

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 License 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:

Date of Initial License for Current Owners: 5/12/95

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Lexington of Wheeling# 0040923 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 bedsN/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	<u>215</u>	Skilled (SNF)	<u>215</u>	<u>76,690</u>	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	<u>215</u>	TOTALS	<u>215</u>	<u>76,690</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>7,841</u>	<u>7,841</u>	8
9	SNF/PED					9
10	ICF	<u>50,476</u>	<u>10,951</u>		<u>61,427</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>50,476</u>	<u>10,951</u>	<u>7,841</u>	<u>69,268</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.32%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Note : 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 5/12/95

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

YES ☐Date NO ☒

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

YES ☒NO ☐If YES, enter number
of beds certified 215 and days of care provided 6,414Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

* All facilities other than governmental must report on the accrual basis.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	365,755	32,387	8,938	407,080		407,080		407,080		1
2	Food Purchase		394,893		394,893		394,893	(18,910)	375,983		2
3	Housekeeping	354,854	38,551		393,405		393,405	402	393,807		3
4	Laundry	99,033	24,535		123,568		123,568		123,568		4
5	Heat and Other Utilities			192,972	192,972		192,972	7,930	200,902		5
6	Maintenance	37,191		154,120	191,311		191,311	86,443	277,754		6
7	Other (specify):* Alloc. From Mgmt Cd							12,032	12,032		7
8	TOTAL General Services	856,833	490,366	356,030	1,703,229		1,703,229	87,897	1,791,126		8
	B. Health Care and Programs										
9	Medical Director			46,025	46,025		46,025		46,025		9
10	Nursing and Medical Records	4,644,649	488,825	109,620	5,243,094		5,243,094	43,076	5,286,170		10
10a	Therapy										10a
11	Activities	222,996	23,951	6,658	253,605		253,605		253,605		11
12	Social Services	125,956		5,197	131,153		131,153		131,153		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. From Mgmt Cd							6,174	6,174		15
16	TOTAL Health Care and Programs	4,993,601	512,776	167,500	5,673,877		5,673,877	49,250	5,723,127		16
	C. General Administration										
17	Administrative	160,233		1,550,337	1,710,570		1,710,570	(1,510,047)	200,523		17
18	Directors Fees										18
19	Professional Services			224,986	224,986		224,986	10,431	235,417		19
20	Dues, Fees, Subscriptions & Promotions			46,592	46,592		46,592	17,177	63,769		20
21	Clerical & General Office Expenses	165,767	35,447	62,827	264,041		264,041	661,392	925,433		21
22	Employee Benefits & Payroll Taxes			955,078	955,078		955,078	17,688	972,766		22
23	Inservice Training & Education			11,673	11,673		11,673	1,061	12,734		23
24	Travel and Seminar			322	322		322	2,830	3,152		24
25	Other Admin. Staff Transportation			2,340	2,340		2,340	20,080	22,420		25
26	Insurance-Prop.Liab.Malpractice			369,503	369,503		369,503	4,354	373,857		26
27	Other (specify):* Alloc. From Mgmt Cd							106,463	106,463		27
28	TOTAL General Administration	326,000	35,447	3,223,658	3,585,105		3,585,105	(668,571)	2,916,534		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,176,434	1,038,589	3,747,188	10,962,211		10,962,211	(531,424)	10,430,787		29

*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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			167,197	167,197		167,197	389,476	556,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,733	77,733		77,733	411,215	488,948			32
33	Real Estate Taxes							440,795	440,795			33
34	Rent-Facility & Grounds			1,826,083	1,826,083		1,826,083	(1,821,733)	4,350			34
35	Rent-Equipment & Vehicles			48,273	48,273		48,273	3,754	52,027			35
36	Other (specify):*											36
37	TOTAL Ownership			2,119,286	2,119,286		2,119,286	(576,493)	1,542,793			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		308,414	1,225,188	1,533,602		1,533,602		1,533,602			39
40	Barber and Beauty Shops			14,727	14,727		14,727		14,727			40
41	Coffee and Gift Shops			3,084	3,084		3,084		3,084			41
42	Provider Participation Fee			499,407	499,407		499,407		499,407			42
43	Other (specify):* Non-Allowable Co	45,472		139,316	184,788		184,788	(184,788)				43
44	TOTAL Special Cost Centers	45,472	308,414	1,881,722	2,235,608		2,235,608	(184,788)	2,050,820			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,221,906	1,347,003	7,748,196	15,317,105		15,317,105	(1,292,705)	14,024,400			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,222)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,752)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(547)	30		9
10	Interest and Other Investment Income	(43,662)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,106)	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	(1)	43		18
19	Entertainment				19
20	Contributions	(555)	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	(48,047)	43		24
25	Fund Raising, Advertising and Promotional	(46,497)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax	(3,208)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	23,826	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (137,771)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 Amount	2 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)	(1,154,934)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,154,934)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,292,705)		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 Yes	2 No	3 Amount	4 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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lexington of Wheeling

ID# 0040923

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (1,638)	43	1
2	Labs-Part A	(2,534)	43	2
3	X-Rays Part A	(13,377)	43	3
4	Marketing Salary	(45,472)	43	4
5	Dues & Subscriptions Marketing	(617)	20	5
6	Trust Fees	(75)	43	6
7	Collections	(6,281)	19	7
8	Reclass LHI to maintenance	1,870	6	8
9	Education and Seminar Marketing	(322)	24	9
10	Unrealized loss on FMV swap	107,257	43	10
11	Misc. Income	(500)	21	11
12	Out of period legal	(9,501)	19	12
13	Development Expense	(4,984)	43	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	23,826		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

[illegible]

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	\$	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	\$ 200	\$ 200	1
2	V	21	Office Supplies		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**			2
3	V	30	Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	331,686	331,686	3
4	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	1,397	1,397	4
5	V	32	Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	434,026	434,026	5
6	V	33	Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	434,083	434,083	6
7	V	34	Rental expense	1,826,083	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,826,083)	7
8	V	43	Trust Fees		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	75	75	8
9	V	43	Unrealized gain on FMV swap	107,257	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(107,257)	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			\$ 1,933,340			\$ 1,201,467	\$ * (731,873)	14

*** 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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.	**	\$ 402	\$ 402	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,719	6,719	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	297	297	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	914	914	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	75,724	75,724	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	8,454	8,454	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	395	395	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	12,032	12,032	22
23	V	10 Medical consultant		Royal Management Corp.	**	4,221	4,221	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	38,855	38,855	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	6,174	6,174	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	40,290	40,290	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	18,983	18,983	27
28	V	19 Professional fees		Royal Management Corp.	**	7,030	7,030	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,289	1,289	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	15,888	15,888	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	629,715	629,715	31
32	V	21 Bank charges		Royal Management Corp.	**	3,486	3,486	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	11,092	11,092	33
34	V	21 Postage		Royal Management Corp.	**	4,493	4,493	34
35	V	23 Inservice Training		Royal Management Corp.	**	1,061	1,061	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		\$			\$ 887,514	\$ * 887,514	39

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

Facility Name & ID Number	Lexington of Wheeling	#	0040923	Report Period Beginning:	01/01/2012	Ending:	12/31/2012
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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.	**	\$ 13,106	\$ 13,106	15
16	V	24	Travel & seminar		Royal Management Corp.	**	3,152	3,152	16
17	V	25	Auto expense		Royal Management Corp.	**	20,080	20,080	17
18	V	26	Insurance general		Royal Management Corp.	**	4,354	4,354	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	106,463	106,463	19
20	V	30	Depreciation		Royal Management Corp.	**	58,337	58,337	20
21	V	32	Interest		Royal Management Corp.	**	17,794	17,794	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,660	1,660	22
23	V	33	Property taxes		Royal Management Corp.	**	6,712	6,712	23
24	V	34	Rent expense		Royal Management Corp.	**	4,350	4,350	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,774	1,774	25
26	V	17	Management fees	1,550,337	Royal Management Corp.	**		(1,550,337)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,980	1,980	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			\$ 1,550,337			\$ 239,762	\$ * (1,310,575)	39

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

Facility Name & ID Number

Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingtondale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Vesta Management	Lombard	Mgmt. Company	3
4			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Group LLC			4
5			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Sambell of	Wheeling	Real Estate	5
6			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Wheeling Ltd. Ptsp.		Property	6
7			Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Royal Management	Lombard	Management	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Corporation		Company	8
9			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Lexington Financial	Lombard	Finance	9
10					Services II, LLC		Company	10
11					Lexington Square	Lombard	Independent	11
12					Life Care of		Assisted Living	12
13					Lombard, LLC			13
14					Lexington Square	Elmhurst	Independent	14
15					Life Care of		Living Facility	15
16					Elmhurst, LLC			16
17					Samvest of	Lombard	Lessor	17
18					Lombard II, LLC			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

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 7A	See Sch 7B	See Sch 7B	Salary	\$ 11,221	L17, C7	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,219	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,948	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,460	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,442	L17, C7	5
6		Member									6
7											7
8				Certain Individuals work in excess of 40 hours per week.							8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 40,290		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

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/2012Ending: 2/31/2012

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days Available	725,412	10	\$ 3,707	\$	78,690	\$ 402	1
2	5	Utilities - gas & electric	Bed Days Available	725,412	10	61,939		78,690	6,719	2
3	5	Utilities - water & sewer	Bed Days Available	725,412	10	2,741		78,690	297	3
4	5	Utilities - maintenance office	Bed Days Available	725,412	10	8,424		78,690	914	4
5	6	Management allocation - salaries	Bed Days Available	725,412	10	698,068	698,068	78,690	75,724	5
6	6	Repairs & maintenance	Bed Days Available	725,412	10	77,933		78,690	8,454	6
7	6	Scavenger & exterminating	Bed Days Available	725,412	10	3,642		78,690	395	7
8	7	Management allocation - employee	Bed Days Available	725,412	10	110,922		78,690	12,032	8
9	10	Medical consultant	Bed Days Available	725,412	10	38,914		78,690	4,221	9
10	10	Management allocation - salaries	Bed Days Available	725,412	10	358,188	358,188	78,690	38,855	10
11	15	Management allocation - employee	Bed Days Available	725,412	10	56,916		78,690	6,174	11
12	17	Management allocation - salaries	Bed Days Available	725,412	10	371,421	371,421	78,690	40,290	12
13	19	Computer consultant & supplies	Bed Days Available	725,412	10	174,999		78,690	18,983	13
14	19	Professional fees	Bed Days Available	725,412	10	64,806		78,690	7,030	14
15	20	Dues & subscriptions	Bed Days Available	725,412	10	11,884		78,690	1,289	15
16	20	Advertising - help wanted	Bed Days Available	725,412	10	146,469		78,690	15,888	16
17	21	Management allocation - salaries	Bed Days Available	725,412	10	5,805,098	5,805,098	78,690	629,715	17
18	21	Bank charges	Bed Days Available	725,412	10	32,134		78,690	3,486	18
19	21	Office supplies & printing	Bed Days Available	725,412	10	102,249		78,690	11,092	19
20	21	Postage	Bed Days Available	725,412	10	41,415		78,690	4,493	20
21	21	Telephone	Bed Days Available	725,412	10	120,819		78,690	13,106	21
22	24	Travel and Seminar	Bed Days Available	725,412	10	29,058		78,690	3,152	22
23	23	Inservice Training	Bed Days Available	725,412	10	9,785		78,690	1,061	23
24										24
25	TOTALS					\$ 8,331,531	\$ 7,232,775		\$ 903,772	25

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	Varies	4/30/07		7,573,000		6,785,580	5/1/2017		0.0625		434,027	2
3																3
4																4
5							Interest on financing insurance premium						1,324	5		
	Working Capital															
6	Shareholders	X		Working Capital	None	Various		675,000		3,111,965	Demand		Prime +1		12,199	6
7	JP Morgan Chase N.A.		X	Line of Credit	Varies	6/29/12		5,600,000		350,000	6/29/13		Libor + 2.25%		33,398	7
8	Shareholders	X		Working Capital	Varies	4/16/12		200,000		800,000	Demand		Prime		30,811	8
9	TOTAL Facility Related						\$	14,048,000	\$	11,047,545				\$	511,759	9
	B. Non-Facility Related*															
10									Amortization of loan costs					1,397	10	
11									Interest income offset					(652)	11	
12									Allocated from management co.					19,454	12	
13									Less: Interest to shareholders					(43,010)	13	
14	TOTAL Non-Facility Related						\$		\$				\$	(22,811)	14	
15	TOTALS (line 9+line14)						\$	14,048,000	\$	11,047,545			\$	488,948	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	391,200	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.)		2011		\$	388,015	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	(3,185)	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	400,800	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.)		Allocated from Mgmt. Co.			6,712																					
				\$	37,768	5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ (1,300) For 2001 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(1,300)	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	440,795	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:	2007	433,316	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>				FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
	2008	451,429	9																							
	2009	343,531	10																							
	2010	379,566	11																							
	2011	388,015	12																							
See attached real estate accrual sheet																										

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Lexington of Wheeling

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0040923

CONTACT PERSON REGARDING THIS REPORT
Karen Gillis

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 03-10-401-027-0000	Land & Building	\$ 388,014.52	\$ 388,014.52
2. Royal Management Corp. (Samvest of Lombard II)		\$ 230,165.98	\$ 6,712.00
3. 05-01-202-021	Land & Building	\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 618,180.50	\$ 394,726.52

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? X YES NO

If YES, attach an explanation and 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	137,650	1993	\$ 595,000	1
2	Management Company Allocation			21,729	2
3	TOTALS	137,650		\$ 616,729	3

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	205		1995	1995	\$ 6,537,447	\$	10-40	\$ 163,223	\$ 163,223	\$ 2,892,130
5	10		2000	2000	98,710	2,468	40	2,468		30,848
6										
7										
8										
	Improvement Type**									
9	Building improvement			1995	3,587		15			3,587
10	Land improvement - sidewalk replacemen			1996	1,927		15			1,927
11	Leasehold improvement - pines & sod			1996	3,431		15			3,431
12	Basement rehab			1997	18,611		10			18,611
13	Building improvement - curtains/track			1997	1,936		35	55	55	801
14	Landscaping			1997	2,002	64	15	64		2,002
15	Wiring for MDS			1998	3,552		10			3,552
16	Parking Lot			1998	2,952		10			2,952
17	Roof repair			2000	1,980		10			1,980
18	Remodel HVAC/exhaust system - office area			2000	7,480	374	20	374		4,675
19	Automatic Door			2000	1,300		10			1,300
20	Rods for beside curtains			2000	2,525		10			2,525
21	Floor tile			2000	10,298		10			10,298
22	Parking lot seal coating and repair			2001	2,177		10			2,177
23	Infrared curtain units for 3 elevators			2001	4,500		5			4,500
24	Boiler vent repairs			2001	3,084		10			3,084
25	Kitchen wall rebuild			2003	22,500	1,125	20	1,125		10,500
26	Elevator upgrade			2004	11,077	554	20	554		4,801
27	Landscaping			2005	450	23	20	23		171
28	HVAC system			2005	27,711	1,386	20	1,386		10,047
29	Lobby, lounge, and reception rehab			2005	22,731	1,137	20	1,137		7,958
30	Lower level therapy room rehab			2005	8,100	405	20	405		3,206
31	First floor therapy room addition			2005	32,167	1,608	20	1,608		12,865
32	Transitional unit addition			2005	18,758	938	20	938		6,800
33	Basement rehab			2005	13,105	655	20	655		4,913
34	Countertops			2005	845		5			845
35	Window treatments			2005	4,090		5			4,090
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

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Landscaping Enhancement	2006	\$ 4,558	\$ 304	15	\$ 304	\$	\$ 1,950	37
38	HVAC	2006	10,034	1,003	10	1,003		6,102	38
39	Emergency A/C	2006	8,110	811	10	811		5,069	39
40	Administration HVAC	2006	6,058	606	10	606		3,787	40
41	Modular units attached to wall	2006	11,010	1,101	10	1,101		7,065	41
42	Transitional Unit	2006	8,017	401	10	401		2,406	42
43	Employee lunch room rehab	2006	2,361	236	10	236		1,554	43
44	Alzheimers Remodel	2007	606	15	40	15		75	44
45	Alzheimers Remodel	2007	10,535	263	40	263		1,315	45
46	Install wireless LAN	2006	5,307	531	10	531		3,186	46
47	Automatic Doors Patio	2006	2,232	223	10	223		1,450	47
48	Parking Lot	2007	3,777	189	20	189		1,008	48
49	HVAC	2007	4,842	242	20	242		1,210	49
50	First Floor Remodel-carpentry, flooring, door frames, plumbing	2007	646,028		40	16,151	16,151	96,905	50
51	First Floor Remodel-painting, carpentry, flooring, plumbing	2007			40				51
52	Landscaping	2008	14,600	973	15	973		4,622	52
53	Second Floor Remodel-carpentry, flooring, electrical, painting	2008	485,694		27	17,662	17,662	73,592	53
54	Special care unit-carpentry, electrical, painting, alarm systems	2008	40,930		27	1,488	1,488	6,200	54
55	Irrigation System	2009	15,185	1,012	15	1,012		3,458	55
56	Landscaping Enhancements	2009	21,445	1,430	15	1,430		5,005	56
57	Roof repairs	2009	137,000	6,850	20	6,850		22,263	57
58	Stamped Concrete	2009	10,512	382	27	382		1,210	58
59	Quick connects	2009	9,678	484	20	484		1,694	59
60									60
61	2nd Floor remodel-Carpentry	2009	8,116	295	27	295		1,131	61
62	Patio Fence	2009	4,824	241	20	241		743	62
63	Patio Pergola	2009	8,299	415	20	415		1,556	63
64	3rd floor remodel-Carpentry, flooring, electrical, wallpaper	2009	443,781		27	16,137	16,137	56,480	64
65	alarms sytem, painting.								65
66	Brick panel replacement	2010	164,474	5,981	27	5,981		13,457	66
67	Office carpentry, flooring, electrical, painting, plumbing, signs	2010	40,017	2,808	27	2,808		5,616	67
68	Landscaping	2010	3,124	208	15	208		468	68
69	Parking lot signs and flagpole	2010	2,870	231	27	231		540	69
70	TOTAL (lines 4 thru 69)		\$ 9,003,057	\$ 37,972		\$ 252,688	\$ 214,716	\$ 3,387,693	70

**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:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,003,057	\$ 37,972		\$ 252,688	\$ 214,716	\$ 3,387,693	1
2	Remove and replace asphalt	2010	17,500	636	27	636		1,537	2
3	Spot cooler	2010	3,456	126	27	126		262	3
4	Admin office HVAC	2010	8,400	305	27	305		788	4
5	Holding tank	2010	13,000	473	27	473		1,064	5
6	Floor sink	2010	13,177	479	27	479		1,277	6
7	Remodel pantry-shelves	2010	8,880	323	27	323		700	7
8	Paint over bed lights	2010	5,770	210	27	210		420	8
9	Remodel library/lounge-flooring,carpentry	2010	10,114	368	27	368		797	9
10	Office carpentry,flooring,electrical,painting,plumbing,signs	2011	2,541	92	27	92		146	10
11	Office doors, keys	2011	16,375	595	27	595		793	11
12	HVAC repair, fire dampers	2011	21,469	780	27	780		868	12
13	Laundry room-tile, painting, electrical	2011	8,717	317	27	317		475	13
14	Common area doors	2011	30,333	1,103	27	1,103		1,195	14
15									15
16	Sprinkler Replacement	2012	10,441	32	27	32		32	16
17	Electrical thru out home	2012	8,728	53	27	53		53	17
18									18
19									19
20									20
21									21
22	Reconcile to book depreciation			546			(546)		22
23									23
24	Land improvements - management company	2002	300,680		40	8,872	8,872	97,638	24
25	HVAC, electrical, security system - management company	2003	2,641		30	653	653	1,721	25
26	Key card system - management company	2004	415		20	21	21	175	26
27	VAV TX controls - management company	2005	126		20	6	6	50	27
28	Interior Signs-management company	2006	92		5	6	6	38	28
29	Building improvements - management company	2008	14,571		5	758	758	3,943	29
30	Building improvements - management company	2009	2,720		5	50	50	509	30
31	Building improvements - management company	2010	2,650		5	109	109	447	31
32	Building improvements - management company	2011	1,872		5	87	87	129	32
33	Building improvements - management company	2012	6,464		5	3	3	149	33
34	TOTAL (lines 1 thru 33)		\$ 9,514,189	\$ 44,410		\$ 269,145	\$ 224,735	\$ 3,502,899	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$1,312,908	\$104,662	\$221,631	\$116,969	5	\$769,829	71
72	Current Year Purchases	116,757	18,125	18,125		5	18,125	72
73	Fully Depreciated Assets	313,281				5	313,281	73
74	Allocated from Mgmt. Co.	528,865		42,938	42,938	5	305,332	74
75	TOTALS	\$2,271,811	\$122,787	\$282,694	\$159,907		\$1,406,567	75

D. Vehicle Costs. (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 Mgmt Co.			51,616		4,834	4,834	5	41,092	79
80	TOTALS			\$51,616	\$	\$4,834	\$4,834		\$41,092	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$12,454,345	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$167,197	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$556,673	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$389,476	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,950,558	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

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	Allocated from Management Company				4,350			6
7	TOTAL				\$ 4,350			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?

16. Rental Amount for movable equipment: \$ 50,047 ☐ YES ☐ NO

Description: Copier-\$9,819; Printer-\$1,121;Mailing System-\$700;Oxy-\$16,598;Med Eq-\$20,035 Alloc. Mgmt Co.-\$1,774
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Management Company			1,980	20
21	TOTAL		\$	\$ 1,980	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. /2013 \$

13. /2014 \$

14. /2015 \$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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.

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

		1	2	3	4	5	6	7	8	
	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	39(3)	hrs	\$	7,354	\$ 405,566	\$	7,354	\$ 405,566	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,853	105,063		1,853	105,063	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		12,100	714,453		12,100	714,453	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				308,414		308,414	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				106			106	12
13	Other (specify):									13
14	TOTAL			\$	21,307	\$ 1,225,188	\$ 308,414	21,307	\$ 1,533,602	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.

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	\$ 244,043	\$ 314,688	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 432,217)	3,124,362	3,124,362	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Refundable taxes	12,354	12,354	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,380,759	\$ 3,451,404	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,867	8,867	12
13	Land		616,729	13
14	Buildings, at Historical Cost		6,537,447	14
15	Leasehold Improvements, at Historical Cost	1,022,009	2,976,742	15
16	Equipment, at Historical Cost	848,413	2,323,427	16
17	Accumulated Depreciation (book methods)	(711,243)	(4,950,558)	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 net cost		27,363	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,168,046	\$ 7,540,017	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,548,805	\$ 10,991,421	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 505,729	\$ 505,729	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,261,965	4,261,965	29
30	Accrued Salaries Payable	458,639	458,639	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,350	8,350	31
32	Accrued Real Estate Taxes(Sch.IX-B)		400,800	32
33	Accrued Interest Payable		35,461	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	8,583,700	3,089,042	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,818,383	\$ 8,759,986	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,785,580	40
41	Bonds Payable			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)	\$	\$ 6,785,580	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,818,383	\$ 15,545,566	46
47	TOTAL EQUITY(page 18, line 24)	\$ (9,269,578)	\$ (4,554,145)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,548,805	\$ 10,991,421	48

*(See instructions.)

Lexington Health Care Center of Wheeling
Provider # 0040923
1/1/12-12/31/12

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Due to Merit Hospice	40,000	40,000
Due to/from rehab care therapy	42,161	42,161
Due to Republic Construction of Illinois, Inc	(35,011)	(35,011)
Due from Lexington Fin Serv LLC	27	27
Accrued Resident Tax	160,896	160,896
Accrued Expenses	66,448	66,448
Accrued Rent	6,780,355	
Accrued Insurance	120,301	120,301
Due to patient trust fund	5,364	5,364
Deferred Income	333,689	333,689
Due to Royal Operations	52,429	52,429
Due to Chicago Ridge	2,990	2,990
Due to Lake Zurich	776	776
Due to Streamwood	871	871
Advance Bi-weekly Part A Payments	44,407	44,407
Uncollectible Part A Co. Pvts	(33,927)	(33,927)
Interest Rate Swap Liability		1,285,697
Prepaid Insurance	46,204	46,204
Escrow Insurance	72,296	72,296
Professional Liabilities Claims	196,043	196,043
Accrued Royal/Vesta Mgmt. Fees	687,381	687,381
	8,583,700	3,089,042

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,643,205)	1
2	Restatements (describe):		2
3	Post closing adjustment	(117,252)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,760,457)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,509,121)	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)	\$ (1,509,121)	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)	\$ (9,269,578)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/2012Ending: 12/31/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,544,796	1
2	Discounts and Allowances for all Levels	(7,899,400)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,645,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,728,676	6
7	Oxygen	1,153	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,729,829	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,185	12
13	Barber and Beauty Care	19,547	13
14	Non-Patient Meals	1,222	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	238,632	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	91,458	19
20	Radiology and X-Ray		20
21	Other Medical Services	77,563	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 431,607	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	652	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 652	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	500	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 500	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,807,984	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,703,229	31
32	Health Care	5,673,877	32
33	General Administration	3,585,105	33
	B. Capital Expense		
34	Ownership	2,119,286	34
	C. Ancillary Expense		
35	Special Cost Centers	1,736,201	35
36	Provider Participation Fee	499,407	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,317,105	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,509,121)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,509,121)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,051,374	44
45	Private Pay - Net Inpatient Revenue	1,844,909	45
46	Medicare - Net Inpatient Revenue	1,219,033	46
47	Other-(specify) <u>Managed Care</u>	530,080	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,645,396	49

* 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.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

^ - Entity is a cash basis tax payer.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,897	2,267	\$ 123,586	\$ 54.52	1
2	Assistant Director of Nursing	23,850	28,920	727,285	25.15	2
3	Registered Nurses	31,444	37,769	1,180,650	31.26	3
4	Licensed Practical Nurses	24,924	29,972	767,148	25.60	4
5	CNAs & Orderlies	125,473	147,981	1,806,025	12.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,914	13,650	151,918	11.13	10
11	Social Service Workers	6,156	6,750	125,956	18.66	11
12	Dietician	1,332	1,446	24,334	16.83	12
13	Food Service Supervisor	1,775	2,093	39,188	18.72	13
14	Head Cook	1,825	2,055	31,008	15.09	14
15	Cook Helpers/Assistants	12,406	14,398	147,914	10.27	15
16	Dishwashers	12,436	14,367	123,311	8.58	16
17	Maintenance Workers	1,852	2,162	37,191	17.20	17
18	Housekeepers	31,256	37,164	354,854	9.55	18
19	Laundry	8,784	10,332	99,033	9.59	19
20	Administrator	1,970	2,486	160,233	64.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,734	10,399	165,767	15.94	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	1,894	2,421	39,955	16.50	31
32	Other Health Care Memory Care	2,896	3,351	71,078	21.21	32
33	Other(specify) Marketing			45,472		33
34	TOTAL (lines 1 - 33)	311,818	369,983	\$ 6,221,906 *	\$ 16.82	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	Monthly	\$ 8,938	1(3)	35
36	Medical Director	Monthly	46,025	9(3)	36
37	Medical Records Consultant	18	976	10(3)	37
38	Nurse Consultant	Monthly	16,876	10(3)	38
39	Pharmacist Consultant	Monthly	13,886	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	97	5,846	11(3)	44
45	Social Service Consultant	12	5,069	12(3)	45
46	Other(specify) Nurse Practitioner	Monthly	44,361	10(3)	46
47	Pulmonary	Monthly	26,796	10(3)	47
48	Medical Consultant	Monthly	4,221	10(7)	48
49	TOTAL (lines 35 - 48)	127	\$ 172,994		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				51
52	Certified Nurse Assistants/Aides	320	6,725	10(3)	52
53	TOTAL (lines 50 - 52)	320	\$ 6,725		53

STATE OF ILLINOIS

0040923

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Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Facility Name & ID Number

Lexington of Wheeling

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lynette Rugg	Administrator	0	\$ 160,233
Catherine Jenkins	Administrator	0	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 160,233
(List each licensed administrator separately.)			

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	\$ 1,145,523
Management Fees-Vesta Mgmt.	404,814
Management Fees (Eliminated in Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	\$ 1,550,337
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center, LLC	Collections	\$ 6,281
Cassiday Schade	Legal	84,425
Duane Morris	Legal	3,456
Scott and Krause	Legal	6,495
McGladrey & Pullen, LLP	Accounting	31,764
Personnel Planners	U/C Consulting	1,440
McCracken & Frank LLC	Legal	287
Much Shelist	Legal	11,967
Pension Administrators	Pension Administration	662
Real Med	Workers Compensation	809
Secretary of State	Filing Fees	145
See Schedule 21C		77,255
TOTAL (agree to Schedule V, line 19, column 3)		\$ 224,986
(If total legal fees exceed \$5,000, attach copy of invoices.)		

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 130,207
Unemployment Compensation Insurance	87,773
FICA Taxes	425,623
Employee Health Insurance	246,984
Employee Meals	17,688
Illinois Municipal Retirement Fund (IMRF)*	
401K	11,982
Uniform Allowance	10,722
Other Employee Benefits	37,734
Tuition Reimbursement	4,053
TOTAL (agree to Schedule V, line 22, col.8)	\$ 972,766

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	33,577
Health Care Worker Background Check (Indicate # of checks performed 108)	1,300
Patient Background Checks	385
Miscellaneous Licenses & Fees	2,105
Miscellaneous Dues & Subscriptions	4,995
Management Company Allocation	17,177
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 63,769

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Management Company Allocation	3,152
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,152

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Lexington Health Care Center of Wheeling
Provider # 0040923
1/1/12-12/31/12
Section XIX.

C. Professional Fees

Schedule 21C

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Serpico, Petrosino & Dipiero, LTD	Legal	
Ability Network	Computer Consulting	1,556
EFAX Corporate	Computer Consulting	1,291
E-HEALTH DATA SOLUTIONS	Computer Consulting	2,400
Elton Designs	Computer Consulting	260
FACILITY WIZARD	Computer Consulting	458
Health MedX	Computer Consulting	15,482
Information Controls	Computer Consulting	1,493
KRONOS	Computer Consulting	2,185
Lintech	Computer Consulting	5,025
Microsoft Licensing	Computer Consulting	3,898
MY Innerview	Computer Consulting	6,335
NATL DATACARE	Computer Consulting	2,548
ON SHIFT	Computer Consulting	9,017
Oracle	Computer Consulting	8,927
PARGAON CLINICAL	Computer Consulting	1,200
REALMED	Computer Consulting	71
Relias Learning	Computer Consulting	3,864
Silver Chair Learning Systems	Computer Consulting	2,172
Soft choice Corporation	Computer Consulting	128
Telemedicine Solutions	Computer Consulting	7,200
Top Notch	Computer Consulting	109
Trisys	Computer Consulting	214
TYMPANI	Computer Consulting	1,196
Virtual Rabbit	Computer Consulting	10
XO COMMUNICATIONS	Computer Consulting	218
Facility Wizard Software	Computer Consulting	
Survey Analytics LLC	Computer Consulting	
		<u>77,255</u>

Lexington Health Care Center of Wheeling
Provider # 0040923
1/1/12-12/31/12
Section XIX.

<u>Allocated from Mgmt. Co.</u>		
Much Shelist	Legal	603
Duane Morris	Legal	40
Cassiday Schade	Legal	2
McGladrey LLP	Accounting	1,438
Illinois Secretary of State	Filing Fees	34
Gilson Labus & Silverman	KEP	403
Tam Kaiden	Investigative Services	51
Bank of America Leasing	UCC Search & Filing	21
Versight Inc.	Annual Report-Health Ins	119
Personnel Planners	U/C Consultant	21
LaSalle Network	Recruiting/Finance	1,523
Pension Administrators, Inc.	401K Administration	294
Gene Whitehorn	Medicaid Reimb Specialist	1,164
Christine Toolan	Social Service Consulting	19
M Werner Consulting	Financial Consultant	1,020
Computer Services	Computer Consulting	18,983
		<u>25,735</u>
		<u><u>25,735</u></u>
Schedule V, line 18, column 8		<u><u>235,417</u></u>

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. \$ 66,602 Line 10(2)

(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. \$ 499,407
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. \$ 17,688 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,222

(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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of \$5,000, 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.