

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0040923</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Lexington of Wheeling</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> 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.																							
Address: <u>730 West Hintz Road</u> <u>Wheeling</u> <u>60090</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 537-7474</u> Fax # <u>(847) 537-7599</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>												
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	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																								
Date of Initial License for Current Owners: <u>5/12/95</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____																									

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	419,241	30,913	2,535	452,689		452,689		452,689			1
2	Food Purchase		377,273		377,273		377,273	(1,583)	375,690			2
3	Housekeeping	517,614	40,101		557,715		557,715	354	558,069			3
4	Laundry		25,664		25,664		25,664		25,664			4
5	Heat and Other Utilities			207,508	207,508		207,508	8,677	216,185			5
6	Maintenance	39,971		160,742	200,713		200,713	88,310	289,023			6
7	Other (specify):* Alloc. From Mgmt Co							11,353	11,353			7
8	TOTAL General Services	976,826	473,951	370,785	1,821,562		1,821,562	107,111	1,928,673			8
	B. Health Care and Programs											
9	Medical Director			48,000	48,000		48,000		48,000			9
10	Nursing and Medical Records	5,238,048	339,771	41,232	5,619,051		5,619,051	39,406	5,658,457			10
10a	Therapy											10a
11	Activities	154,702	24,582	19,321	198,605		198,605		198,605			11
12	Social Services	183,692		3,292	186,984		186,984		186,984			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt Co							5,141	5,141			15
16	TOTAL Health Care and Programs	5,576,442	364,353	111,845	6,052,640		6,052,640	44,547	6,097,187			16
	C. General Administration											
17	Administrative	71,036		1,806,025	1,877,061		1,877,061	(1,745,291)	131,770			17
18	Directors Fees											18
19	Professional Services			239,769	239,769		239,769	22,189	261,958			19
20	Dues, Fees, Subscriptions & Promotions			56,852	56,852		56,852	13,703	70,555			20
21	Clerical & General Office Expenses	237,328	28,436	52,701	318,465		318,465	775,426	1,093,891			21
22	Employee Benefits & Payroll Taxes			1,297,027	1,297,027		1,297,027		1,297,027			22
23	Inservice Training & Education			12,266	12,266		12,266	393	12,659			23
24	Travel and Seminar							1,189	1,189			24
25	Other Admin. Staff Transportation			3,208	3,208		3,208	12,965	16,173			25
26	Insurance-Prop.Liab.Malpractice			455,582	455,582		455,582	3,211	458,793			26
27	Other (specify):* Alloc. From Mgmt Co							113,878	113,878			27
28	TOTAL General Administration	308,364	28,436	3,923,430	4,260,230		4,260,230	(802,337)	3,457,893			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,861,632	866,740	4,406,060	12,134,432		12,134,432	(650,679)	11,483,753			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			114,585	114,585		114,585	339,273	453,858			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			196,332	196,332		196,332	259,617	455,949			32
33	Real Estate Taxes							617,303	617,303			33
34	Rent-Facility & Grounds			2,118,212	2,118,212		2,118,212	(2,113,001)	5,211			34
35	Rent-Equipment & Vehicles			38,985	38,985		38,985	2,471	41,456			35
36	Other (specify):*											36
37	TOTAL Ownership			2,468,114	2,468,114		2,468,114	(894,337)	1,573,777			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		234,154	891,692	1,125,846		1,125,846		1,125,846			39
40	Barber and Beauty Shops			12,250	12,250		12,250		12,250			40
41	Coffee and Gift Shops			4,443	4,443		4,443	(5,822)	(1,379)			41
42	Provider Participation Fee			487,826	487,826		487,826		487,826			42
43	Other (specify):* Non-Allowable Cos	60,546		254,722	315,268		315,268	(315,268)				43
44	TOTAL Special Cost Centers	60,546	234,154	1,650,933	1,945,633		1,945,633	(321,090)	1,624,543			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,922,178	1,100,894	8,525,107	16,548,179		16,548,179	(1,866,106)	14,682,073			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,583)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,469)	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	1,585	30		9
10	Interest and Other Investment Income	(164,419)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,606)	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	(5,980)	43		18
19	Entertainment				19
20	Contributions	(1,043)	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	(182,973)	43		24
25	Fund Raising, Advertising and Promotional	(25,060)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,498)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	173,432	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (229,614)		\$	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)	(1,636,492)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,636,492)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,866,106)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (1,031)	43	1
2	Labs-Part A	(6,434)	43	2
3	X-Rays Part A	(8,628)	43	3
4	Marketing Salary	(60,546)	43	4
5	Gift Shop Income	(5,822)	41	5
6	Trust Fees	(160)	43	6
7	Collections	(9,791)	19	7
8	Out of Period & Non-Allowable Legal	(496)	19	8
9	Unrealized Loss on FMV Swap	277,061	43	9
10	Non-Allowable Professional Fees	(1,373)	21	10
11	Salesforce.com Offset	(6,493)	21	11
12	Non-Allowable Dues	(2,855)	20	12
13				13
14				14
15				15
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	173,432		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.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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.	**	\$ 250	\$ 250	1
2	V	30	Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	229,272	229,272	2
3	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	1,397	1,397	3
4	V	32	Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	402,926	402,926	4
5	V	33	Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	610,212	610,212	5
6	V	34	Rental Income	2,118,212	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(2,118,212)	6
7	V	43	Trust Fees		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	160	160	7
8	V	43	Unrealized gain on FMV swap	277,061	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(277,061)	8
9	V	20	Licenses & Permits		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	100	100	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			\$ 2,395,273			\$ 1,244,317	\$ * (1,150,956)	14

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

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.	**	\$ 354	\$ 354	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,822	7,822	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	330	330	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	525	525	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	80,533	80,533	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	7,440	7,440	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	337	337	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	11,353	11,353	22
23	V	10 Medical consultant		Royal Management Corp.	**	2,938	2,938	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	36,468	36,468	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	5,141	5,141	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	60,734	60,734	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	16,258	16,258	27
28	V	19 Professional fees		Royal Management Corp.	**	23,834	23,834	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	2,421	2,421	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	14,037	14,037	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	747,044	747,044	31
32	V	21 Bank charges		Royal Management Corp.	**	2,990	2,990	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,102	10,102	33
34	V	21 Postage		Royal Management Corp.	**	3,760	3,760	34
35	V	21 Telephone		Royal Management Corp.	**	11,530	11,530	35
36	V							36
37	V							37
38	V	** The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.						38
39	Total		\$			\$ 1,045,951	\$ * 1,045,951	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:	01/01/2016	Ending:	12/31/2016
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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	23	Inservice Training	\$	Royal Management Corp.	**	\$ 393	\$ 393	15
16	V	24	Travel and Seminar		Royal Management Corp.	**	1,189	1,189	16
17	V	25	Auto expense		Royal Management Corp.	**	12,965	12,965	17
18	V	26	Insurance general		Royal Management Corp.	**	3,211	3,211	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	113,878	113,878	19
20	V	30	Depreciation		Royal Management Corp.	**	108,416	108,416	20
21	V	32	Interest		Royal Management Corp.	**	17,273	17,273	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,440	2,440	22
23	V	33	Property taxes		Royal Management Corp.	**	7,091	7,091	23
24	V	34	Rent expense		Royal Management Corp.	**	5,211	5,211	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,516	1,516	25
26	V	17	Management fees	1,806,025	Royal Management Corp.	**		(1,806,025)	26
27	V	35	Auto Lease		Royal Management Corp.	**	955	955	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								38
39	Total			\$ 1,806,025			\$ 274,538	\$ * (1,531,487)	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:

01/01/2016

Ending:

12/31/2016

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	<u>James Samatas Discretionary Trust</u>	<u>33.33</u>	<u>Lexington HC Ctr. of Bloomingdale, Inc.</u>	<u>Bloomingdale</u>	<u>Eastgate Manor</u>	<u>Algonquin</u>	<u>Supportive</u>	1
2	<u>John Samatas Discretionary Trust</u>	<u>33.33</u>	<u>Lexington HC Ctr. of Chicago Ridge, Inc.</u>	<u>Chicago Ridge</u>	<u>of Algonquin, LLC</u>		<u>Living Facility</u>	2
3	<u>Cynthia Thiem Discretionary Trust</u>	<u>33.34</u>	<u>Lexington HC Ctr. of Elmhurst, Inc.</u>	<u>Elmhurst</u>	<u>Lexington Square</u>	<u>Lombard</u>	<u>Independent and</u>	3
4			<u>Lexington HC Ctr. of LaGrange, Inc.</u>	<u>LaGrange</u>	<u>Life Care</u>		<u>Assisted Living</u>	4
5			<u>Lexington HC Ctr. of Lake Zurich, Inc.</u>	<u>Lake Zurich</u>	<u>of Lombard, LLC</u>		<u>Facility</u>	5
6			<u>Lexington HC Ctr. of Lombard, Inc.</u>	<u>Lombard</u>	<u>Lexington Square</u>	<u>Elmhurst</u>	<u>Independent</u>	6
7			<u>Lexington HC Ctr. of Orland Park, Inc.</u>	<u>Orland Park</u>	<u>Life Care</u>		<u>Living Facility</u>	7
8			<u>Lexington HC Ctr. of Schaumburg, Inc.</u>	<u>Schaumburg</u>	<u>of Elmhurst, LLC</u>			8
9			<u>Lexington HC Ctr. of Streamwood, Inc.</u>	<u>Streamwood</u>	<u>Vesta Management</u>	<u>Lombard</u>	<u>Mgmt. Company</u>	9
10					<u>Group LLC</u>			10
11					<u>Lexington Health</u>	<u>Wheeling</u>	<u>Real Estate</u>	11
12					<u>Care Systems of</u>		<u>Property</u>	12
13					<u>Wheeling Ltd. Ptsp.</u>			13
14					<u>Royal Management</u>	<u>Lombard</u>	<u>Mgmt. Company</u>	14
15					<u>Corporation</u>			15
16					<u>Lexington Financial</u>	<u>Lombard</u>	<u>Finance Company</u>	16
17					<u>Services II, LLC</u>			17
18					<u>Heron Point</u>	<u>Lombard</u>	<u>Mgmt. Company</u>	18
19					<u>Management Corp</u>			19
20					<u>Samvest of Lombard</u>	<u>Lombard</u>	<u>Lessor</u>	20
21					<u>II, LLC</u>			21
22					<u>North Heron</u>	<u>Lombard</u>	<u>Finance Company</u>	22
23					<u>Investments, LLC</u>			23
24					<u>Lexington Home</u>	<u>Lombard</u>	<u>Home Health</u>	24
25					<u>Health Care, Inc.</u>			25
26					<u>Lexington Hospice</u>	<u>Lombard</u>	<u>Hospice</u>	26
27					<u>Services, LLC</u>			27
28					<u>Lexington Private</u>	<u>Lombard</u>	<u>Healthcare</u>	28
29					<u>Home Care</u>			29
30								30

Facility Name & ID Number

Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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					Merit Sleep	Lombard	Mgmt. Company	1
2					Management, LLC			2
3					Sambell of	Bloomingtondale	Real Estate	3
4					Bloomingtondale Ltd.		Property	4
5					Ptsp.			5
6					Sambell of Chicago	Chicago Ridge	Real Estate	6
7					Ridge Ltd. Ptsp.		Property	7
8					Sambell of Elmhurst	Elmhurst	Real Estate	8
9					II Ltd. Ptsp.		Property	9
10					Sambell of	LaGrange	Real Estate	10
11					LaGrange Ltd. Ptsp.		Property	11
12					Lexington HC Sys	Lake Zurich	Real Estate	12
13					of Lake Zurich Ltd.		Property	13
14					Ptsp.			14
15					Lexington HC Sys	Lombard	Real Estate	15
16					of Lombard Ltd. Ptsp.		Property	16
17					Lexington HC Sys	Orland Park	Real Estate	17
18					of Orland Park Ltd.		Property	18
19					Ptsp.			19
20					Sambell of	Schaumburg	Real Estate	20
21					Schaumburg Ltd. Ptsp		Property	21
22					Sambell of	Streamwood	Real Estate	22
23					Streamwood Ltd. Ptsp		Property	23
24					Samvest of Algonquin	Algonquin	Real Estate	24
25					Ltd. Ptsp.		Property	25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	\$ 10,128	L17, C7	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,045	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,394	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	14,069	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	20,099	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,734		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:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	3	Housekeeping supplies	Bed Days Available	724,314	10	\$ 3,263	\$ 78,690	\$ 354	1
2	5	Utilities - gas & electric	Bed Days Available	724,314	10	72,000	78,690	7,822	2
3	5	Utilities - water & sewer	Bed Days Available	724,314	10	3,036	78,690	330	3
4	5	Utilities - maintenance office	Bed Days Available	724,314	10	4,835	78,690	525	4
5	6	Management allocation - salaries	Bed Days Available	724,314	10	741,281	741,281	80,533	5
6	6	Repairs & maintenance	Bed Days Available	724,314	10	68,481	78,690	7,440	6
7	6	Scavenger & exterminating	Bed Days Available	724,314	10	3,101	78,690	337	7
8	7	Management allocation - employee	Bed Days Available	724,314	10	104,504	78,690	11,353	8
9	10	Medical consultant	Bed Days Available	724,314	10	27,047	78,690	2,938	9
10	10	Management allocation - salaries	Bed Days Available	724,314	10	335,674	335,674	36,468	10
11	15	Management allocation - employee	Bed Days Available	724,314	10	47,322	78,690	5,141	11
12	17	Management allocation - salaries	Bed Days Available	724,314	10	559,036	559,036	60,734	12
13	19	Computer consultant & supplies	Bed Days Available	724,314	10	149,651	78,690	16,258	13
14	19	Professional fees	Bed Days Available	724,314	10	219,386	78,690	23,834	14
15	20	Dues & subscriptions	Bed Days Available	724,314	10	22,289	78,690	2,421	15
16	20	Advertising - help wanted	Bed Days Available	724,314	10	129,203	78,690	14,037	16
17	21	Management allocation - salaries	Bed Days Available	724,314	10	6,876,284	6,876,284	747,044	17
18	21	Bank charges	Bed Days Available	724,314	10	27,523	78,690	2,990	18
19	21	Office supplies & printing	Bed Days Available	724,314	10	92,982	78,690	10,102	19
20	21	Postage	Bed Days Available	724,314	10	34,606	78,690	3,760	20
21	21	Telephone	Bed Days Available	724,314	10	106,126	78,690	11,530	21
22									22
23									23
24									24
25	TOTALS				\$ 9,627,630	\$ 8,512,275		\$ 1,045,951	25

Ending: 2/31/2016

((630) 458-4796

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	5,998,030	5/1/2017	0.0650	402,926	2
3												3
4								Finance Charge - Insurance Policy			1,850	4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	675,000	3,190,467	Demand	Prime +1	88,000	6
7	Shareholders	X		Working Capital	Varies	Various	2,000,000	2,000,000	Demand	Varies	72,000	7
8	American Chartered Bank		X	Line of Credit	Varies	3/25/2016	5,600,000		6/24/2017	Libor + 2.5%	2,017	8
9	TOTAL Facility Related						\$ 15,848,000	\$ 11,188,497			\$ 566,793	9
	B. Non-Facility Related*											
10								Amortization of loan costs			1,397	10
11								Interest Income Offset			(2,569)	11
12								Less: Interest to Shareholders			(160,000)	12
13								See Sch 9A			50,328	13
14	TOTAL Non-Facility Related						\$				\$ (110,844)	14
15	TOTALS (line 9+line14)						\$ 15,848,000	\$ 11,188,497			\$ 455,949	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.)

Facility Name: Lexington of Wheeling
IDPH License ID Number: 0040923
Fiscal Year End: 12/31/2016

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	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							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$0.00		\$ 0	\$ 0			\$ 0	9
	B. Non-Facility Related*											
10								Allocated from Management Co.		19,713		10
11								Fee Line of Credit		832		11
12								Imputed Interest		31,589		12
13								Microsoft Software Interest		44		13
14								Non-Allowable Finance Charge		(1,850)		14
15												15
16	TOTAL Non-Facility Related				\$0.00		\$ 0	\$ 0			\$ 50,328	16

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Wheeling, Inc. 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 2015 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 2015.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>03-10-401-027-0000</u>	<u>Land & Building</u>	\$ <u>531,064.70</u>	\$ <u>534,064.70</u>
2.	<u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>249,002.30</u>	\$ <u>7,091.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>780,067.00</u></u>	\$ <u><u>541,155.70</u></u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies 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:	N/A	2. Number of Years Over Which it is Being Amortized:	N/A
----------------------------------	------------	---	------------

3. Current Period Amortization:	N/A	4. Dates Incurred:	N/A
--	------------	---------------------------	------------

Nature of Costs:

(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			21,901	2
3	TOTALS	137,650		\$ 616,901	3

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	205		1995	1995	\$ 6,537,447	\$	10-40	\$ 163,223	\$ 163,223	\$ 3,545,022	4
5	1		2000	2000	98,710	2,468	40	2,468		40,720	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvement			1995	3,587		15			3,587	9
10	Land improvement - sidewalk replacement			1996	1,927		15			1,927	10
11	Leasehold improvement - pines & sod			1996	3,431		15			3,431	11
12	Basement rehab			1997	18,611		10			18,611	12
13	Building improvement - curtains/track			1997	1,936		35	55	55	1,021	13
14	Landscaping			1997	2,002		15			2,002	14
15	Wiring for MDS			1998	3,552		10			3,552	15
16	Parking Lot			1998	2,952		10			2,952	16
17	Roof repair			2000	1,980		10			1,980	17
18	Remodel HVAC/exhaust system - office area			2000	7,480	374	20	374		6,171	18
19	Automatic Door			2000	1,300		10			1,300	19
20	Rods for beside curtains			2000	2,525		10			2,525	20
21	Floor tile			2000	10,298		10			10,298	21
22	Parking lot seal coating and repair			2001	2,177		10			2,177	22
23	Infrared curtain units for 3 elevators			2001	4,500		5			4,500	23
24	Boiler vent repairs			2001	3,084		10			3,084	24
25	Kitchen wall rebuild			2003	22,500	1,125	20	1,125		15,000	25
26	Elevator upgrade			2004	11,077	554	20	554		7,017	26
27	Landscaping			2005	450	23	20	23		263	27
28	HVAC system			2005	27,711	1,386	20	1,386		15,591	28
29	Lobby, lounge, and reception rehab			2005	22,731	1,137	20	1,137		12,506	29
30	Lower level therapy room rehab			2005	8,100	405	20	405		4,826	30
31	First floor therapy room addition			2005	32,167	1,608	20	1,608		19,297	31
32	Transitional unit addition			2005	18,758	938	20	938		10,552	32
33	Basement rehab			2005	13,105	655	20	655		7,533	33
34	Countertops			2005	845		5			845	34
35	Window treatments			2005	4,090		5			4,090	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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	\$	\$ 3,166	37
38	HVAC	2006	10,034	923	10	923		10,034	38
39	Emergency A/C	2006	8,110	608	10	608		8,110	39
40	Administration HVAC	2006	6,058	453	10	453		6,058	40
41	Modular units attached to wall	2006	11,010	642	10	642		11,010	41
42	Transitional Unit	2006	8,017	401	10	401		4,010	42
43	Employee lunch room rehab	2006	2,361	99	10	99		2,361	43
44	Alzheimers Remodel	2007	606	15	40	15		135	44
45	Alzheimers Remodel	2007	10,535	263	40	263		2,367	45
46	Install wireless LAN	2006	5,307	528	10	528		5,307	46
47	Automatic Doors Patio	2006	2,232	113	10	113		2,232	47
48	Parking Lot	2007	3,777	189	20	189		1,764	48
49	HVAC	2007	4,842	242	20	242		2,178	49
50	First Floor Remodel-carpentry, flooring, door frames, plumbing	2007	646,028		40	16,151	16,151	161,509	50
51	First Floor Remodel-painting, carpentry, flooring, plumbing	2007			40				51
52	Landscaping	2008	14,600	973	15	973		8,514	52
53	Second Floor Remodel-carpentry, flooring, electrical, painting	2008	485,694		27	17,662	17,662	144,240	53
54	Special care unit-carpentry, electrical, painting, alarm systems	2008	40,930		27	1,488	1,488	12,152	54
55	Irrigation System	2009	15,185	1,012	15	1,012		7,506	55
56	Landscaping Enhancements	2009	21,445	1,430	15	1,430		10,893	56
57	Roof repairs	2009	137,000	6,850	20	6,850		49,663	57
58	Stamped Concrete	2009	10,512	382	27	382		2,738	58
59	Quick connects	2009	9,678	484	20	484		3,630	59
60									60
61	2nd Floor remodel-Carpentry	2009	8,116	295	27	295		2,311	61
62	Patio Fence	2009	4,824	241	20	241		1,707	62
63	Patio Pergola	2009	8,299	415	20	415		3,216	63
64	3rd floor remodel-Carpentry, flooring, electrical, wallpaper	2009	443,781		27	16,137	16,137	121,028	64
65	alarms sytem, painting.								65
66	Brick panel replacement	2010	164,474	5,981	27	5,981	0	37,381	66
67	Office carpentry, flooring, electrical, painting, plumbing, signs	2010	40,017	2,808	27	2,808	0	16,848	67
68	Landscaping	2010	3,124	208	15	208	0	1,133	68
69	Parking lot signs and flagpole	2010	2,870	231	27	231	0	1,464	69
70	TOTAL (lines 4 thru 69)		\$ 9,003,057	\$ 36,763		\$ 251,481	\$ 214,718	\$ 4,397,045	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:

01/01/2016 Ending: 12/31/2016

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	
1	Totals from Page 12A, Carried Forward		\$ 9,003,057	\$ 36,763		\$ 251,481	\$ 214,718	\$ 4,397,045	1
2	Remove and replace asphalt	2010	17,500	636	27	636		4,081	2
3	Spot cooler	2010	3,456	126	27	126		766	3
4	Admin office HVAC	2010	8,400	305	27	305		2,008	4
5	Holding tank	2010	13,000	473	27	473		2,956	5
6	Floor sink	2010	13,177	479	27	479		3,193	6
7	Remodel pantry-shelves	2010	8,880	323	27	323		1,992	7
8	Paint over bed lights	2010	5,770	210	27	210		1,260	8
9	Remodel library/lounge-flooring,carpentry	2010	10,114	368	27	368		2,269	9
10	Office carpentry,flooring,electrical,painting,plumbing,signs	2011	2,541	92	27	92		514	10
11	Office doors, keys	2011	16,375	595	27	595		3,173	11
12	HVAC repair, fire dampers	2011	21,469	780	27	780		3,988	12
13	Laundry room-tile, painting, electrical	2011	8,717	317	27	317		1,744	13
14	Common area doors	2011	30,333	1,103	27	1,103		5,607	14
15									15
16	Sprinkler Replacement	2012	10,441	380	27	380		1,551	16
17	Electrical thru out home	2012	8,728	317	27	317		1,321	17
18									18
19	EMR Wiring- Entire Facility	2013	18,523	674	27	674		2,246	19
20									20
21	Install Trees - Main Entrance	2014	10,320	229	15	229		687	21
22	Remove and replace asphalt parking lot	2014	17,400	264	27	264		792	22
23	Install french drain - kitchen	2014	2,750	33	27	33		99	23
24	R/M Reclass: Replace pistons, rods, and fans - Mechanical Room	2014	2,585		27	96	96	240	24
25									25
26	Building Wiring - Entire Facility	2015	5,243	191	27	191		302	26
27	R&M - Asphalt work in the parking lot	2015	5,000		20	250	250	375	27
28									28
29	Room Renovations - 1st floor chair rails	2016	13,770	167	27	167		167	29
30									30
31									31
32	Reconcile to book depreciation			(1,240)			1,240		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,257,549	\$ 43,585		\$ 259,889	\$ 216,304	\$ 4,438,376	34

**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:

01/01/2016 Ending: 12/31/2016

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,257,549	\$ 43,585		\$ 259,889	\$ 216,304	\$ 4,438,376	1
2									2
3	Land improvements - management company	2002	303,059		40	8,956	8,956	134,469	3
4	HVAC, electrical, security system - management company	2003	2,662		30	636	636	2,114	4
5	Key card system - management company	2004	418		20	21	21	260	5
6	VAV TX controls - management company	2005	127		20	6	6	75	6
7	Interior Signs-management company	2006	93		20	6	6	63	7
8	Building improvements - management company	2008	14,686		20	162	162	6,418	8
9	Building improvements - management company	2009	2,741		20	50	50	1,113	9
10	Building improvements - management company	2010	2,672		20	49	49	1,026	10
11	Building improvements - management company	2011	1,886		20	87	87	482	11
12	Building improvements - management company	2012	6,515		20	12	12	1,112	12
13	Building improvements - management company	2013	4,923		20	356	356	1,171	13
14	Building improvements - management company	2014	2,664		20	265	265	669	14
15	Building improvements - management company	2015	468		20	57	57	86	15
16	Building improvements - management company	2016	7,731		20	222	222	222	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	TOTAL (lines 1 thru 33)		\$ 9,608,194	\$ 43,585		\$ 270,774	\$ 227,189	\$ 4,587,656	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	\$ 1,223,806	\$ 71,000	\$ 85,555	\$ 14,555	5-10	\$ 954,681	71
72	Current Year Purchases				-			72
73	Fully Depreciated Assets	550,486			-	5-7	550,486	73
74	Allocated from Mgmt. Co.	628,565		94,709	94,709	5	518,645	74
75	TOTALS	\$ 2,402,857	\$ 71,000	\$ 180,264	\$ 109,264		\$ 2,023,812	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				\$ -	\$ -	\$ -			\$ -
77					-	-	-		
78					-	-	-		
79	Allocated from Mgmt. Co.			56,664	-	2,820	2,820	5	50,316
80	TOTALS			\$ 56,664	\$ -	\$ 2,820	\$ 2,820		\$ 50,316

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)			\$	12,684,616
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	114,585
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	453,858
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	339,273
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	6,661,784

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
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. YESNO

		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				5,211			6
7	TOTAL				\$ 5,211			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: YESNO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$40,501Description: See Sch 14A
(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			955	20
21	TOTAL		\$	\$ 955	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. | /2017 | \$ |
| 13. | /2018 | \$ |
| 14. | /2019 | \$ |

* 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:Lexington of Wheeling

IDPH License ID Number:0040923

Fiscal Year End:12/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	7,207
Printer	2,523
Postage	323
Medical Equipment	28,932
Allocation from Management Company	1,516
Total - Line 16	40,501

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	\$	4,927	\$ 316,954	\$	4,927	\$ 316,954	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,425	85,080		1,425	85,080	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		12,236	479,876		12,236	479,876	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				226,778		226,778	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				9,782			9,782	12
13	Other (specify): Sch 16A	39(2)					7,376		7,376	13
14	TOTAL			\$	18,588	\$ 891,692	\$ 234,154	18,588	\$ 1,125,846	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.

Facility Name: Lexington of Wheeling
IDPH License ID Number: 0040923
Fiscal Year End: 12/31/2016

Schedule 16A

XIV. Special Services (Direct Cost)
Line 13 Other (specify)

Description	Units	Amount
DME		2,131
Oxygen		5,245
Total - Line 13		7,376

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	\$ 511,746	\$ 597,480	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,174,556)	1,928,749	1,928,749	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,421	14,421	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,454,916	\$ 2,540,650	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,867	8,867	12
13	Land		616,901	13
14	Buildings, at Historical Cost		6,537,447	14
15	Leasehold Improvements, at Historical Cost	1,051,456	3,070,747	15
16	Equipment, at Historical Cost	550,285	2,459,521	16
17	Accumulated Depreciation (book methods)	(889,160)	(6,661,784)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage Cost, Net</u>		21,774	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 721,448	\$ 6,053,473	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,176,364	\$ 8,594,123	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 307,491	\$ 307,491	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	5,190,467	5,190,467	29
30	Accrued Salaries Payable	407,006	407,006	30
31	Accrued Taxes Payable (excluding real estate taxes)	51,525	51,525	31
32	Accrued Real Estate Taxes(Sch.IX-B)		598,000	32
33	Accrued Interest Payable		35,031	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	13,125,485	3,047,081	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 19,081,974	\$ 9,636,601	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,998,030	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)	\$	\$ 5,998,030	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 19,081,974	\$ 15,634,631	46
47	TOTAL EQUITY(page 18, line 24)	\$ (15,905,610)	\$ (7,040,508)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,176,364	\$ 8,594,123	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (14,354,135)	1
2	Restatements (describe):		2
3	Post closing adjustment	130,625	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (14,223,510)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,682,100)	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)	\$ (1,682,100)	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)	\$ (15,905,610)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 22,165,047	1
2	Discounts and Allowances for all Levels	(10,859,841)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,305,206	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,817,308	6
7	Oxygen	15,525	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,832,833	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	5,822	12
13	Barber and Beauty Care	15,193	13
14	Non-Patient Meals	1,583	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	268,615	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	75,006	19
20	Radiology and X-Ray	12,503	20
21	Other Medical Services	346,749	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 725,471	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,569	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,569	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,866,079	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,821,562	31
32	Health Care	6,052,640	32
33	General Administration	4,260,230	33
	B. Capital Expense		
34	Ownership	2,468,114	34
	C. Ancillary Expense		
35	Special Cost Centers	1,457,807	35
36	Provider Participation Fee	487,826	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,548,179	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,682,100)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,682,100)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,968,451	44
45	Private Pay - Net Inpatient Revenue	1,803,785	45
46	Medicare - Net Inpatient Revenue	508,231	46
47	Other-(specify) <u>Managed Care</u>	1,024,739	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,305,206	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 taxpayer.

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	1,650	2,297	\$ 120,848	\$ 52.62	1
2	Assistant Director of Nursing	1,859	2,130	78,313	36.77	2
3	Registered Nurses	26,360	31,050	1,052,138	33.89	3
4	Licensed Practical Nurses	35,653	41,574	1,087,256	26.15	4
5	CNAs & Orderlies	138,876	157,701	2,310,817	14.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,311	2,432	45,136	18.56	9
10	Activity Assistants	9,094	10,177	109,566	10.77	10
11	Social Service Workers	7,385	8,348	183,692	22.01	11
12	Dietician	1,136	1,299	21,235	16.35	12
13	Food Service Supervisor	1,978	2,207	51,886	23.51	13
14	Head Cook	2,009	2,242	39,884	17.79	14
15	Cook Helpers/Assistants	25,744	28,981	306,236	10.57	15
16	Dishwashers					16
17	Maintenance Workers	1,891	2,156	39,971	18.54	17
18	Housekeepers	41,027	47,208	517,614	10.96	18
19	Laundry					19
20	Administrator	997	1,132	71,036	62.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,820	13,211	237,328	17.96	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	1,830	2,211	41,748	18.88	31
32	Other Health Care See Sch 20A	17,904	22,452	546,927	24.36	32
33	Other(specify) Marketing	1,572	1,748	60,547	34.65	33
34	TOTAL (lines 1 - 33)	330,098	380,554	\$ 6,922,178 *	\$ 18.19	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		\$		35
36	Medical Director	Monthly	48,000	9(3)	36
37	Medical Records Consultant	Monthly	748	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,142	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	Monthly	4,704	11(3)	44
45	Social Service Consultant	Monthly	3,292	12(3)	45
46	Other(specify) Pulmonary	Monthly	13,986	10(3)	46
47	Post Acute Consultant	Monthly	2,956	10(3)	47
48	See Sch20B	Monthly	11,338	Var.	48
49	TOTAL (lines 35 - 48)		\$ 100,166		49

C. CONTRACT NURSES

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

Facility Name: Lexington of Wheeling
IDPH License ID Number: 0040923
Fiscal Year End: 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Memory Care	-	8	185	\$ 23.63
Staffing Coordinator	1,402	2,141	26,590	\$ 12.42
Unit Secretary	4,373	5,440	110,139	\$ 20.25
Accounts Coordinator	1,756	2,312	30,034	\$ 12.99
Admissions	973	1,096	29,643	\$ 27.04
MDS	5,975	7,437	237,750	\$ 31.97
Clinical Coordinator	76	88	3,067	\$ 35.00
Dietetic Technician	786	854	14,413	\$ 16.87
Wound Care Coordinator	2,563	3,076	95,107	\$ 30.92
Total - Line 32 Other Health Care (specify):	17,904	22,452	546,927	24.36

Facility Name: Lexington of Wheeling
IDPH License ID Number: 0040923
Fiscal Year End: 12/31/2016

Schedule 20B

XVIII. Staffing and Salary Costs
B. Consultant Services
Line 48

Description	# of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Sch V Line & Column Reference
Medical Consultant	Monthly	2,938	10(7)
Telemedicine Consultant	Monthly	8,400	10(3)
Total - Line 48		11,338	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description	Amount		
Amy Saltzman	Administrator	0	\$ 71,036	Workers' Compensation Insurance	\$	235,281	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance		53,927	Advertising: Employee Recruitment	26,121		
				FICA Taxes		511,704	Health Care Worker Background Check			
				Employee Health Insurance		432,126	(Indicate # of checks performed 99)	1,197		
				Employee Meals			Patient Background Checks 354	4,248		
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees	5,486		
				401K		24,073	Miscellaneous Dues & Subscriptions	11,441		
				Uniform Allowance		3,956	Non Allowable Dues	(2,855)		
				Other Employee Benefits		35,960	Management Company Allocation	16,458		
							IHCA Dues	6,469		
							Less: Public Relations Expense	()		
							Non-allowable advertising	()		
							Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,036	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,297,027	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 70,555
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
Management Fees-Royal Operating			\$ 1,361,472	N/A		\$	Out-of-State Travel	\$		
Management Fees-Vesta Mgmt.			444,553							
Management Fees (Eliminated in Column 7)							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,806,025							
C. Professional Services							Seminar Expense			
Vendor/Payee	Type		Amount				Management Company Allocation	1,189		
American Chartered Bank	Financial		\$ 47,740							
Attadale	Operations Consulting		9,990							
Cassidy Schade	Legal		38,465							
Duane Morris	Legal		1,199							
Grabowski Law	Legal		170							
RSM US LLP	Accounting		41,130							
Much Shelist	Collections		6,902							
Much Shelist	Legal		5,965							
Personnel Planners	U/C Consulting		1,215							
Pension Administrators	401K Administration		940							
SB2 Inc.	Medicaid Consulting		2,484							
See Schedule 21C	See Schedule 21C		83,569				Entertainment Expense	()		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 239,769	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 1,189

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Lexington of Wheeling
IDPH License ID Number: 0040923
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Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Cash Receipts	Collections	2,719
Scott & Kraus	Legal	108
Vesta	Tax Consulting	1,373
Voya	Financial	5
Information Controls	Computer Services	13,349
MHC	Computer Services	1,568
Ntt	Computer Services	732
Ability	Computer Services	6,251
Avatier	Computer Services	188
Cinetec	Computer Services	851
Citrix	Computer Services	702
Corepoint	Computer Services	1,436
DocuSign	Computer Services	462
Ehealth	Computer Services	872
OnShift	Computer Services	9,321
Relias	Computer Services	8,489
Salesforce	Computer Services	6,493
Sophos	Computer Services	(5,518)
Symbria	Computer Services	2,200
Tableau Software	Computer Services	411
Availity	Computer Services	267
HealthMedx	Computer Services	16,026
National Datacare Corp	Computer Services	2,556
Provinet	Computer Services	112
Softchoice Corporation	Computer Services	11,215
Microsoft Licensing	Computer Services	1,381
Total (agree to Schedule V, line 19, column 3)		239,769
Legal Allocated from Real Estate		250
Less: Non-Allowable Professional Fees		(1,373)
Less: Non-Allowable Legal Fees		(10,287)
Less: Non-Allowable Computer Services		(6,493)
Allocated from SV of Lombard II		
Gilson Labus & Silverman Accounting		132
Illinois Secretary of State Filing Fees		10
		142
Allocated from Management Company		
RSM US LLP Accounting		3,606
Marcum LLP Accounting		431
Gilson Labus & Silverman Accounting		112
Illinois Secretary of State Filing Fees		51
LaSalle Network Recruiting/Finance		2,507
Callan Associates, Ltd. Recruiting		13,426
Pension Administrators, Inc. 401K Administration		430
Voya Financial 401K Administration		18
Gene Whitehorn Medicaid Reimb Specialist		1,936
M. Werner Consulting Financial Consultant		1,030
M. Rodeghier Consulting Process Improvement Consultant		78
Wordy.com Proofreading		69
Computer Services Computer Consulting		16,258
Total (agree to Schedule V, line 19, column 8)		261,958

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>IHCA - \$6,469</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>Yes</u> <u>Yes</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>N/A</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>61,081</u> Line <u>10(2)</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	<u>N/A</u>
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>487,826</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? (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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?	\$ <u>-</u> <u>Yes</u> Indicate the amount. \$ <u>1,583</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> <u>No</u> \$ <u>N/A</u> <u>0</u> <u>Adequate records have been maintained</u> <u>Yes</u> <u>N/A</u> <u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees	<u>Yes</u>