ 216,286	\$ * (799,525)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	4.4	11.00	Salary	\$ 34,016	L17, C7	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule C	4.4	11.00	Salary	24,297	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	4.4	11.00	Salary	24,297	L17, C7	3
4	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	4.4	11.00	Salary	18,068	L17, C7	4
5	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule C	2.2	5.50	Salary	4,087	L10, C7	5
6	Jeremy Samatas	Corporate Director	Quality Assurance	0.00	See Schedule C	4.4	11.00	Salary	9,841	L21, 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	\$ 114,606		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 Wheeling

0040923

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	744,965	10	\$ 2,086		80,665	\$ 226	1
2	5	Utilities - gas & electric	744,965	10	39,549		80,665	4,282	2
3	5	Utilities - water & sewer	744,965	10	1,244		80,665	135	3
4	5	Utilities - maintenance office	744,965	10	8,043		80,665	871	4
5	6	Management allocation - salaries	744,965	10	402,200	402,200	80,665	43,550	5
6	6	Repairs & maintenance	744,965	10	40,648		80,665	4,401	6
7	6	Scavenger & exterminating	744,965	10	1,366		80,665	148	7
8	7	Management allocation - employee b	744,965	10	50,893		80,665	5,511	8
9	10	Medical consultant	744,965	10	29,034		80,665	3,144	9
10	17	Management allocation - salaries	744,965	10	929,789	929,789	80,665	100,678	10
11	19	Computer consultant & supplies	744,965	10	75,717		80,665	8,199	11
12	19	Professional fees	744,965	10	58,113		80,665	6,292	12
13	20	Dues & subscriptions	744,965	10	7,935		80,665	859	13
14	20	Advertising - help wanted	744,965	10	5,488		80,665	594	14
15	21	Management allocation - salaries	744,965	10	2,908,810	2,908,810	80,665	314,967	15
16	21	Bank charges	744,965	10	3,883		80,665	420	16
17	21	Office supplies & printing	744,965	10	92,737		80,665	10,042	17
18	21	Postage	744,965	10	31,985		80,665	3,463	18
19	21	Telephone	744,965	10	49,035		80,665	5,310	19
20	24	Travel & seminar	744,965	10	34,717		80,665	3,759	20
21	25	Auto expense	744,965	10	141,593		80,665	15,332	21
22	26	Insurance general	744,965	10	34,142		80,665	3,697	22
23									23
24									24
25	TOTALS				\$ 4,949,007	\$ 4,240,799		\$ 535,880	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Royal Management
 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	27	Management allocation - employee b	Bed Days	744,965	10	\$ 485,728	\$ 80,665	\$ 52,595	1
2	30	Depreciation - vehicles	Bed Days	744,965	10	45,792	80,665	4,958	2
3	30	Depreciation - leasehold improv.	Bed Days	744,965	10	63,466	80,665	6,872	3
4	30	Depreciation - equipment	Bed Days	744,965	10	187,456	80,665	20,298	4
5	32	Interest	Bed Days	744,965	10	168,318	80,665	18,226	5
6	32	Amortization of mortgage costs	Bed Days	744,965	10	299	80,665	32	6
7	33	Property taxes	Bed Days	744,965	10	24,448	80,665	2,647	7
8	34	Rent expense	Bed Days	744,965	10	38,371	80,665	4,155	8
9	35	Equipment rental	Bed Days	744,965	10	15,142	80,665	1,640	9
10	43	Meals & Entertainment	Bed Days	744,965	10	1,795	80,665	194	10
11	10	Management allocation - salaries	Bed Days	744,965	10	858,074	858,074	92,912	11
12	15	Management allocation - employee b	Bed Days	744,965	10	108,579	80,665	11,757	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,997,468	\$ 858,074	\$ 216,286	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/06 Ending: 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
	A. Directly Facility Related																				
	Long-Term																				
1	Lexington Financial					\$	\$			\$	1										
2	Services II, L.L.C	X		Mortgage	\$49,514.00	12/29/98	6,513,000	4,900,528	12/29/08	0.0675	338,742	2									
3												3									
4												4									
5												5									
	Working Capital																				
6	Shareholders	X		Working Capital	None	Various	675,000	2,591,270	Demand	Prime + 1	95,214	6									
7	LaSalle Bank, N.A.		X	Line of Credit	Various	12/1/02	1,000,000	600,000	5/31/07	Prime	45,598	7									
8												8									
9	TOTAL Facility Related				\$49,514.00		\$ 8,188,000	\$ 8,091,798			\$ 479,554	9									
	B. Non-Facility Related*																				
10								Amortization of loan costs			3,653	10									
11								Interest income offset			(15)	11									
12								Allocated from management company			18,258	12									
13								Less: Interest to shareholders			(95,214)	13									
14	TOTAL Non-Facility Related						\$	\$			(73,318)	14									
15	TOTALS (line 9+line14)						\$ 8,188,000	\$ 8,091,798			\$ 406,236	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 Wheeling# 0040923

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	402,000	1
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	\$	412,618	2
3. Under or (over) accrual (line 2 minus line 1).			\$	10,618	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	425,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	23,946	5
		Allocated from Management Company		2,647	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 14,735 For 2003 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(14,735)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	447,476	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2001	<u>379,253</u>	<u>8</u>			
2002	<u>410,289</u>	<u>9</u>			
2003	<u>390,362</u>	<u>10</u>			
2004	<u>391,007</u>	<u>11</u>			
2005	<u>412,618</u>	<u>12</u>			
2005 tax bill paid \$ 412,618					
Est. Tax with 3% Increase \$ 424,996					
Use: \$425,000					
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

- 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 Wheeling COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040923

CONTACT PERSON REGARDING THIS REPORT Susan 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 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1. 03-10-401-027-0000	Land & Building	\$ 412,617.84	\$ 412,617.84
2. Royal Management Corp. (Samvest of Lombard II)		\$ 126,705.00	\$ 2,647.00
3. 05-01-202-019		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ <u>539,322.84</u>	\$ <u>415,264.84</u>

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 Wheeling

0040923 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>137,650</u>	<u>1993</u>	<u>\$ 595,000</u>	<u>1</u>
2	<u>Allocated from Management Company</u>		<u>2002</u>	<u>17,446</u>	<u>2</u>
3	TOTALS	137,650		\$ 612,446	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	211		1995	1995	\$ 6,537,447	\$	10-40	\$ 163,258	\$ 163,258	\$ 1,905,990	4
5	10		2000	2000	98,710	2,468	40	2,468		16,041	5
6											6
7											7
8											8
	Improvement Type**										
9		Building improvement	1995		3,587			239	239	2,780	9
10		Land improvement - sidewalk replacement	1996		1,927	128	15	128		1,349	10
11		Leasehold improvement - pines & sod	1996		3,432	229	15	229		2,402	11
12		Basement rehab	1997		18,611	1,861	15	1,861		17,680	12
13		Building improvement - curtains/track	1997		1,936		10	55	55	526	13
14		Landscaping	1997		2,002	134	35	134		1,269	14
15		Wiring for MDS	1998		3,552	355	15	355		3,019	15
16		Parking Lot	1998		2,952	295	10	295		2,509	16
17		Roof repair	2000		1,980	198	10	198		1,287	17
18		Remodel HVAC/exhaust system - office area	2000		7,480	374	10	374		2,431	18
19		Automatic Door	2000		1,300	130	20	130		845	19
20		Rods for beside curtains	2000		2,525	252	10	252		1,640	20
21		Floor tile	2000		10,298	1,030	10	1,030		6,694	21
22		Parking lot seal coating and repair	2001		2,177	218	10	218		1,198	22
23		Infrared curtain units for 3 elevators	2001		4,500	450	10	450		4,500	23
24		Boiler vent repairs	2001		3,084	308	5	308		1,696	24
25		Kitchen wall rebuild	2003		22,500	1,125	10	1,125		3,750	25
26		Elevator upgrade	2004		11,077	554	20	554		1,477	26
27		Landscaping	2005		450	23	20	23		34	27
28		HVAC system	2005		27,711	1,386	20	1,386		1,732	28
29		Lobby, lounge, and reception rehab	2005		22,731	1,137	20	1,137		1,138	29
30		Lower level therapy room rehab	2005		8,100	405	20	405		776	30
31		First floor therapy room addition	2005		32,167	1,608	20	1,608		3,216	31
32		Transitional unit addition	2005		18,758	938	20	938		1,172	32
33		Basement rehab	2005		13,105	655	20	655		983	33
34		Countertops	2005		845	169	5	169		282	34
35		Window treatments	2005		4,090	818	5	818		1,636	35
36											36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	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	2006	4,558	127	15	127		127	38
39	2006	10,034	84	10	84		84	39
40	2006	8,110	203	10	203		203	40
41	2006	6,058	151	10	151		151	41
42	2006	11,010	459	10	459		459	42
43	2006	8,017		10				43
44	2006	2,361	138	10	138		138	44
45								45
46	2006	5,307		10				46
47	2006	2,232	112	10	112		112	47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62	2002	27,497		15	1,714	1,714	9,013	62
63	2002	213,924		40	5,000	5,000	26,295	63
64	2003	2,120		30	137	137	497	64
65	2004	333		20	16	16	40	65
66	2005	101		20	5	5	9	66
67	2006	74		5	1	1	1	67
68								68
69								69
70		\$ 7,170,770	\$ 18,522		\$ 188,947	\$ 170,425	\$ 2,027,181	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 Wheeling # 0040923 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 547,287	\$ 23,398	\$ 31,010	\$ 7,612	3-10	\$ 510,788	71
72	Current Year Purchases	100,479	3,346	3,346		5-7	3,346	72
73	Fully Depreciated Assets	84,147					84,147	73
74	Allocated from management company	251,372		20,298	20,298		95,056	74
75	TOTALS	\$ 983,285	\$ 26,744	\$ 54,654	\$ 27,910		\$ 693,337	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			56,620		4,958	4,958		38,731	79
80	TOTALS			\$ 56,620	\$	\$ 4,958	\$ 4,958		\$ 38,731	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)	\$ 8,823,121	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,266	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 248,559	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 203,293	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,759,249	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	First floor remodel	\$ 616,190	92
93	Alzheimers remodel	11,141	93
94			94
95		\$ 627,331	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>4,155</u>			6
7	TOTAL				\$ 4,155			7

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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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: \$ 46,903 Description: Copier 7,858; Medical Equip 24,926; Oxygen Equip 12,479; Mgmt. Co.Allocation 1,640
(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	<u>Management Company allocation</u>			<u>1,981</u>	18
19					19
20					20
21	TOTAL		\$	\$ 1,981	21

* 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.

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/06 Ending: 12/31/06

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>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>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<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	\$	3,756	\$ 286,967	\$	3,756	\$ 286,967	1
2	Licensed Speech and Language Development Therapist	L10A C3	hrs		1,504	111,658		1,504	111,658	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C3	hrs		7,743	360,842		7,743	360,842	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				231,647		231,647	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Schedule 16A</u>	L39 C3				6,807			6,807	13
14	TOTAL			\$	13,003	\$ 766,274	\$ 231,647	13,003	\$ 997,921	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.

Provider # 0040923

1/1/06-12/31/06

Schedule 16A

Special Services - Line 13 (Other)

Service	Sch V Line Ref	Outside Practitioner	
		Units	Costs
Wound Therapy	L39 C3		1,968
Ambulance	L39 C3		4,839
			<u>6,807</u>

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 11,026	\$ 39,866	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>926,210</u>)	1,928,023	1,928,023	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,469	40,469	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	144	193,644	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,979,662	\$ 2,202,002	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	11,368	11,368	12
13	Land		612,446	13
14	Buildings, at Historical Cost		6,528,926	14
15	Leasehold Improvements, at Historical Cost	384,010	641,844	15
16	Equipment, at Historical Cost	370,270	1,039,905	16
17	Accumulated Depreciation (book methods)	(262,889)	(2,759,249)	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>Constr-in-process</u>)	627,131	627,131	22
23	Other(specify): <u>Loan costs, net of amort.</u>		43,831	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,129,890	\$ 6,746,202	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,109,552	\$ 8,948,204	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 365,775	\$ 365,775	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,191,270	3,463,241	29
30	Accrued Salaries Payable	224,768	224,768	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,807	6,807	31
32	Accrued Real Estate Taxes(Sch.IX-B)		425,000	32
33	Accrued Interest Payable		27,565	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	3,554,776	862,970	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,343,396	\$ 5,376,126	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		4,628,557	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,628,557	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,343,396	\$ 10,004,683	46
47	TOTAL EQUITY (page 18, line 24)	\$ (4,233,844)	\$ (1,056,479)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,109,552	\$ 8,948,204	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Wheeling, Inc.
 Provider # 0040923
 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>
Real Estate Tax Escrow	-	193,500
Due to/from Employees	144	144
	<hr/>	<hr/>
Total line 9	144	193,644
	<hr/> <hr/>	<hr/> <hr/>

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Medicaid Audit Settlement	262,085	262,085
Due to Royal	8,415	8,415
Due to La Grange	1,806	1,806
Due to Lake Zurich	439	439
Bond Withholding	481	481
401K Withholding	8,004	8,004
Accrued 401K	15,697	15,697
Accrued Expenses	238,701	238,701
Accrued RoyalGenl Mgmt	130,731	130,731
Accrued Rent	2,691,806	-
Advance - Biweekly Part A	45,483	45,483
Accrued Wage Assignment	271	271
A/R Refund-Insurance	2,195	2,195
Escrow - Insurance	148,618	148,618
Due from Ins Carrier	44	44
	<hr/>	<hr/>
Total line 36	3,554,776	862,970
	<hr/> <hr/>	<hr/> <hr/>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,711,263)	1
2	Restatements (describe):		2
3			3
4	Post closing adjustments	(269,987)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,981,250)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,252,594)	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	()	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)	\$ (1,252,594)	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)	\$ (4,233,844)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/06

Ending:

12/31/06

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	\$ 12,817,825	1
2	Discounts and Allowances for all Levels	(4,408,478)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,409,347	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,279,079	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,279,079	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	2,096	12
13	Barber and Beauty Care	22,493	13
14	Non-Patient Meals	348	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	434,039	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,614	19
20	Radiology and X-Ray	8,583	20
21	Other Medical Services	117,718	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 609,891	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Investment income	2,068	28
28a	Bad debt recovery-995; Rental income-200	1,195	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,263	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,301,595	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,377,026	31
32	Health Care	4,885,983	32
33	General Administration	2,515,666	33
B. Capital Expense			
34	Ownership	1,876,166	34
C. Ancillary Expense			
35	Special Cost Centers	778,352	35
36	Provider Participation Fee	120,996	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,554,189	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,252,594)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,252,594)	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 Wheeling

0040923

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,066	2,231	\$ 102,825	\$ 46.09	1
2	Assistant Director of Nursing	5,497	5,887	196,851	33.44	2
3	Registered Nurses	44,272	47,700	1,560,517	32.72	3
4	Licensed Practical Nurses	7,596	8,430	212,975	25.26	4
5	CNAs & Orderlies	98,863	105,872	1,308,024	12.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,884	10,754	139,606	12.98	8
9	Activity Director	2,007	2,136	35,172	16.47	9
10	Activity Assistants	17,038	17,997	181,003	10.06	10
11	Social Service Workers	3,241	3,377	67,136	19.88	11
12	Dietician	2,014	2,158	34,083	15.79	12
13	Food Service Supervisor	1,918	2,037	29,776	14.62	13
14	Head Cook	1,918	2,137	27,543	12.89	14
15	Cook Helpers/Assistants	10,331	10,933	88,091	8.06	15
16	Dishwashers	18,509	19,325	133,542	6.91	16
17	Maintenance Workers	2,002	2,167	32,699	15.09	17
18	Housekeepers	36,221	38,681	285,305	7.38	18
19	Laundry	9,097	9,816	73,492	7.49	19
20	Administrator	2,168	2,195	106,740	48.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,740	15,759	239,068	15.17	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	988	1,021	14,104	13.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	290,370	310,613	\$ 4,868,552 *	\$ 15.67	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	259	\$ 12,807	L1,C3	35
36	Medical Director	Monthly	28,000	L9,C3	36
37	Medical Records Consultant	24	1,537	L10,C3	37
38	Nurse Consultant	Monthly	3,144	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	113	5,472	L11,C3	44
45	Social Service Consultant	96	4,810	L12,C3	45
46	Other(specify)				46
47	MDS consultant	16	832	L10,C3	47
48	Psychosocial Consultant	24	1,112	L12,C3	48
49	TOTAL (lines 35 - 48)	532	\$ 60,114		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

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Katherine Dyhouse	Administrator	0	\$ 14,404	Workers' Compensation Insurance	\$ 52,525	IDPH License Fee	\$ 1,990	
Brian Celerio	Administrator	0	92,336	Unemployment Compensation Insurance	68,681	Advertising: Employee Recruitment	56,674	
				FICA Taxes	345,498	Health Care Worker Background Check		
				Employee Health Insurance	191,003	(Indicate # of checks performed <u>200</u>)	2,000	
				Employee Meals	12,737	Patient Background Checks <u>200</u>	2,000	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	2,456	
				401K Contributions	15,697	Miscellaneous Dues & Subscriptions	1,373	
				Life Insurance	7,068			
				Other Employee Benefits	21,464			
TOTAL (agree to Schedule V, line 17, col. 1)						Management Company Allocation	1,453	
(List each licensed administrator separately.)			\$ 106,740			Less: Public Relations Expense	(474)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees (eliminated in Col 7)			\$ 1,015,811					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,015,811	TOTAL (agree to Schedule V, line 22, col.8)	\$ 714,673	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 67,472	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Altschuler, Melvoin and Glasser LLP			\$				Out-of-State Travel	\$
Altschuler, Melvoin and Glasser LLF Accounting			13,378					
Aronberg Goldgehn Davis & Garmis 401K			103					
Cassiday, Schade & Gloor	Legal		63,271				In-State Travel	
Gilson, Labus & Silverman	Accounting		435					
ING	401K		771					
James Samatas, Atty at law	Legal		100				Seminar Expense	5,588
Personnel Planners	U/C Consulting		930				Management Company allocation	3,759
RSM McGladrey	Accounting		6,941					
Sachnoff & Weaver	Legal		2,684				Entertainment Expense	()
Scott & Krause	Legal		542				(agree to Sch. V, line 24, col. 8)	
See attached schedule 21C			27,362				TOTAL	\$ 9,347
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 116,517					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Wheeling, Inc.
 Provider # 0040923
 1/1/06-12/31/06

Schedule 21C

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Systematic Management Systems	Billing Services	8,252
National Datacare Corporation	Computer consulting	1,907
Information Control, Inc.	Computer consulting	1,185
AAOD	Computer consulting	2,010
eHealth Solutions	Computer consulting	2,400
AdminaStar	Computer consulting	363
Krakau	Computer consulting	959
Action Computer Service	Computer consulting	324
Microsoft	Computer consulting	2,275
Gigatrend	Computer consulting	215
Visual Click	Computer consulting	120
CDW	Computer consulting	611
Lanac	Computer consulting	1,757
Lintech	Computer consulting	2,994
Royal/Shaker Advertising	Computer consulting	1,990
	To Page 21(c)	<u>27,362</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u>116,517</u>
Allocated from management co.		
James Samatas	Filing and recording fees	17
RSM McGladrey, Inc.	Accounting	221
Altschuler, Melvoin and Glasser LLP	Accounting	2,674
ING Administration Fee	Accounting	203
Aronberg, Goldfehn, Davis	Accounting	8
Personnel Planners	U/C Consulting	15
Pension Administrators	401(k) Administration	1,189
Gene Whitehorn	Medicaid Rembursement	1,965
Various vendors	Computer services & supplies	8,199
Allocated from building partnership		
James Samatas	Filing and recording fees	135
Nonallowable legal fees		
Cassiday, Schade & Gloor	Legal-out of period fees	(6,833)
Total, Agrees to Schedule V, Line 19, Column 8		<u>124,310</u>

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling

Report Period Beginning: 01/01/06 Ending: 12/31/06

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				N/A									
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. \$ 49,232 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.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 120,996
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. \$ 12,737 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 348
- (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