

Facility Name & ID Number Lexington of Wheeling

0040923 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	215	Skilled (SNF)	215	78,690	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	215	TOTALS	215	78,690	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,614	1,028	7,406	12,048	8
9	SNF/PED					9
10	ICF	42,630	6,663	1,498	50,791	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,244	7,691	8,904	62,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.86%

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

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

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

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

None

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

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

YES NO

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

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

YES NO

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

Date started 5/12/95

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

YES Date New Construction NO

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

YES NO If YES, enter number

of beds certified 215 and days of care provided 7,325

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	389,245	42,671	14,919	446,835		446,835		446,835		1
2	Food Purchase		301,514		301,514		301,514	(14,740)	286,774		2
3	Housekeeping	331,036	36,188		367,224		367,224	491	367,715		3
4	Laundry	84,647	18,780		103,427		103,427		103,427		4
5	Heat and Other Utilities			242,839	242,839		242,839	7,255	250,094		5
6	Maintenance	37,282		150,265	187,547		187,547	49,753	237,300		6
7	Other (specify):* Mgmt. Co. Alloc Bene							5,404	5,404		7
8	TOTAL General Services	842,210	399,153	408,023	1,649,386		1,649,386	48,163	1,697,549		8
	B. Health Care and Programs										
9	Medical Director			64,800	64,800		64,800		64,800		9
10	Nursing and Medical Records	3,697,059	238,002	8,816	3,943,877		3,943,877	19,153	3,963,030		10
10a	Therapy			1,006,680	1,006,680		1,006,680		1,006,680		10a
11	Activities	245,126	30,118	7,825	283,069		283,069		283,069		11
12	Social Services	121,932		7,351	129,283		129,283		129,283		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt. Co. Alloc Bene							3,226	3,226		15
16	TOTAL Health Care and Programs	4,064,117	268,120	1,095,472	5,427,709		5,427,709	22,379	5,450,088		16
	C. General Administration										
17	Administrative	99,124		1,158,551	1,257,675		1,257,675	(1,098,635)	159,040		17
18	Directors Fees										18
19	Professional Services			90,062	90,062		90,062	6,209	96,271		19
20	Dues, Fees, Subscriptions & Promotions			32,122	32,122		32,122	5,068	37,190		20
21	Clerical & General Office Expenses	344,823	31,552	24,143	400,518		400,518	426,977	827,495		21
22	Employee Benefits & Payroll Taxes			736,489	736,489		736,489	14,570	751,059		22
23	Inservice Training & Education			3,367	3,367		3,367		3,367		23
24	Travel and Seminar			5,771	5,771		5,771	627	6,398		24
25	Other Admin. Staff Transportation			3,999	3,999		3,999	21,398	25,397		25
26	Insurance-Prop.Liab.Malpractice			188,237	188,237		188,237	3,295	191,532		26
27	Other (specify):* Mgmt. Co. Alloc Bene							64,797	64,797		27
28	TOTAL General Administration	443,947	31,552	2,242,741	2,718,240		2,718,240	(555,694)	2,162,546		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,350,274	698,825	3,746,236	9,795,335		9,795,335	(485,152)	9,310,183		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.

Facility Name & ID Number Lexington of Wheeling

#0040923

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			74,869	74,869		74,869	278,772	353,641			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			149,161	149,161		149,161	308,735	457,896			32
33	Real Estate Taxes							417,037	417,037			33
34	Rent-Facility & Grounds			1,805,621	1,805,621		1,805,621	(1,801,593)	4,028			34
35	Rent-Equipment & Vehicles			41,296	41,296		41,296	4,503	45,799			35
36	Other (specify):*											36
37	TOTAL Ownership			2,070,947	2,070,947		2,070,947	(792,546)	1,278,401			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		306,913		306,913		306,913		306,913			39
40	Barber and Beauty Shops			22,371	22,371		22,371		22,371			40
41	Coffee and Gift Shops			7,302	7,302		7,302		7,302			41
42	Provider Participation Fee			118,035	118,035		118,035		118,035			42
43	Other (specify):* Non-allowable cost			94,212	94,212		94,212	(94,212)				43
44	TOTAL Special Cost Centers		306,913	241,920	548,833		548,833	(94,212)	454,621			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,350,274	1,005,738	6,059,103	12,415,115		12,415,115	(1,371,910)	11,043,205			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(170)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,903)	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				9
10	Interest and Other Investment Income	(146,215)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,297)	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	(44,285)	43		24
25	Fund Raising, Advertising and Promotional	(19,394)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,728)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg 5A</u>	(120,698)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (338,690)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,033,220)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,033,220)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,371,910)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Wheeling

ID# 0040923

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salary	\$ (74,997)	21	1
2	Labs-Part A	(8,152)	43	2
3	X-Rays-Part A	(14,453)	43	3
4	Miscellaneous Income	(742)	21	4
5	Nonallowable Accounting Fees	(1,297)	19	5
6	Nonallowable Collection Fees	(20,524)	19	6
7	Nonallowable Legal Fees	(533)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(120,698)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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	21 Office supplies		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	105	105	2	
3	V	30 Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	225,541	225,541	3	
4	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	1,252	1,252	4	
5	V	32 Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	433,870	433,870	5	
6	V	33 Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	413,621	413,621	6	
7	V	34 Rental expense	1,805,621	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,805,621)	7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V	**The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Lexington Health Care Systems of Wheeling Ltd. Ptsp.							13
14	Total		\$ 1,805,621			\$ 1,074,639	\$ * (730,982)	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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.	**	\$ 491	\$ 491	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,036	6,036	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	153	153	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,066	1,066	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	44,236	44,236	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	5,248	5,248	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	269	269	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,404	5,404	22
23	V	10 Medical consultant		Royal Management Corp.	**	4,713	4,713	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	26,405	26,405	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,226	3,226	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	59,916	59,916	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	22,600	22,600	27
28	V	19 Professional fees		Royal Management Corp.	**	5,713	5,713	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	3,861	3,861	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	1,207	1,207	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	463,688	463,688	31
32	V	21 Bank charges		Royal Management Corp.	**	5,464	5,464	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	10,325	10,325	33
34	V	21 Postage		Royal Management Corp.	**	3,292	3,292	34
35	V							35
36	V							36
37	V							37
38	V	** Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.						38
39	Total		\$			\$ 673,313	\$ * 673,313	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Telephone	\$	Royal Management Corp.	**	\$ 7,877	\$ 7,877	15
16	V	24	Travel & seminar		Royal Management Corp.	**	627	627	16
17	V	25	Auto expense		Royal Management Corp.	**	21,398	21,398	17
18	V	26	Insurance general		Royal Management Corp.	**	3,295	3,295	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	64,797	64,797	19
20	V	30	Depreciation		Royal Management Corp.	**	53,231	53,231	20
21	V	32	Interest		Royal Management Corp.	**	19,798	19,798	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	30	30	22
23	V	33	Property taxes		Royal Management Corp.	**	3,416	3,416	23
24	V	34	Rent expense		Royal Management Corp.	**	4,028	4,028	24
25	V	35	Equipment rental		Royal Management Corp.	**	970	970	25
26	V	17	Management fees	1,158,551	Royal Management Corp.	**		(1,158,551)	26
27	V	35	Auto Lease		Royal Management Corp.	**	3,533	3,533	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.						38
39	Total			\$ 1,158,551			\$ 183,000	\$ * (975,551)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.

Provider # 0040923

1/1/08-12/31/08

Schedule 6B

VII. Related Parties

Related Nursing Homes

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	3.77	7.50	Salary	\$ 19,972	L17, C7	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule 7A	3.77	7.50	Salary	19,972	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule 7A	3.77	7.50	Salary	19,972	L17, C7	3
4	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	0.67	1.35	Salary	1,389	L21, C7	4
5	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	5.38	11.00	Salary	19,658	L17/21, C7	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	\$ 80,963		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	731,268	10	\$ 4,564		78,690	\$ 491	1
2	5	Utilities - gas & electric	731,268	10	56,094		78,690	6,036	2
3	5	Utilities - water & sewer	731,268	10	1,425		78,690	153	3
4	5	Utilities - maintenance office	731,268	10	9,903		78,690	1,066	4
5	6	Management allocation - salaries	731,268	10	411,084	411,084	78,690	44,236	5
6	6	Repairs & maintenance	731,268	10	48,773		78,690	5,248	6
7	6	Scavenger & exterminating	731,268	10	2,504		78,690	269	7
8	7	Management allocation - employe	731,268	10	50,217		78,690	5,404	8
9	10	Medical consultant	731,268	10	43,800		78,690	4,713	9
10	10	Management allocation - salaries	731,268	10	245,385	245,385	78,690	26,405	10
11	15	Management allocation - employe	731,268	10	29,975		78,690	3,226	11
12	17	Management allocation - salaries	731,268	10	556,800	556,807	78,690	59,916	12
13	19	Computer consultant & supplies	731,268	10	210,020		78,690	22,600	13
14	19	Professional fees	731,268	10	53,093		78,690	5,713	14
15	20	Dues & subscriptions	731,268	10	35,880		78,690	3,861	15
16	20	Advertising - help wanted	731,268	10	11,214		78,690	1,207	16
17	21	Management allocation - salaries	731,268	10	4,309,068	4,039,070	78,690	463,688	17
18	21	Bank charges	731,268	10	50,778		78,690	5,464	18
19	21	Office supplies & printing	731,268	10	95,951		78,690	10,325	19
20	21	Postage	731,268	10	30,589		78,690	3,292	20
21	21	Telephone	731,268	10	73,204		78,690	7,877	21
22	24	Travel and Seminar	731,268	10	5,826		78,690	627	22
23									23
24									24
25	TOTALS				\$ 6,336,147	\$ 5,252,346		\$ 681,817	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	731,268	10	\$ 198,854	\$	78,690	\$ 21,398	1
2	26	Insurance general	731,268	10	30,619		78,690	3,295	2
3	27	Management allocation - employee	731,268	10	602,157		78,690	64,797	3
4	30	Depreciation	731,268	10	494,680		78,690	53,231	4
5	32	Interest	731,268	10	183,980		78,690	19,798	5
6	32	Amortization of mortgage costs	731,268	10	283		78,690	30	6
7	33	Property taxes	731,268	10	31,746		78,690	3,416	7
8	34	Rent expense	731,268	10	37,431		78,690	4,028	8
9	35	Equipment rental	731,268	10	9,010		78,690	970	9
10	35	Auto Lease	731,268	10	32,828		78,690	3,533	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				\$ 1,621,588	\$		\$ 174,496	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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	6,705,000	7,392,312	5/2017	0.0625	433,870	2
3												3
4												4
5							Interest on financing insurance premium				2,249	5
Working Capital												
6	Shareholders	X		Working Capital	None	Various	675,000	2,886,250	Demand	Prime +1	111,010	6
7	JP Morgan Chase N.A.		X	Line of Credit	Various	4/30/07	1,100,000	1,100,000	5/1/10	Libor +1	35,902	7
8												8
9	TOTAL Facility Related						\$ 8,480,000	\$ 11,378,562			\$ 583,031	9
B. Non-Facility Related*												
10											1,252	10
11											(35,205)	11
12											19,828	12
13											(111,010)	13
14	TOTAL Non-Facility Related						\$	\$			(125,135)	14
15	TOTALS (line 9+line14)						\$ 8,480,000	\$ 11,378,562			\$ 457,896	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Wheeling# 0040923 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	453,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2007	\$	433,316	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(20,284)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	446,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	8,203	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 20,698 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Allocated from Management Company		3,416	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	417,037	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2003	<u>390,362</u>	<u>8</u>			
2004	<u>391,007</u>	<u>9</u>			
2005	<u>412,618</u>	<u>10</u>			
2006	<u>417,477</u>	<u>11</u>			
2007	<u>433,316</u>	<u>12</u>			
<u>2006 tax bill paid \$433,316</u>					
<u>Est. Tax with 3% Increase \$446,316</u>					
<u>Use: \$446,400</u>					
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Wheeling COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040923

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1. 03-10-401-027-0000	Land & Building	\$ 433,316.43	\$ 433,316.43
2. Royal Management Corp. (Samvest of Lombard II)		\$	\$
3. 05-01-202-021	Land & Building	\$ 174,993.86	\$ 3,416.00
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>608,310.29</u>	\$ <u>436,732.43</u>

B. **Real Estate Tax Cost Allocation:**

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

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

C. **Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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).

NA

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>137,650</u>	<u>1993</u>	<u>\$ 595,000</u>	<u>1</u>
2	<u>Allocated from Management Company</u>		<u>2002</u>	<u>17,371</u>	<u>2</u>
3	TOTALS	137,650		\$ 612,371	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	205		1995	1995	\$ 6,537,447	\$	10-40	\$ 163,223	\$ 163,223	\$ 2,230,717	4
5	10		2000	2000	98,710	2,468	40	2,468		20,976	5
6											6
7											7
8											8
	Improvement Type**										
9		Building improvement	1995	1995	3,587			239	239	3,268	9
10		Land improvement - sidewalk replacement	1996	1996	1,927	128	15	128		1,606	10
11		Leasehold improvement - pines & sod	1996	1996	3,431	229	15	229		2,860	11
12		Basement rehab	1997	1997	18,611		15			18,611	12
13		Building improvement - curtains/track	1997	1997	1,936		10	55	55	636	13
14		Landscaping	1997	1997	2,002	134	35	134		1,536	14
15		Wiring for MDS	1998	1998	3,552	178	15	178		3,552	15
16		Parking Lot	1998	1998	2,952	148	10	148		2,952	16
17		Roof repair	2000	2000	1,980	198	10	198		1,683	17
18		Remodel HVAC/exhaust system - office area	2000	2000	7,480	374	10	374		3,179	18
19		Automatic Door	2000	2000	1,300	130	20	130		1,105	19
20		Rods for beside curtains	2000	2000	2,525	252	10	252		2,145	20
21		Floor tile	2000	2000	10,298	1,030	10	1,030		8,754	21
22		Parking lot seal coating and repair	2001	2001	2,177	218	10	218		1,633	22
23		Infrared curtain units for 3 elevators	2001	2001	4,500		10			4,500	23
24		Boiler vent repairs	2001	2001	3,084	308	5	308		2,313	24
25		Kitchen wall rebuild	2003	2003	22,500	1,125	10	1,125		6,000	25
26		Elevator upgrade	2004	2004	11,077	554	20	554		2,585	26
27		Landscaping	2005	2005	450	23	20	23		79	27
28		HVAC system	2005	2005	27,711	1,386	20	1,386		4,503	28
29		Lobby, lounge, and reception rehab	2005	2005	22,731	1,137	20	1,137		3,410	29
30		Lower level therapy room rehab	2005	2005	8,100	405	20	405		1,586	30
31		First floor therapy room addition	2005	2005	32,167	1,608	20	1,608		6,433	31
32		Transitional unit addition	2005	2005	18,758	938	20	938		3,048	32
33		Basement rehab	2005	2005	13,105	655	20	655		2,293	33
34		Countertops	2005	2005	845	169	5	169		620	34
35		Window treatments	2005	2005	4,090	818	5	818		3,272	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	Landscaping Enhancement	2006	\$ 4,558	\$ 304	15	\$ 304	\$	\$ 734	37
38	HVAC	2006	10,034	1,003	10	1,003		2,090	38
39	Emergency A/C	2006	8,110	811	10	811		1,825	39
40	Administration HVAC	2006	6,058	606	10	606		1,363	40
41	Modular units attached to wall	2006	11,010	1,101	10	1,101		2,661	41
42	Transitional Unit	2006	8,017	401	10	401		802	42
43	Employee lunch room rehab	2006	2,361	236	10	236		610	43
44	Alzheimers Remodel	2007	606	15	40	15		15	44
45	Alzheimers Remodel	2007	10,535	263	40	263		263	45
46	Install wireless LAN	2006	5,307	531	10	531		1,062	46
47	Automatic Doors Patio	2006	2,232	223	10	223		558	47
48	Parking Lot	2007	3,777	189	20	189		252	48
49	HVAC	2007	4,842	242	20	242		242	49
50	First Floor Remodel-carpentry, flooring, door frames, plumbing	2007	484,373		40	12,110	12,110	24,219	50
51	First Floor Remodel-painting, carpentry, flooring, plumbing	2007	161,654		40	4,041	4,041	8,082	51
52	Landscaping	2008	14,600	730	15	730		730	52
53	Second Floor Remodel-carpentry, flooring, electrical, painting	2008	485,694		27	2,944	2,944	2,944	53
54	Special care unit-carpentry, electrical, painting, alarm systems	2008	40,930		27	248	248	248	54
55									55
56									56
57									57
58									58
59									59
60									60
61	Land improvements - management company	2002	27,378		15	6,331	6,331	12,647	61
62	Building - management company	2002	213,000		40	36,831	36,831	36,831	62
63	HVAC, electrical, security system - management company	2003	2,111		30	379	379	788	63
64	Key card system - management company	2004	332		20	60	60	73	64
65	VAV TX controls - management company	2005	101		20	18	18	19	65
66	Interior Signs-management company	2006	74		5	11	11	11	66
67	Building improvements - management company	2008	45		5	9	9	9	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,376,772	\$ 21,268		\$ 247,767	\$ 226,499	\$ 2,444,933	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	\$ 508,653	\$ 51,118	\$ 88,635	\$ 37,517	5	\$ 252,635	71
72	Current Year Purchases	76,200	2,483	7,646	5,163	5	7,646	72
73	Fully Depreciated Assets	32,134					32,134	73
74	Allocated from Management Co.	272,753		4,483	4,483	5	167,001	74
75	TOTALS	\$ 889,740	\$ 53,601	\$ 100,764	\$ 47,163		\$ 459,416	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 Co.			38,984		5,110	5,110		25,558	79
80	TOTALS			\$ 38,984	\$	\$ 5,110	\$ 5,110		\$ 25,558	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)	\$ 9,917,867	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,869	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 353,641	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 278,772	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,929,907	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Third floor remodel	\$ 166,653	92
93			93
94			94
95		\$ 166,653	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from management co.</u>				<u>4,028</u>			6
7	TOTAL				\$ 4,028			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 42,266 Description: Copier-\$5046; Fax Machine-\$2,650; Med Equip-\$18,892; Oxygen-\$14,708; Mgmt. Co.-\$970
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>Allocated from management company</u>			<u>3,533</u>	18
19					19
20					20
21	TOTAL		\$	\$ 3,533	21

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

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

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	5,900	\$ 412,734	\$	5,900	\$ 412,734	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,477	104,782		1,477	104,782	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		6,466	489,164		6,466	489,164	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				306,913		306,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	13,843	\$ 1,006,680	\$ 306,913	13,843	\$ 1,313,593	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/2008

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 448,269	\$ 478,827	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>466,677</u>)	3,019,821	3,019,821	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,417	13,417	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	7,237	1,120,801	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,488,744	\$ 4,632,866	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,509	7,509	12
13	Land		612,371	13
14	Buildings, at Historical Cost		6,636,157	14
15	Leasehold Improvements, at Historical Cost	418,270	1,740,615	15
16	Equipment, at Historical Cost	378,748	928,724	16
17	Accumulated Depreciation (book methods)	(302,223)	(2,929,907)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	166,653	166,653	22
23	Other(specify): <u>Mortgage Cost, net</u>		32,952	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 668,957	\$ 7,195,074	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,157,701	\$ 11,827,940	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 442,418	\$ 442,418	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,986,250	3,986,250	29
30	Accrued Salaries Payable	292,695	292,695	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,661	4,661	31
32	Accrued Real Estate Taxes(Sch.IX-B)		446,400	32
33	Accrued Interest Payable		38,922	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See attached schedule 17A</u>	4,654,275	910,989	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,380,299	\$ 6,122,335	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,392,312	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)	\$	\$ 7,392,312	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,380,299	\$ 13,514,647	46
47	TOTAL EQUITY (page 18, line 24)	\$ (5,222,598)	\$ (1,686,707)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,157,701	\$ 11,827,940	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/08 - 12/31/08

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Escrow-Insurance	26,238	26,238
Accrued 401k	(13,385)	(13,385)
Due to - Republic Construction	(3,873)	(3,873)
Accrued expenses	(159,247)	(159,247)
Accrued royl genl mgmt fees	(32,111)	(32,111)
Accrued rent	(4,108,950)	-
Accrued wage assignment	(271)	(271)
Deferred Income	(400,478)	(400,478)
Advance - biweekly Part A	37,802	37,802
Interest Rate Swap Liability	-	(365,664)
Total line 36	<u>(4,654,275)</u>	<u>(910,989)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,049,170)	1
2	Restatements (describe):		2
3	Post Closing Adjustments	124,118	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,925,052)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(297,546)	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)	\$ (297,546)	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)	\$ (5,222,598)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling# 0040923Report Period Beginning: 01/01/2008Ending: 12/31/2008**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,368,068	1
2	Discounts and Allowances for all Levels	(5,966,765)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,401,303	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,224,337	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,224,337	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	6,911	12
13	Barber and Beauty Care	22,625	13
14	Non-Patient Meals	170	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	335,625	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,113	19
20	Radiology and X-Ray	6,425	20
21	Other Medical Services	82,317	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 486,186	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,881	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,881	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	742	28
28a	<u>Investment Income</u>	120	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 862	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,117,569	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,649,386	31
32	Health Care	5,427,709	32
33	General Administration	2,718,240	33
B. Capital Expense			
34	Ownership	2,070,947	34
C. Ancillary Expense			
35	Special Cost Centers	430,798	35
36	Provider Participation Fee	118,035	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,415,115	40
41	Income before Income Taxes (line 30 minus line 40)**	(297,546)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (297,546)	43

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

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

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

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

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	1,575	1,662	\$ 79,406	\$ 47.78	1
2	Assistant Director of Nursing	8,586	8,806	303,901	34.51	2
3	Registered Nurses	41,887	46,013	1,542,613	33.53	3
4	Licensed Practical Nurses	9,054	10,443	277,487	26.57	4
5	CNAs & Orderlies	98,339	106,050	1,324,419	12.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,096	12,012	153,180	12.75	8
9	Activity Director	1,889	1,957	33,527	17.13	9
10	Activity Assistants	17,432	18,836	211,599	11.23	10
11	Social Service Workers	7,234	7,234	121,932	16.86	11
12	Dietician					12
13	Food Service Supervisor	1,845	1,966	36,914	18.78	13
14	Head Cook	1,643	1,792	29,437	16.43	14
15	Cook Helpers/Assistants	16,641	17,468	174,873	10.01	15
16	Dishwashers	16,886	18,063	148,021	8.19	16
17	Maintenance Workers	2,058	2,259	37,282	16.50	17
18	Housekeepers	36,933	39,361	331,036	8.41	18
19	Laundry	9,024	9,737	84,647	8.69	19
20	Administrator	2,026	2,153	99,124	46.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,535	21,182	344,823	16.28	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	938	1,019	16,053	15.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	304,621	328,013	\$ 5,350,274 *	\$ 16.31	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	280	\$ 14,919	L1,C3	35
36	Medical Director	Monthly	64,800	L9,C3	36
37	Medical Records Consultant	25	1,419	L10,C3	37
38	Nurse Consultant	23	1,351	L10,C3	38
39	Pharmacist Consultant	Monthly	4,780	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	105	5,178	L11,C3	44
45	Social Service Consultant	96	5,047	L12,C3	45
46	Other(specify) <u>Psychosocial</u>	44	2,304	L12,C3	46
47	<u>Medical Consultant</u>	Monthly	4,713	L10,C7	47
48					48
49	TOTAL (lines 35 - 48)	573	\$ 104,511		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 424	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 424		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	
Brian Celerio	Administrator	0%	\$ 99,124	Workers' Compensation Insurance	\$ 82,005	IDPH License Fee	\$ 26,387	
				Unemployment Compensation Insurance	43,599	Advertising: Employee Recruitment		
				FICA Taxes	385,341	Health Care Worker Background Check		
				Employee Health Insurance	172,020	(Indicate # of checks performed <u>39</u>)	467	
				Employee Meals	14,570	Patient Background Checks <u>128</u>	1,533	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,559	
				401K	13,627	Miscellaneous Dues & Subscriptions	2,176	
				Other Employee Benefits	39,897	Allocated from Management Co	5,068	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 37,190	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
B. Administrative - Other				Description	Line #	Amount	Description	Amount
Description								
Management Fees-Royal Operating (Eliminated in col. 7)							Out-of-State Travel	\$
Management Fees-Royal General (Eliminated in col. 7)								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							In-State Travel	
							Seminar Expense	5,771
							Allocated from Management Co	627
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$	TOTAL	\$ 6,398

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Wheeling, Inc.
 Provider # 0040923
 1/1/08-12/31/08

Schedule 21C

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Gene Whitehorn	Medicaid Reimb Specialist	957
Contract Healthcare	Regulatory Consultant	450
Action Computer Service	Computer Consulting	324
Alperian Technology	Computer Consulting	215
B2B Computer	Computer Consulting	1,665
C.D.W. Direct	Computer Consulting	324
Converged Comm	Computer Consulting	140
E-Health Data Solutions	Computer Consulting	2,400
Equus Computer Systems	Computer Consulting	29
Healthware Consulting	Computer Consulting	2,060
Information Control	Computer Consulting	1,318
Krakau Business	Computer Consulting	126
Lanac Technology	Computer Consulting	2,368
Lintech LLC	Computer Consulting	5,412
Microsoft2	Computer Consulting	4,676
MJN Technologies	Computer Consulting	405
National Datacare	Computer Consulting	2,178
Silver Chair Learning	Computer Consulting	4,300
Vision Share, Inc.	Computer Consulting	580
		<u>29,927</u>

Total, Agrees to Schedule V, Line 19, Column 3 90,062

Allocated from Management Co.		
James Samatas	Legal-Filing Fees	28
Sachnoff & Weaver	Legal	1,520
Duane Morris	Legal	12
McGladrey & Pullen, LLP	Accounting	413
RSM McGladrey, Inc.	Accounting	436
Gilson Labus & Silverman	Accounting	1,630
Pension Administrators, Inc.	401(k) Administration	459
Personnel Planners, Inc.	Unemployment Consultant	32
Beth Schwarz	Operations Consultant	18
Gene Whitehorn	Medicaid Reimb Specialist	842
See Schedule 21D for Vendor Listing	Computer Consulting	22,600
		<u>27,990</u>

Allocated from building partnership 250

Allocated from Samvest of Lombard II		
Gilson, Labus & Silverman	Accounting	323

Nonallowable legal fees		
James Samatas	Legal-out of period fees	(150)
Reed Smith/Sachnoff & Weaver	Legal-out of period fees	(383)
Grabowski Law Center	Collections	<u>(20,524)</u>
		<u>(21,057)</u>

Nonallowable Accounting Fees		
Gilson Labus & Silverman	Accounting	(1,297)

Total, Agrees to Schedule V, Line 19, Column 8 96,271

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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,039 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 118,035
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,570 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 170
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT