

		FOR OHF USE				

LL 1

**2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0040923</u></p> <p><b>Facility Name:</b> <u>Lexington of Wheeling</u></p> <p><b>Address:</b> <u>730 W. Hintz Road</u> <u>Wheeling</u> <u>60090</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(847) 537-7474</u> <b>Fax #</b> <u>(847) 537-7599</u></p> <p><b>IDPA ID Number:</b> <u>363885225001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>05/12/95</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Charles J. Fischer</u> <b>Telephone Number:</b> <u>(312) 634-3400</u>  <b>Please send copies of desk review and audit adjustments to address on this page</b></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/01</u> to <u>12/31/01</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 634-3400</u> <b>Fax #</b> <u>(312) 634-5518</u></td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	<b>Paid Preparer</b>	(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> <b>Fax #</b> <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																					
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																					
	<input checked="" type="checkbox"/> "Sub-S" Corp.																																						
	<input type="checkbox"/> Limited Liability Co.																																						
	<input type="checkbox"/> Trust																																						
	<input type="checkbox"/> Other _____																																						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____																																						
	(Type or Print Name) _____																																						
	(Title) _____																																						
	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____																																						
<b>Paid Preparer</b>	(Print Name and Title) _____																																						
	(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>																																						
	(Telephone) <u>(312) 634-3400</u> <b>Fax #</b> <u>(312) 634-5518</u>																																						

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

# 0040923 Report Period Beginning: 1/01/01 Ending: 12/31/01

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>221</u>	Skilled (SNF)	<u>221</u>	<u>80,665</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>221</u>	TOTALS	<u>221</u>	<u>80,665</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>36,882</u>	<u>4,867</u>	<u>6,292</u>	<u>48,041</u>	8
9	SNF/PED					9
10	ICF	<u>18,572</u>	<u>2,380</u>	<u>784</u>	<u>21,736</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>55,454</u>	<u>7,247</u>	<u>7,076</u>	<u>69,777</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.50%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES  NO

I. On what date did you start providing long term care at this location? Date started 05/12/95

J. Was the facility purchased or leased after January 1, 1978? YES  Date New Construction NO

K. Was the facility certified for Medicare during the reporting year? YES  NO  If YES, enter number of beds certified 32 and days of care provided 5,129

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/01/01 Ending: 12/31/01

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	334,183	38,383	13,318	385,884		385,884		385,884		1
2	Food Purchase		282,733		282,733		282,733	(12,188)	270,545		2
3	Housekeeping	295,217	40,998		336,215		336,215		336,215		3
4	Laundry	59,204	28,233		87,437		87,437	(4,042)	83,395		4
5	Heat and Other Utilities			159,059	159,059		159,059	3,156	162,215		5
6	Maintenance	63,243		100,892	164,135		164,135	1,051	165,186		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	751,847	390,347	273,269	1,415,463		1,415,463	(12,023)	1,403,440		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,050	13,050		13,050		13,050		9
10	Nursing and Medical Records	3,247,537	197,863	2,300	3,447,700		3,447,700		3,447,700		10
10a	Therapy			647,751	647,751		647,751		647,751		10a
11	Activities	165,864	26,410	3,936	196,210		196,210		196,210		11
12	Social Services	64,460		2,741	67,201		67,201		67,201		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,477,861	224,273	669,778	4,371,912		4,371,912		4,371,912		16
	<b>C. General Administration</b>										
17	Administrative	194,911		352,367	547,278		547,278	(352,367)	194,911		17
18	Directors Fees										18
19	Professional Services			39,778	39,778		39,778	3,021	42,799		19
20	Dues, Fees, Subscriptions & Promotions			30,523	30,523		30,523	3,248	33,771		20
21	Clerical & General Office Expenses	416,975	31,115	24,284	472,374		472,374	19,371	491,745		21
22	Employee Benefits & Payroll Taxes			535,774	535,774		535,774	58,096	593,870		22
23	Inservice Training & Education			160	160		160		160		23
24	Travel and Seminar			4,491	4,491		4,491	1,650	6,141		24
25	Other Admin. Staff Transportation							9,543	9,543		25
26	Insurance-Prop.Liab.Malpractice			121,947	121,947		121,947	2,350	124,297		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	611,886	31,115	1,109,324	1,752,325		1,752,325	(255,088)	1,497,237		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,841,594	645,735	2,052,371	7,539,700		7,539,700	(267,111)	7,272,589		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			29,891	29,891		29,891	219,140	249,031		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			2,259	2,259		2,259	405,263	407,522		32
33	Real Estate Taxes							393,125	393,125		33
34	Rent-Facility & Grounds			1,591,331	1,591,331		1,591,331	(1,591,331)			34
35	Rent-Equipment & Vehicles			178	178		178	649	827		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,623,659	1,623,659		1,623,659	(573,154)	1,050,505		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		109,800	34,710	144,510		144,510		144,510		39
40	Barber and Beauty Shops			35,558	35,558		35,558		35,558		40
41	Coffee and Gift Shops			3,838	3,838		3,838		3,838		41
42	Provider Participation Fee			120,997	120,997		120,997		120,997		42
43	Other (specify):* <b>Nonallowable costs</b>			5,077	5,077		5,077	(5,077)			43
44	<b>TOTAL Special Cost Centers</b>		109,800	200,180	309,980		309,980	(5,077)	304,903		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,841,594	755,535	3,876,210	9,473,339		9,473,339	(845,342)	8,627,997		45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

# 0040923

Report Period Beginning: 1/01/01

Ending: 12/31/01

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(163)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,042)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,426)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(920)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,095)	43		24
25	Fund Raising, Advertising and Promotional	(11,062)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	23,925	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(6,154)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (26,937)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(818,405)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (818,405)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (845,342)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington of Wheeling**  
**Provider # 0040923**  
**1/1/01 - 12/31/01**

**Schedule A**

Schedule VI. Adjustment detail  
Line 29, Other

Description	Amount	Reference
Nonallowable collections and out of period legal fees	(4,336)	19
Offset miscellaneous income	(1,818)	21
Total	<u>(6,154)</u>	

**See Accountants' Compilation Report**

Lexington of Wheeling

ID# 0040923  
 Report Period Beginning: 1/01/01  
 Ending: 12/31/01

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

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Lexington of Wheeling

# 0040923

Report Period Beginning:

1/01/01

Ending:

12/31/01

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(163)	0	0	0	0	0	0	0	0	0	0	(163)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,042)	0	0	0	0	0	0	0	0	0	0	(4,042)	4
5	Heat and Other Utilities	0	0	3,156	0	0	0	0	0	0	0	0	3,156	5
6	Maintenance	0	0	1,051	0	0	0	0	0	0	0	0	1,051	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,205)</b>	<b>0</b>	<b>4,207</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	(352,367)	0	0	0	0	0	0	0	(352,367)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50	7,307	0	0	0	0	0	0	0	0	7,357	19
20	Fees, Subscriptions & Promotions	0	0	3,248	0	0	0	0	0	0	0	0	3,248	20
21	Clerical & General Office Expenses	0	75	21,114	0	0	0	0	0	0	0	0	21,189	21
22	Employee Benefits & Payroll Taxes	0	0	46,071	0	0	0	0	0	0	0	0	46,071	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,650	0	0	0	0	0	0	0	0	1,650	24
25	Other Admin. Staff Transportation	0	0	9,543	0	0	0	0	0	0	0	0	9,543	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,350	0	0	0	0	0	0	0	2,350	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>125</b>	<b>88,933</b>	<b>(350,017)</b>	<b>0</b>	<b>(260,959)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(4,205)</b>	<b>125</b>	<b>93,140</b>	<b>(350,017)</b>	<b>0</b>	<b>(260,957)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

1/01/01

Ending:

12/31/01

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	0	206,195	0	12,945	0	0	0	0	0	0	0	219,140 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(11,426)	415,418	0	1,271	0	0	0	0	0	0	0	405,263 32
33	Real Estate Taxes	0	391,331	0	1,794	0	0	0	0	0	0	0	393,125 33
34	Rent-Facility & Grounds	0	(1,591,331)	0	0	0	0	0	0	0	0	0	(1,591,331) 34
35	Rent-Equipment & Vehicles	0	0	0	649	0	0	0	0	0	0	0	649 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(11,426)</b>	<b>(578,387)</b>	<b>0</b>	<b>16,659</b>	<b>0</b>	<b>(573,154) 37</b>						
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(5,152)	75	0	0	0	0	0	0	0	0	0	(5,077) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(5,152)</b>	<b>75</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,077) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(20,783)</b>	<b>(578,187)</b>	<b>93,140</b>	<b>(333,358)</b>	<b>0</b>	<b>(839,188) 45</b>						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%			Lexington Health		Real estate ptsp.
John Samatas	33.33%	See attached Schedule B		Care Systems of		
Cynthia Thiem	33.34%			Wheeling Ltd. Ptsp.		
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial	Lombard	Finance Co.
				Services II, L.L.C.		

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.	**	\$ 50	\$ 50 1	
2	V	21 Bank charges		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	75	75 2	
3	V	30 Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	206,195	206,195 3	
4	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	3,653	3,653 4	
5	V	32 Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	411,765	411,765 5	
6	V	33 Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	391,331	391,331 6	
7	V	34 Rental expense	1,591,331	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,591,331) 7	
8	V	43 State replacement tax		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	75	75 8	
9	V							
10	V							
11	V							
12	V							
13	V	** The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Lexington Health Care Systems of Wheeling Limited Partnership						
14	Total		\$ 1,591,331			\$ 1,013,144	\$ * (578,187) 14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington of Wheeling**  
**Provider # 0040923**  
**1/1/01 - 12/31/01**

**Schedule B**

VII. Related Parties  
Related Nursing Homes

Name of facility

City

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

Lombard  
Bloomingdale  
Chicago Ridge  
Elmhurst  
LaGrange  
Lake Zurich  
Schaumburg  
Streamwood  
Orland Park

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 1/01/01Ending: 12/31/01

## 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	5	Utilities - gas & electric	Royal Management Corp.	**	\$ 2,791	\$ 2,791
16	V	5	Utilities - water & sewer	Royal Management Corp.	**	365	365
17	V	6	Repairs & maintenance	Royal Management Corp.	**	732	732
18	V	6	Scavenger & exterminating	Royal Management Corp.	**	306	306
19	V	6	Security service	Royal Management Corp.	**	13	13
20	V	19	Computer consultant & supplies	Royal Management Corp.	**	5,587	5,587
21	V	19	Professional fees	Royal Management Corp.	**	1,720	1,720
22	V	20	Advertising - help wanted	Royal Management Corp.	**	2,658	2,658
23	V	20	Dues & subscriptions	Royal Management Corp.	**	590	590
24	V	21	Bank charges	Royal Management Corp.	**	3,183	3,183
25	V	21	Communications	Royal Management Corp.	**	575	575
26	V	21	Office supplies & printing	Royal Management Corp.	**	6,867	6,867
27	V	21	Postage	Royal Management Corp.	**	2,900	2,900
28	V	21	Telephone	Royal Management Corp.	**	7,589	7,589
29	V	22	FICA	Royal Management Corp.	**	28,263	28,263
30	V	22	FUTA	Royal Management Corp.	**	583	583
31	V	22	SUTA	Royal Management Corp.	**	1,104	1,104
32	V	22	Insurance - W/C	Royal Management Corp.	**	356	356
33	V	22	Insurance - Hospitalization	Royal Management Corp.	**	11,802	11,802
34	V	22	401(k) and other emp. benefits	Royal Management Corp.	**	3,963	3,963
35	V	24	Travel & seminar	Royal Management Corp.	**	1,650	1,650
36	V	25	Auto expense	Royal Management Corp.	**	9,543	9,543
37	V						
38	V		** Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.				
39	Total		\$			\$ 93,140	\$ * 93,140

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	26 Insurance - general	\$	Royal Management Corp.	**	\$ 2,350	\$ 2,350
16	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,973	3,973
17	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	2,445	2,445
18	V	30 Depreciation - equipment		Royal Management Corp.	**	6,527	6,527
19	V	32 Interest		Royal Management Corp.	**	1,271	1,271
20	V	33 Property taxes		Royal Management Corp.	**	1,794	1,794
21	V	35 Equipment rental		Royal Management Corp.	**	649	649
22	V	17 Management fees	352,367	Royal Management Corp.	**		(352,367)
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 352,367			\$ 19,009	\$ * (333,358)

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

Facility Name & ID Number      Lexington of Wheeling      #      0040923      Report Period Beginning:      1/01/01      Ending:      12/31/01

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	5	10.00%	Salary	\$ 39,783	L17, C1	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule C	2	4.00%	Salary	17,495	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	5.00%	Salary	21,953	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4.00%	Salary	8,961	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12.00%	Salary	12,097	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 100,289		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington of Wheeling**  
**Provider # 0040923**  
**1/1/01 - 12/31/01**

**Schedule C**

VII. Related Parties

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

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	13,615	30,961	17,085	6,975	9,414	78,050
Lexington Health Care Center of Chicago Ridge, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Elmhurst, Inc.	11,728	26,672	14,718	6,009	8,110	67,237
Lexington Health Care Center of LaGrange, Inc.	8,628	19,621	10,827	4,420	5,966	49,462
Lexington Health Care Center of Lake Zurich, Inc.	16,123	36,664	20,230	8,260	11,148	92,425
Lexington Health Care Center of Lombard, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Orland Park, Inc.	20,900	47,523	26,222	10,707	14,447	119,799
Lexington Health Care Center of Schaumburg, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Streamwood, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence	3,608	8,205	4,528	1,849	2,495	20,685
<b>Total</b>	<b>145,530</b>	<b>330,934</b>	<b>182,610</b>	<b>74,556</b>	<b>100,620</b>	<b>834,250</b>

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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	5	Utilities - gas & electric	Bed Days	751,703	11	\$ 26,007	\$ 80,665	\$ 2,791	1
2	5	Utilities - water & sewer	Bed Days	751,703	11	3,397	80,665	365	2
3	6	Repairs & maintenance	Bed Days	751,703	11	6,818	80,665	732	3
4	6	Scavenger & exterminating	Bed Days	751,703	11	2,851	80,665	306	4
5	6	Security Service	Bed Days	751,703	11	125	80,665	13	5
6	19	Computer consultant & supplies	Bed Days	751,703	11	52,068	80,665	5,587	6
7	19	Professional fees	Bed Days	751,703	11	16,027	80,665	1,720	7
8	20	Advertising - help wanted	Bed Days	751,703	11	24,766	80,665	2,658	8
9	20	Dues & subscriptions	Bed Days	751,703	11	5,496	80,665	590	9
10	21	Bank charges	Bed Days	751,703	11	29,664	80,665	3,183	10
11	21	Communications	Bed Days	751,703	11	5,359	80,665	575	11
12	21	Office supplies & printing	Bed Days	751,703	11	63,988	80,665	6,867	12
13	21	Postage	Bed Days	751,703	11	27,021	80,665	2,900	13
14	21	Telephone	Bed Days	751,703	11	70,716	80,665	7,589	14
15	22	FICA	Bed Days	751,703	11	263,374	80,665	28,263	15
16	22	FUTA	Bed Days	751,703	11	5,433	80,665	583	16
17	22	SUTA	Bed Days	751,703	11	10,292	80,665	1,104	17
18	22	Insurance - W/C	Bed Days	751,703	11	3,319	80,665	356	18
19	22	Insurance - Hospitalization	Bed Days	751,703	11	109,982	80,665	11,802	19
20	22	401(k) and other emp. benefits	Bed Days	751,703	11	36,931	80,665	3,963	20
21	24	Travel & seminar	Bed Days	751,703	11	15,373	80,665	1,650	21
22	25	Auto expense	Bed Days	751,703	11	88,927	80,665	9,543	22
23									23
24									24
25	TOTALS					\$ 867,934	\$	\$ 93,140	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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	26 Insurance - general	Bed Days	751,703	11	\$ 21,896	\$	80,665	\$ 2,350	1
2	30 Depreciation - vehicles	Bed Days	751,703	11	37,022		80,665	3,973	2
3	30 Depreciation - leasehold improv.	Bed Days	751,703	11	22,789		80,665	2,445	3
4	30 Depreciation - equipment	Bed Days	751,703	11	60,826		80,665	6,527	4
5	32 Interest	Bed Days	751,703	11	11,844		80,665	1,271	5
6	33 Property taxes	Bed Days	751,703	11	16,719		80,665	1,794	6
7	35 Equipment rental	Bed Days	751,703	11	6,049		80,665	649	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 177,145	\$		\$ 19,009	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

1/01/01

Ending:

12/31/01

## 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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Lexington Financial					\$	\$			\$	1									
2	Services II, L.L.C.	x		Mortgage	\$49,514.00	12/29/98	6,513,000	6,016,035	12/29/08	0.0675	411,765	2								
3											3									
4											4									
5											5									
	<b>Working Capital</b>																			
6	Shareholders	x		Working Capital	None	Various	587,000		Demand	0.0500	2,259	6								
7											7									
8											8									
9	TOTAL Facility Related				\$49,514.00		\$ 7,100,000	\$ 6,016,035			\$ 414,024	9								
	<b>B. Non-Facility Related*</b>																			
10							Amortization of loan costs				3,653	10								
11							Interest income offset				(11,426)	11								
12							Allocated from management company				1,271	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (6,502)	14								
15	TOTALS (line 9+line14)						\$ 7,100,000	\$ 6,016,035			\$ 407,522	15								

\* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lexington of Wheeling COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040923

CONTACT PERSON REGARDING THIS REPORT Ms. Susan Rojek

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

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-10-401-027-0000</u>	<u>Land &amp; Building</u>	\$ <u>379,330.96</u>	\$ <u>379,330.96</u>
2. <u>Royal Management Corp. (Omni Partners)</u>		\$ _____	\$ _____
3. <u>06-19-201-018</u>	<u>Land &amp; Building</u>	\$ <u>68,214.22</u>	\$ <u>1,794.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>447,545.18</u>	\$ <u>381,124.96</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lexington of Wheeling# 0040923 Report Period Beginning:1/01/01 Ending:12/31/01

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/AF. 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/A3. 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	<u>Resident Care</u>	<u>137,650</u>	<u>1993</u>	<u>\$ 595,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>137,650</u>		<u>\$ 595,000</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

# 0040923

Report Period Beginning:

1/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	211	1995	1995	\$ 6,537,447	\$	10-40	\$ 164,075	\$ 164,075	\$ 1,087,000	4
5	10	2000	2000	98,710	1,234	40	2,468	1,234	3,702	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Building improvement	1995		3,587		15	239	239	1,585	9
10	Land improvement - sidewalk replacement	1996		1,927	128	15	128		706	10
11	Leasehold improvement - pines & sod	1996		3,432	229	15	229		1,259	11
12	Basement rehab	1997		18,611	1,860	10	1,860		8,373	12
13	Building improvement - curtains/track	1997		1,936		35	55	55	249	13
14	Landscaping	1997		2,002	134	15	134		602	14
15	Wiring for MDS	1998		3,552	355	10	355		1,243	15
16	Parking Lot	1998		2,952	294	10	294		1,031	16
17	Roof repair	2000		1,980	99	10	99		297	17
18	Remodel HVAC/exhaust system - office area	2000		7,480	187	20	187		561	18
19	Automatic Door	2000		1,300	65	10	65		195	19
20	Rods for beside curtains	2000		2,525	126	10	126		378	20
21	Floor tile	2000		10,298	515	10	515		1,545	21
22	Parking lot seal coating and repair	2001		2,177	109	10	109		109	22
23	Infrared curtain units for 3 elevators	2001		4,500	450	5	450		450	23
24	Boiler vent repairs	2001		3,083	154	10	154		154	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Allocated from management company	1995	\$ 10,777	\$	35	\$ 333	\$ 333	\$ 2,002	37
38	Allocated from management company	1996	8,775		35	271	271	1,376	38
39	Allocated from management company	1989	302		31	9	9	129	39
40	Allocated from management company - HVAC	1998	227		35	7	7	26	40
41	Allocated from management company - offices	1999	573		35	18	18	44	41
42	Allocated from management company -offices	2000	272		35	8	8	12	42
43	Allocated from management company	1987	55,454		31	1,716	1,716	24,286	43
44	Allocated from management company	1993	30		39	1	1	5	44
45	Allocated from management company	1995	1,247		39	39	39	206	45
46	Allocated from management company	1996	252		39	8	8	33	46
47	Allocated from management company - Sidewalk	1998	522		39	16	16	44	47
48	Allocated from management company - Roof	1998	19		15	1	1	6	48
49	Allocated from management company - Awnings	1999	147		39	5	5	9	49
50	Allocated from management company - Parking lot	1999	323		15	10	10	74	50
51	Allocated from management company - Façade	2001	46		39	1	1	1	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 6,786,465	\$ 5,939		\$ 173,985	\$ 168,046	\$ 1,137,692	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Wheeling

# 0040923

Report Period Beginning:

1/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 6,786,465	\$ 5,939		\$ 173,985	\$ 168,046	\$ 1,137,692		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,786,465	\$ 5,939		\$ 173,985	\$ 168,046	\$ 1,137,692		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Wheeling

# 0040923

Report Period Beginning:

1/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 6,786,465	\$ 5,939		\$ 173,985	\$ 168,046	\$ 1,137,692		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,786,465	\$ 5,939		\$ 173,985	\$ 168,046	\$ 1,137,692		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Wheeling

# 0040923

Report Period Beginning:

1/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 6,786,465	\$ 5,939		\$ 173,985	\$ 168,046	\$ 1,137,692		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,786,465	\$ 5,939		\$ 173,985	\$ 168,046	\$ 1,137,692		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 559,455	\$ 22,200	\$ 64,026	\$ 41,826	5-10 years	\$ 336,972	71
72	Current Year Purchases	5,185	518	518		5-10 years	518	72
73	Fully Depreciated Assets							73
74	Allocated from management company	70,510		6,529	6,529		51,231	74
75	TOTALS	\$ 635,150	\$ 22,718	\$ 71,073	\$ 48,355		\$ 388,721	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management company			31,915		3,973	3,973		20,793	79
80	TOTALS			\$ 31,915	\$	\$ 3,973	\$ 3,973		\$ 20,793	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,048,530	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,657	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 249,031	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 220,374	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,547,206	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

Facility Name & ID Number Lexington of Wheeling

# 0040923

Report Period Beginning: 1/01/01

Ending: 12/31/01

**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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

Fiscal Year Ending      Annual Rent

12.        /2002      \$ \_\_\_\_\_  
13.        /2003      \$ \_\_\_\_\_  
14.        /2004      \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO      Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 827

Description: Postage meter - \$176; Allocated from management - \$651

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	17,204	\$ 240,243	\$	17,204	\$ 240,243	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		8,478	60,812		8,478	60,812	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		24,742	346,696		24,742	346,696	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				109,800		109,800	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See attached Schedule D</a>					34,710			34,710	13
14	<b>TOTAL</b>			\$	50,424	\$ 682,461	\$ 109,800	50,424	\$ 792,261	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Schaumburg, Inc.**  
**Provider # 0040923**  
**1/1/01 - 12/31/01**

**Schedule D**

**Schedule XIV. Special Services**  
**Line 13, Other**

<u>Service</u>	<u>Cost</u>	<u>Line Reference</u>
Clinitron Beds	29,331	L 39, C 3
Oxygen	2,771	L 39, C 3
Laboratory	2,084	L 39, C 3
Radiology	524	L 39, C 3
Total	<u><u>34,710</u></u>	

**See Accountants' Compilation Report**

Facility Name &amp; ID Number Lexington of Wheeling

# 0040923

Report Period Beginning: 1/01/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 308,968	\$ 325,773
2	Cash-Patient Deposits		
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 300,000 )	2,170,070	2,170,070
4	Supply Inventory (priced at )		
5	Short-Term Investments		
6	Prepaid Insurance	47,688	47,688
7	Other Prepaid Expenses		
8	Accounts Receivable (owners or related parties)	37,683	37,683
9	Other(specify): See attached Schedule E		125,496
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,564,409	\$ 2,706,710
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		
12	Long-Term Investments	7,107	7,107
13	Land		595,000
14	Buildings, at Historical Cost		6,528,926
15	Leasehold Improvements, at Historical Cost	164,529	257,539
16	Equipment, at Historical Cost	146,378	667,065
17	Accumulated Depreciation (book methods)	(88,234)	(1,547,206)
18	Deferred Charges		
19	Organization & Pre-Operating Costs		
20	Accumulated Amortization - Organization & Pre-Operating Costs		
21	Restricted Funds		
22	Other Long-Term Assets (specify):		
23	Other(specify): Unamortized mortgage costs		62,096
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 229,780	\$ 6,570,527
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,794,189	\$ 9,277,237

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 271,582	\$ 271,582
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable		
30	Accrued Salaries Payable	194,924	194,924
31	Accrued Taxes Payable (excluding real estate taxes)	3,139	3,139
32	Accrued Real Estate Taxes(Sch.IX-B)		396,000
33	Accrued Interest Payable		33,840
34	Deferred Compensation		
35	Federal and State Income Taxes		
<b>Other Current Liabilities(specify):</b>			
36	See attached Schedule E	548,106	155,895
37			
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,017,751	\$ 1,055,380
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		
40	Mortgage Payable		6,016,035
41	Bonds Payable		
42	Deferred Compensation		
<b>Other Long-Term Liabilities(specify):</b>			
43			
44			
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,016,035
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,017,751	\$ 7,071,415
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,776,438	\$ 2,205,822
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,794,189	\$ 9,277,237

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington of Wheeling  
Provider # 0040923  
1/1/01 - 12/31/01

Schedule E

XV. Balance Sheet  
A. Current Assets

9. Other Current Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Escrow		125,496
Total line 9	<u>                    </u>	<u>125,496</u>

XV. Balance Sheet  
C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Rent	392,211	-
Accrued management fees	103,379	103,379
Accrued 401 (k) contribution	22,112	22,112
Due to related parties	1,223	1,223
Other accrued expenses	29,181	29,181
Total line 36	<u>548,106</u>	<u>155,895</u>

XVII. Income Statement  
E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Vending Machine Income	30
Miscellaneous Income	1,818
Investment Income in Lexington Financial Services, LLC II	1,823
Total line 28	<u>3,671</u>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,297,179	1
2	Restatements (describe):		2
3	<b>Prior year post closing entries</b>	(81,935)	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,215,244	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	621,194	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	(60,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 561,194	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,776,438	24 *

Operating entity only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

# 0040923

Report Period Beginning: 1/01/01

Ending: 12/31/01

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,157,143	1
2	Discounts and Allowances for all Levels	(439,613)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,717,530	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,095,347	6
7	Oxygen	1,988	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,097,335	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,977	12
13	Barber and Beauty Care	44,330	13
14	Non-Patient Meals	163	14
15	Telephone, Television and Radio	420	15
16	Rental of Facility Space		16
17	Sale of Drugs	134,352	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,514	19
20	Radiology and X-Ray	743	20
21	Other Medical Services	65,030	21
22	Laundry	4,042	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 264,571	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	11,426	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,426	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See attached Schedule E	3,671	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,671	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,094,533	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,415,463	31
32	Health Care	4,371,912	32
33	General Administration	1,752,325	33
<b>B. Capital Expense</b>			
34	Ownership	1,623,659	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	188,983	35
36	Provider Participation Fee	120,997	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,473,339	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	621,194	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 621,194	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis tax return.

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

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

Facility Name & ID Number **Lexington of Wheeling**

# **0040923**

Report Period Beginning: **1/01/01**

Ending:

**12/31/01**

**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	1,991	2,095	\$ 72,917	\$ 34.81	1
2	Assistant Director of Nursing	4,137	4,137	105,215	25.43	2
3	Registered Nurses	53,556	56,435	1,313,896	23.28	3
4	Licensed Practical Nurses	13,200	13,999	276,328	19.74	4
5	Nurse Aides & Orderlies	120,130	124,346	1,428,513	11.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,157	4,345	50,668	11.66	8
9	Activity Director	1,257	1,300	15,767	12.13	9
10	Activity Assistants	16,695	17,276	150,097	8.69	10
11	Social Service Workers	3,852	3,852	64,460	16.73	11
12	Dietician	2,203	2,310	34,423	14.90	12
13	Food Service Supervisor	2,023	2,079	31,155	14.99	13
14	Head Cook	3,458	3,706	37,207	10.04	14
15	Cook Helpers/Assistants	15,330	16,064	120,849	7.52	15
16	Dishwashers	17,722	18,317	110,549	6.04	16
17	Maintenance Workers	1,759	1,879	63,243	33.66	17
18	Housekeepers	41,448	43,810	295,217	6.74	18
19	Laundry	8,621	9,070	59,204	6.53	19
20	Administrator	2,017	2,098	94,622	45.10	20
21	Assistant Administrator					21
22	Other Administrative	738	746	100,289	134.44	22
23	Office Manager					23
24	Clerical	23,226	24,843	416,975	16.78	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	337,520	352,707	\$ 4,841,594 *	\$ 13.73	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	\$ 13,318	L1, C3	35
36	Medical Director	Monthly	13,050	L9, C3	36
37	Medical Records Consultant	22	1,100	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,936	L11, C3	44
45	Social Service Consultant	Monthly	2,741	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	22	\$ 35,345		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

# 0040923

Report Period Beginning: 1/01/01

Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Debbie Randon	Administrator	0.00%	\$ 94,622	Workers' Compensation Insurance	\$ 52,635	IDPH License Fee	\$ 400	
James Samatas	Admin/Plant Ops	33.33%	39,783	Unemployment Compensation Insurance	27,382	Advertising: Employee Recruitment	28,292	
John Samatas	Administrative	33.33%	17,495	FICA Taxes	353,034	Health Care Worker Background Check		
Cynthia Thiem	Administrative	33.34%	21,953	Employee Health Insurance	88,893	(Indicate # of checks performed <u>26</u> )	312	
George Samatas	Administrative	0.00%	8,961	Employee Meals	12,025	Miscellaneous Dues & Subs	576	
Jason Samatas	Administrative	0.00%	12,097	Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	943	
				401(k) Contribution	24,635			
				CNA Transportation	22,392			
				Other employee benefits	12,874			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 194,911			Allocated from management company	3,248	
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount			Non-allowable advertising	( )	
Management fees (eliminated in column 7)			\$ 352,367			Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 352,367	TOTAL (agree to Schedule V, line 22, col.8)	\$ 593,870	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 33,771	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Aetna Life Insurance & Annuity	401(k) Administration		\$ 585				Out-of-State Travel	\$
Altschuler, Melvoin & Glasser, LLP	Accounting		13,358					
American Express Tax & Bus. Sys.	Accounting		6,634				In-State Travel	
Freedman, Anselmo & Lindberg	Collections		3,840					
James Samatas	Legal		50					
Personnel Planners	U/C Consulting		850					
Robert Stachura	Accounting		27				Seminar Expense	4,491
Royal Management Corp.	Website Development		611					
Sachnoff and Weaver	Legal		2,541					
Sytematic Management Systems	Billing Consulting		7,081				Allocated from management company	1,650
See attached Schedule F			4,201				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 39,778	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 6,141

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Lexington of Wheeling**  
**Provider # 0040923**  
**1/1/01 - 12/31/01**

**Schedule F**

XIX. Support Schedules  
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Advanced Information Management	Computer services	2,735
Information Control, Inc.	Computer services	1,466
		<u>4,201</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u><u>39,778</u></u>
Allocated from management co.		
Altschuler, Melvoyn & Glasser, LLP/ American Express Tax & Business Services	Accounting	1,113
BDO Seidman, LLP	Accounting	17
Robert Stachura	Accounting	2
James Samatas	Legal	4
Sachnoff and Weaver	Legal	55
Pension Administrators / Aetna Life Ins & Annuity	401 (k) Administration	310
Various	Consulting	219
Various	Computer Services	5,587
Allocated from building partnership		
James Samatas	Filing and recording fees	50
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(3,840)
Sachnoff & Weaver	Legal-out of period	(496)
Total, Agrees to Schedule V, Line 19, Column 8		<u><u>42,799</u></u>

**See Accountants' Compilation Report.**

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

1/01/01

Ending:

12/31/01**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? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 68,196 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 120,997  
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 12,025 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 163
- (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 are maintained
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	334,183	38,383	13,318	385,884	0	385,884	0	385,884
2. Food Pr	0	282,733	0	282,733	0	282,733	-12,188	270,545
3. Housek	295,217	40,998	0	336,215	0	336,215	0	336,215
4. Laundry	59,204	28,233	0	87,437	0	87,437	-4,042	83,395
5. Heat an	0	0	159,059	159,059	0	159,059	3,156	162,215
6. Mainten	63,243	0	100,892	164,135	0	164,135	1,051	165,186
7. Other (€	0	0	0	0	0	0	0	0
8. Total Gr	751,847	390,347	273,269	1,415,463	0	1,415,463	-12,023	1,403,440
9. Medical	0	0	13,050	13,050	0	13,050	0	13,050
10. Nursin	3,247,537	197,863	2,300	3,447,700	0	3,447,700	0	3,447,700
10a. Ther:	0	0	647,751	647,751	0	647,751	0	647,751
11. Activiti	165,864	26,410	3,936	196,210	0	196,210	0	196,210
12. Social	64,460	0	2,741	67,201	0	67,201	0	67,201
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	3,477,861	224,273	669,778	4,371,912	0	4,371,912	0	4,371,912
17. Admin	194,911	0	352,367	547,278	0	547,278	-352,367	194,911
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	39,778	39,778	0	39,778	3,021	42,799
20. Fees,	0	0	30,523	30,523	0	30,523	3,248	33,771
21. Cleric:	416,975	31,115	24,284	472,374	0	472,374	19,371	491,745
22. Emplo	0	0	535,774	535,774	0	535,774	58,096	593,870
23. Inservi	0	0	160	160	0	160	0	160
24. Travel	0	0	4,491	4,491	0	4,491	1,650	6,141
25. Other .	0	0	0	0	0	0	9,543	9,543
26. Insura	0	0	121,947	121,947	0	121,947	2,350	124,297
27. Other	0	0	0	0	0	0	0	0
28. Total C	611,886	31,115	1,109,324	1,752,325	0	1,752,325	-255,088	1,497,237
29. Total C	4,841,594	645,735	2,052,371	7,539,700	0	7,539,700	-267,111	7,272,589
30. Depre:	0	0	29,891	29,891	0	29,891	219,140	249,031
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	2,259	2,259	0	2,259	405,263	407,522
33. Real E	0	0	0	0	0	0	393,125	393,125
34. Rent -	0	0	1,591,331	1,591,331	0	1,591,331	#####	0
35. Rent -	0	0	178	178	0	178	649	827
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	1,623,659	1,623,659	0	1,623,659	-573,154	1,050,505
38. Medic:	0	0	0	0	0	0	0	0
39. Ancilla	0	109,800	34,710	144,510	0	144,510	0	144,510
40. Barber	0	0	35,558	35,558	0	35,558	0	35,558
41. Coffee	0	0	3,838	3,838	0	3,838	0	3,838
42. Provid	0	0	120,997	120,997	0	120,997	0	120,997
43. Other	0	0	5,077	5,077	0	5,077	-5,077	0
44. Total €	0	109,800	200,180	309,980	0	309,980	-5,077	304,903
45. Grand	4,841,594	755,535	3,876,210	9,473,339	0	9,473,339	-845,342	8,627,997

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	308,968	325,773
2. Cash - F	0	0
3. Account	2,170,070	2,170,070
4. Supply I	0	0
5. Short-Ter	0	0
6. Prepaid	47,688	47,688
7. Other Pr	0	0
8. Account	37,683	37,683
9. Other (s	0	125,496
10. Total c	2,564,409	2,706,710
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	7,107	7,107
13. Land	0	595,000
14. Buildin	0	6,528,926
15. Lease	164,529	257,539
16. Equipm	146,378	667,065
17. Accum	-88,234	-1,547,206
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (c	0	62,096
24. Total L	229,780	6,570,527
25. Total A	2,794,189	9,277,237
CURRENT LIABILITIES		
26. Accour	271,582	271,582
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	194,924	194,924
31. Accrue	3,139	3,139
32. Accrue	0	396,000
33. Accrue	0	33,840
34. Deferre	0	0
35. Federa	0	0
36. Other C	548,106	155,895
37. Other C	0	0
38. Total C	1,017,751	1,055,380
LONG TERM LIABILITES		
39. Long-Ter	0	0
40. Mortgag	0	6,016,035
41. Bonds F	0	0
42. Deferre	0	0
43. Other L	0	0
44. Other L	0	0
45. Total Lc	0	6,016,035
46. Total Li:	1,017,751	7,071,415
47. Total Ec	1,776,438	2,205,822
48. Total Li:	2,794,189	9,277,237

Balance per  
Medicaid  
Trial Balance

1. Gross F 9,157,143  
2. Discour -439,613

Subtota 8,717,530  
4. Day Ca 0  
5. Other C 0  
6. Therap 1,095,347  
7. Oxygen 1,988

Subtota 1,097,335  
9. Paymer 0  
10. Other 0  
11. Nurse: 0  
12. Gift an 5,977  
13. Barber 44,330  
14. Non-P 163  
15. Telept 420  
16. Rental 0  
17. Sale o 134,352  
18. Sale o 0  
19. Labor: 9,514  
20. Radiol 743  
21. Other 65,030  
22. Laund 4,042

Subtot 264,571  
24. Contrl 0  
25. Intere: 11,426

Subtot 11,426  
27. Other 3,671  
28. Other 0  
Subtot 3,671

30. Total F #####  
31. Gener 1,415,463  
32. Health 4,371,912  
33. Gener 1,752,325  
34. Owner 1,623,659  
35. Specie 188,983  
35. Provid 120,997  
37. Other 0  
40. Total E 9,473,339  
41. Incom 621,194  
42. Incom 0  
43. Net In 621,194

Page

1

2

3

4

5

6

7

8

9

10 Attachment of Real Estate Bill and fill out form

11

12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

13

14

15

16

17

18

19 The bottom right side of page under \*\*, you must write in any comments

20

21

22

23

RECONCILIATION REPORT

Lexington of Wheeling

03:16 PM

11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-845,342	equal to	-845,342	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	407,522	equal to	407,522	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	393,125	equal to	393,125	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	249,031	equal to	249,031	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	827	equal to	827	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	647,751	equal to	647,751	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4-40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	109,800	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,415,463	equal to	1,415,463	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,371,912	equal to	4,371,912	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	1,752,325	equal to	1,752,325	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,623,659	equal to	1,623,659	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	188,983	equal to	188,983	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+	N/A	38to41+43	4
Income Stat. Prov. Partic.	120,997	equal to	120,997	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,196,869	equal to	3,247,537	-50,668	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	165,864	equal to	165,864	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	64,460	equal to	64,460	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	334,183	equal to	334,183	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	63,243	equal to	63,243	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	295,217	equal to	295,217	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	59,204	equal to	59,204	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	194,911	equal to	194,911	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	416,975	equal to	416,975	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,841,594	equal to	4,841,594	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	13,318	< or = to	13,318	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	13,050	< or = to	13,050	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,300	< or = to	2,300	0	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,936	< or = to	3,936	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,741	< or = to	2,741	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	194,911	equal to	194,911	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	352,367	equal to	352,367	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	39,778	equal to	39,778	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	593,870	equal to	593,870	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	33,771	equal to	33,771	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,141	equal to	6,141	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	120,997	equal to	120,997	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	12,025	< or = to	58,096	-46,071	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	12,025	equal to	12,025	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	5,129	equal to	6,292	-1,163	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-818,405	equal to	-818,405	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4l	B.	14	8
Total loan balance	6,016,035	equal to	6,016,035	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	396,000	equal to	396,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	595,000	equal to	595,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,786,465	equal to	6,786,465	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	667,065	equal to	667,065	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,547,206	equal to	1,547,206	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,776,438	equal to	1,776,438	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	621,194	equal to	621,194	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,794,189	equal to	2,794,189	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1