

Facility Name & ID Number Lexington of Wheeling

0040923 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	78,475	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	78,475	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
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF			8,961	8,961	8
9	SNF/PED					9
10	ICF	57,175	3,807		60,982	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,175	3,807	8,961	69,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.13%

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 _____ NO

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

YES NO If YES, enter number of beds certified 206 and days of care provided 6,606

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	380,633	37,390	1,865	419,888		419,888		419,888		1
2	Food Purchase		422,104		422,104		422,104	(21,535)	400,569		2
3	Housekeeping	409,790	43,616		453,406		453,406	281	453,687		3
4	Laundry	88,639	28,894		117,533		117,533		117,533		4
5	Heat and Other Utilities			215,320	215,320		215,320	8,416	223,736		5
6	Maintenance	39,505		172,433	211,938		211,938	79,730	291,668		6
7	Other (specify):* Alloc. From Mgmt Cd							11,499	11,499		7
8	TOTAL General Services	918,567	532,004	389,618	1,840,189		1,840,189	78,391	1,918,580		8
	B. Health Care and Programs										
9	Medical Director			34,625	34,625		34,625		34,625		9
10	Nursing and Medical Records	5,051,587	312,194	50,388	5,414,169		5,414,169	50,428	5,464,597		10
10a	Therapy										10a
11	Activities	229,892	25,427	7,467	262,786		262,786		262,786		11
12	Social Services	120,883		3,817	124,700		124,700		124,700		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. From Mgmt Cd							6,890	6,890		15
16	TOTAL Health Care and Programs	5,402,362	337,621	96,297	5,836,280		5,836,280	57,318	5,893,598		16
	C. General Administration										
17	Administrative	74,911		1,661,067	1,735,978		1,735,978	(1,602,299)	133,679		17
18	Directors Fees										18
19	Professional Services			158,022	158,022		158,022	19,528	177,550		19
20	Dues, Fees, Subscriptions & Promotions			38,291	38,291		38,291	4,513	42,804		20
21	Clerical & General Office Expenses	221,314	29,451	48,644	299,409		299,409	679,677	979,086		21
22	Employee Benefits & Payroll Taxes			1,249,877	1,249,877		1,249,877	19,648	1,269,525		22
23	Inservice Training & Education			8,178	8,178		8,178	847	9,025		23
24	Travel and Seminar			62	62		62	1,677	1,739		24
25	Other Admin. Staff Transportation			13,008	13,008		13,008	15,583	28,591		25
26	Insurance-Prop.Liab.Malpractice			467,470	467,470		467,470	11,426	478,896		26
27	Other (specify):* Alloc. From Mgmt Cd							107,679	107,679		27
28	TOTAL General Administration	296,225	29,451	3,644,619	3,970,295		3,970,295	(741,721)	3,228,574		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,617,154	899,076	4,130,534	11,646,764		11,646,764	(606,012)	11,040,752		29

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

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

Facility Name & ID Number Lexington of Wheeling

#0040923

Report Period Beginning:

01/01/14

Ending:

12/31/14

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			166,488	166,488	166,488	362,385	528,873				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			187,088	187,088	187,088	264,727	451,815				32
33	Real Estate Taxes						517,116	517,116				33
34	Rent-Facility & Grounds			1,901,314	1,901,314	1,901,314	(1,896,594)	4,720				34
35	Rent-Equipment & Vehicles			58,755	58,755	58,755	2,676	61,431				35
36	Other (specify):*											36
37	TOTAL Ownership			2,313,645	2,313,645	2,313,645	(749,690)	1,563,955				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		259,759	1,176,642	1,436,401	1,436,401		1,436,401				39
40	Barber and Beauty Shops	6,250		4,430	10,680	10,680		10,680				40
41	Coffee and Gift Shops			6,150	6,150	6,150		6,150				41
42	Provider Participation Fee			502,575	502,575	502,575		502,575				42
43	Other (specify):* Non-Allowable Co	132,167		175,244	307,411	307,411	(307,411)					43
44	TOTAL Special Cost Centers	138,417	259,759	1,865,041	2,263,217	2,263,217	(307,411)	1,955,806				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,755,571	1,158,835	8,309,220	16,223,626	16,223,626	(1,663,113)	14,560,513				45

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

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0040923

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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	(1,887)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,350)	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	46	30		9
10	Interest and Other Investment Income	(177,502)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,026)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	43		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	(99,234)	43		24
25	Fund Raising, Advertising and Promotional	(32,422)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,162)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	79,183	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (254,784)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(1,408,329)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,408,329)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,663,113)		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

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Diagnostics Managed Care	\$ (2,579)	43	1
2	Labs-Part A	(7,713)	43	2
3	X-Rays Part A	(10,328)	43	3
4	Marketing Salary	(132,167)	43	4
5	Misc. Income	(3,395)	21	5
6	Trust Fees	(75)	43	6
7	Collections	(5,655)	19	7
8	Out of period legal and retainer	(201)	19	8
9	Reclass LHI to maintenance	(570)	19	9
10	Education and Seminar Marketing	(62)	43	10
11	Unrealized loss on FMV swap	250,228	43	11
12	R/M Reclass to LHI	(2,585)	06	12
13	Salesforce.com Offset	(5,594)	19	13
14	Nonallowable Dues	(121)	20	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		79,183	49

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
1	V	19 Professional fees	\$	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	\$ 200	\$ 200	1	
2	V	30 Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	288,067	288,067	2	
3	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	1,397	1,397	3	
4	V	32 Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	423,064	423,064	4	
5	V	33 Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	509,314	509,314	5	
6	V	34 Rental expense	1,901,314	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,901,314)	6	
7	V	43 Trust Fees		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	75	75	7	
8	V	43 Unrealized gain on FMV swap	250,228	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(250,228)	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		\$ 2,151,542			\$ 1,222,117	\$ * (929,425)	14	

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

VII. RELATED PARTIES (continued)

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

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

1	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.	**	\$ 281	\$	281	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,338		7,338	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	328		328	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	750		750	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	75,649		75,649	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	6,631		6,631	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	35		35	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	11,499		11,499	22
23	V	10 Medical consultant		Royal Management Corp.	**	5,100		5,100	23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	45,328		45,328	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	6,890		6,890	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	58,768		58,768	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	16,828		16,828	27
28	V	19 Professional fees		Royal Management Corp.	**	13,950		13,950	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	2,272		2,272	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	2,362		2,362	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	649,644		649,644	31
32	V	21 Bank charges		Royal Management Corp.	**	2,631		2,631	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	13,296		13,296	33
34	V	21 Postage		Royal Management Corp.	**	4,709		4,709	34
35	V	21 Telephone		Royal Management Corp.	**	12,792		12,792	35
36	V								36
37	V								37
38	V	** The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 937,081	\$ *	937,081	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	23 <u>Inservice Training</u>	\$	<u>Royal Management Corp.</u>	**	\$ 847	\$	847	15
16	V	24 <u>Travel & seminar</u>		<u>Royal Management Corp.</u>	**	1,739		1,739	16
17	V	25 <u>Auto expense</u>		<u>Royal Management Corp.</u>	**	15,583		15,583	17
18	V	26 <u>Insurance general</u>		<u>Royal Management Corp.</u>	**	11,426		11,426	18
19	V	27 <u>Management allocation - employee benefits</u>		<u>Royal Management Corp.</u>	**	107,679		107,679	19
20	V	30 <u>Depreciation</u>		<u>Royal Management Corp.</u>	**	74,842		74,842	20
21	V	32 <u>Interest</u>		<u>Royal Management Corp.</u>	**	15,164		15,164	21
22	V	32 <u>Amortization of mortgage costs</u>		<u>Royal Management Corp.</u>	**	2,604		2,604	22
23	V	33 <u>Property taxes</u>		<u>Royal Management Corp.</u>	**	7,802		7,802	23
24	V	34 <u>Rent expense</u>		<u>Royal Management Corp.</u>	**	4,720		4,720	24
25	V	35 <u>Equipment rental</u>		<u>Royal Management Corp.</u>	**	1,521		1,521	25
26	V	17 <u>Management fees</u>	1,661,067	<u>Royal Management Corp.</u>	**			(1,661,067)	26
27	V	35 <u>Auto Lease</u>		<u>Royal Management Corp.</u>	**	1,155		1,155	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,661,067			\$ 245,082	\$ *	(1,415,985)	39

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

Facility Name & ID Number

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Ending:

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Lombard, Inc.	Lombard	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingtondale	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Vesta Management	Lombard	Mgmt. Company	3
4			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Group LLC			4
5			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lexington Health Care	Wheeling	Real Estate	5
6			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Systems of Wheeling I		Property	6
7			Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Royal Management	Lombard	Management	7
8			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Corporation		Company	8
9			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Lexington Financial	Lombard	Finance	9
10					Services II, LLC		Company	10
11					Lexington Square	Lombard	Independent	11
12					Life Care of		Assisted Living	12
13					Lombard, LLC			13
14					Lexington Square	Elmhurst	Independent	14
15					Life Care of		Living Facility	15
16					Elmhurst, LLC			16
17					Heron Point Mgmt.	Lombard	Mgmt. Company	17
18					Corporation			18
19					Samvest of	Lombard	Lessor	19
20					Lombard II, LLC			20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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0040923

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Sambell of	Bloomingtondale	Real Estate	1
2					Bloomingtondale Ltd. Ptsp.		Property	2
3								3
4					Sambell of Chicago	Chicago Ridge	Real Estate	4
5					Ridge Ltd. Ptsp.		Property	5
6								6
7					Sambell of	Elmhurst	Real Estate	7
8					Elmhurst II Ltd. Ptsp.		Property	8
9								9
10					Sambell of	LaGrange	Real Estate	10
11					LaGrange Ltd. Ptsp.		Property	11
12								12
13					Lexington Health	Lake Zurich	Real Estate	13
14					Care Systems of		Property	14
15					Lake Zurich Ltd. Ptsp.			15
16								16
17					Lexington Health	Lombard	Real Estate	17
18					Care Systems of		Property	18
19					Lombard Ltd. Ptsp.			19
20								20
21					Lexington Health	Orland Park	Real Estate	21
22					Care Systems of		Property	22
23					Orland Park Ltd. Ptsp.			23
24								24
25					Sambell of	Schaumburg	Real Estate	25
26					Schaumburg Ltd. Ptsp.		Property	26
27								27
28					Sambell of	Streamwood	Real Estate	28
29					Streamwood Ltd. Ptsp.		Property	29
30								30

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 10,321	L17, C7	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,521	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,423	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	12,246	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	19,257	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 58,768		13

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

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

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	Bed Days Available	723,430	10	\$ 2,591	\$ 78,475	\$ 281	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,650	78,475	7,338	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	3,027	78,475	328	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	6,910	78,475	750	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	697,374	697,374	75,649	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	61,125	78,475	6,631	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	320	78,475	35	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	106,001	78,475	11,499	8
9	10	Medical consultant	Bed Days Available	723,430	10	47,016	78,475	5,100	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	417,860	417,860	45,328	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	63,515	78,475	6,890	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	541,757	541,757	58,768	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	155,132	78,475	16,828	13
14	19	Professional fees	Bed Days Available	723,430	10	128,599	78,475	13,950	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	20,945	78,475	2,272	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	21,776	78,475	2,362	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	5,988,811	5,988,811	649,644	17
18	21	Bank charges	Bed Days Available	723,430	10	24,252	78,475	2,631	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	122,570	78,475	13,296	19
20	21	Postage	Bed Days Available	723,430	10	43,413	78,475	4,709	20
21	21	Telephone	Bed Days Available	723,430	10	117,921	78,475	12,792	21
22									22
23									23
24									24
25	TOTALS					\$ 8,638,565	\$ 7,645,802	\$ 937,081	25

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	23	Inservice Training	Bed Days Available	723,430	10	\$ 7,807	\$ 78,475	\$ 847	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	16,032	78,475	1,739	2
3	25	Auto expense	Bed Days Available	723,430	10	143,653	78,475	15,583	3
4	26	Insurance general	Bed Days Available	723,430	10	105,333	78,475	11,426	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	992,646	78,475	107,679	5
6	30	Depreciation	Bed Days Available	723,430	10	689,938	78,475	74,842	6
7	32	Interest	Bed Days Available	723,430	10	139,794	78,475	15,164	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	24,007	78,475	2,604	8
9	33	Property taxes	Bed Days Available	723,430	10	71,926	78,475	7,802	9
10	34	Rent expense	Bed Days Available	723,430	10	43,516	78,475	4,720	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,023	78,475	1,521	11
12	35	Auto Lease	Bed Days Available	723,430	10	10,648	78,475	1,155	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					\$ 2,259,323	\$	\$ 245,082	25

Facility Name & ID Number

Lexington of Wheeling

0040923

Report Period Beginning:

01/01/14

Ending:

12/31/14

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		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Lexington Financial						\$	\$		\$	1						
2	Services II, L.L.C	X		Mortgage	Varies	4/30/07	7,573,000	6,417,768	5/1/2017	0.0650	423,064	2					
3												3					
4										Finance Charge - Insurance Policy	1,400	4					
5												5					
	Working Capital																
6	Shareholders	X		Working Capital	None	Various	675,000	3,143,162	Demand	Prime +1	15,638	6					
7	JP Morgan Chase N.A.		X	Line of Credit	Varies	6/29/12	5,600,000		6/29/15	Libor + 2.25%	10,116	7					
8	See Sch 9A	X		Working Capital	Varies	Various	2,000,000	2,000,000	Demand	Varies	159,935	8					
9	TOTAL Facility Related						\$ 15,848,000	\$ 11,560,930			\$ 610,153	9					
	B. Non-Facility Related*																
10										Amortization of loan costs	4,001	10					
11										Interest income offset	(1,930)	11					
12										Allocated from management co.	15,164	12					
13										Less: Interest to shareholders	(175,572)	13					
14	TOTAL Non-Facility Related						\$	\$			(158,338)	14					
15	TOTALS (line 9+line14)						\$ 15,848,000	\$ 11,560,930			\$ 451,815	15					

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

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

Facility Name: Lexington of Wheeling
 IDPH License ID Number: 0040923
 Fiscal Year End: 12/31/14

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related*				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$				\$	1						
2													2						
3													3						
4													4						
5													5						
	Working Capital																		
6	Shareholders	X		Working Capital	Varies	Various	900,000	900,000	Demand	Varies	72,000		6						
7	Shareholders	X		Working Capital	Varies	Various	1,100,000	1,100,000	Demand	Varies	87,935		7						
8													8						
9	TOTAL Facility Related				\$0.00		\$ 2,000,000	\$ 2,000,000			\$ 159,935		9						
	B. Non-Facility Related*																		
10													10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related				\$0.00		\$ 0	\$ 0			\$ 0		14						

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Wheeling COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040923

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(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 & Building</u>	\$ <u>478,291.89</u>	\$ <u>478,291.89</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>282,411.00</u>	\$ <u>7,802.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>760,702.89</u></u>	\$ <u><u>486,093.89</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Lexington of Wheeling

0040923 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>137,650</u>	<u>1993</u>	<u>\$ 595,000</u>	<u>1</u>
2	<u>Management Company Allocation</u>			<u>22,098</u>	<u>2</u>
3	TOTALS	137,650		\$ 617,098	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	205	1995	1995	\$ 6,537,447	\$	10-40	\$ 163,223	\$ 163,223	\$ 3,218,576	4
5	1	2000	2000	98,710	2,468	40	2,468		35,784	5
6										6
7										7
8										8
Improvement Type**										
9	Building improvement		1995	3,587		15			3,587	9
10	Land improvement - sidewalk replacemen		1996	1,927		15			1,927	10
11	Leasehold improvement - pines & sod		1996	3,431		15			3,431	11
12	Basement rehab		1997	18,611		10			18,611	12
13	Building improvement - curtains/track		1997	1,936		35	55	55	911	13
14	Landscaping		1997	2,002		15			2,002	14
15	Wiring for MDS		1998	3,552		10			3,552	15
16	Parking Lot		1998	2,952		10			2,952	16
17	Roof repair		2000	1,980		10			1,980	17
18	Remodel HVAC/exhaust system - office area		2000	7,480	374	20	374		5,423	18
19	Automatic Door		2000	1,300		10			1,300	19
20	Rods for beside curtains		2000	2,525		10			2,525	20
21	Floor tile		2000	10,298		10			10,298	21
22	Parking lot seal coating and repair		2001	2,177		10			2,177	22
23	Infrared curtain units for 3 elevators		2001	4,500		5			4,500	23
24	Boiler vent repairs		2001	3,084		10			3,084	24
25	Kitchen wall rebuild		2003	22,500	1,125	20	1,125		12,750	25
26	Elevator upgrade		2004	11,077	554	20	554		5,909	26
27	Landscaping		2005	450	23	20	23		217	27
28	HVAC system		2005	27,711	1,386	20	1,386		12,819	28
29	Lobby, lounge, and reception rehab		2005	22,731	1,137	20	1,137		10,232	29
30	Lower level therapy room rehab		2005	8,100	405	20	405		4,016	30
31	First floor therapy room addition		2005	32,167	1,608	20	1,608		16,081	31
32	Transitional unit addition		2005	18,758	938	20	938		8,676	32
33	Basement rehab		2005	13,105	655	20	655		6,223	33
34	Countertops		2005	845		5			845	34
35	Window treatments		2005	4,090		5			4,090	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Landscaping Enhancement	2006	\$ 4,558	\$ 304	15	\$ 304	\$	\$ 2,558	37
38	HVAC	2006	10,034	1,003	10	1,003		8,108	38
39	Emergency A/C	2006	8,110	811	10	811		6,691	39
40	Administration HVAC	2006	6,058	606	10	606		4,999	40
41	Modular units attached to wall	2006	11,010	1,101	10	1,101		9,267	41
42	Transitional Unit	2006	8,017	401	10	401		3,208	42
43	Employee lunch room rehab	2006	2,361	236	10	236		2,026	43
44	Alzheimers Remodel	2007	606	15	40	15		105	44
45	Alzheimers Remodel	2007	10,535	263	40	263		1,841	45
46	Install wireless LAN	2006	5,307	531	10	531		4,248	46
47	Automatic Doors Patio	2006	2,232	223	10	223		1,896	47
48	Parking Lot	2007	3,777	189	20	189		1,386	48
49	HVAC	2007	4,842	242	20	242		1,694	49
50	First Floor Remodel-carpentry, flooring, door frames, plumbing	2007	646,028		40	16,151	16,151	129,207	50
51	First Floor Remodel-painting, carpentry, flooring, plumbing	2007			40				51
52	Landscaping	2008	14,600	973	15	973		6,568	52
53	Second Floor Remodel-carpentry, flooring, electrical, painting	2008	485,694		27	17,662	17,662	108,916	53
54	Special care unit-carpentry, electrical, painting, alarm systems	2008	40,930		27	1,488	1,488	9,176	54
55	Irrigation System	2009	15,185	1,012	15	1,012		5,482	55
56	Landscaping Enhancements	2009	21,445	1,430	15	1,430		8,033	56
57	Roof repairs	2009	137,000	6,850	20	6,850		35,963	57
58	Stamped Concrete	2009	10,512	382	27	382		1,974	58
59	Quick connects	2009	9,678	484	20	484		2,662	59
60									60
61	2nd Floor remodel-Carpentry	2009	8,116	295	27	295		1,721	61
62	Patio Fence	2009	4,824	241	20	241		1,225	62
63	Patio Pergola	2009	8,299	415	20	415		2,386	63
64	3rd floor remodel-Carpentry, flooring, electrical, wallpaper	2009	443,781		27	16,137	16,137	88,754	64
65	alarms sytem, painting.								65
66	Brick panel replacement	2010	164,474	5,981	27	5,981		25,419	66
67	Office carpentry, flooring, electrical, painting, plumbing, signs	2010	40,017	2,808	27	2,808		11,232	67
68	Landscaping	2010	3,124	208	15	208		717	68
69	Parking lot signs and flagpole	2010	2,870	231	27	231		1,002	69
70	TOTAL (lines 4 thru 69)		\$ 9,003,057	\$ 37,908		\$ 252,624	\$ 214,716	\$ 3,892,942	70

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

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,003,057	\$ 37,908		\$ 252,624	\$ 214,716	\$ 3,892,942	1
2	Remove and replace asphalt	2010	17,500	636	27	636		2,809	2
3	Spot cooler	2010	3,456	126	27	126		514	3
4	Admin office HVAC	2010	8,400	305	27	305		1,398	4
5	Holding tank	2010	13,000	473	27	473		2,010	5
6	Floor sink	2010	13,177	479	27	479		2,235	6
7	Remodel pantry-shelves	2010	8,880	323	27	323		1,346	7
8	Paint over bed lights	2010	5,770	210	27	210		840	8
9	Remodel library/lounge-flooring,carpentry	2010	10,114	368	27	368		1,533	9
10	Office carpentry,flooring,electrical,painting,plumbing,signs	2011	2,541	92	27	92		330	10
11	Office doors, keys	2011	16,375	595	27	595		1,983	11
12	HVAC repair, fire dampers	2011	21,469	780	27	780		2,428	12
13	Laundry room-tile, painting, electrical	2011	8,717	317	27	317		1,108	13
14	Common area doors	2011	30,333	1,103	27	1,103		3,401	14
15									15
16	Sprinkler Replacement	2012	10,441	380	27	380		791	16
17	Electrical thru out home	2012	8,728	317	27	317		687	17
18									18
19	EMR Wiring- Entire Facility	2013	18,523	674	27	674		898	19
20									20
21	Install Trees - Main Entrance	2014	10,320	229	15	229		229	21
22	Remove and replace asphalt parking lot	2014	17,400	264	27	264		264	22
23	Install french drain - kitchen	2014	2,750	33	27	33		33	23
24	R/M Reclass: Replace pistons, rods, and fans - Mechanical Room	2014	2,585		27	48	48	48	24
25									25
26									26
27									27
28									28
29									29
30	Reconcile to book depreciation			572			(572)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,233,536	\$ 46,184		\$ 260,376	\$ 214,192	\$ 3,917,829	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,233,536	\$ 46,184		\$ 260,376	\$ 214,192	\$ 3,917,829	1
2									2
3	Land improvements - management company	2002	305,788		40	8,970	8,970	117,488	3
4	HVAC, electrical, security system - management company	2003	2,686		30	648	648	1,970	4
5	Key card system - management company	2004	422		20	21	21	220	5
6	VAV TX controls - management company	2005	128		20	6	6	63	6
7	Interior Signs-management company	2006	93		5	6	6	51	7
8	Building improvements - management company	2008	14,767		5	486	486	5,549	8
9	Building improvements - management company	2009	2,744		5	50	50	815	9
10	Building improvements - management company	2010	2,677		5	110	110	803	10
11	Building improvements - management company	2011	1,903		5	88	88	309	11
12	Building improvements - management company	2012	6,506		5	12	12	631	12
13	Building improvements - management company	2013	4,968		5	357	357	458	13
14	Building improvements - management company	2014	2,688		5	135	135	137	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)		\$ 9,578,906	\$ 46,184		\$ 271,265	\$ 225,081	\$ 4,046,323	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,646,790	\$ 117,679	\$ 191,030	\$ 73,351	5	\$ 1,218,872	71
72	Current Year Purchases	31,280	2,625	2,625	0	5	2,625	72
73	Fully Depreciated Assets	109,039				5	109,039	73
74	Allocated from Mgmt. Co.	521,518		59,906	59,906	5-7	335,681	74
75	TOTALS	\$ 2,308,627	\$ 120,304	\$ 253,562	\$ 133,258		\$ 1,666,217	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from Mgmt. Co.			55,320		4,046	4,046	5	48,396	79
80	TOTALS			\$ 55,320	\$	\$ 4,046	\$ 4,046		\$ 48,396	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)	\$ 12,559,951	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,488	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 528,873	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 362,385	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,760,936	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from Management Company</u>				<u>4,720</u>			6
7	TOTAL				\$ <u>4,720</u>			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 60,275 Description: Copier-\$8,262; Printer-\$3,633;Mailing System-\$180;Oxy-\$18,317;Med Eq-\$28,362 Alloc. Mgmt Co.-\$1,521

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocated from Management Company</u>			<u>1,155</u>	20
21	TOTAL		\$	\$ <u>1,155</u>	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: 01/01/14 Ending: 12/31/14
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><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 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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	39(3)	hrs	\$	6,708	\$	336,620	\$	6,708	\$	336,620	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,893		188,641		2,893		188,641	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39(3)	hrs		11,181		644,230		11,181		644,230	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation		hrs									8	
9	Pharmacy	39(2)	# of prescrpts					253,765			253,765	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): <u>Ambulance</u>	39(3)					7,151				7,151	12	
13	Other (specify): <u>Sch 16A</u>	39(2), (3)						5,994			#VALUE!	13	
14	TOTAL			\$	20,782	\$	1,176,642	\$	259,759	20,782	\$	#VALUE!	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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$				\$		\$	
2	Licensed Speech and Language Development Therapist		hrs								
3	Licensed Recreational Therapist		hrs								
4	Licensed Physical Therapist		hrs								
5	Physician Care		visits								
6	Dental Care		visits								
7	Work Related Program		hrs								
8	Habilitation		hrs								
9	Pharmacy		# of prescripts								
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
11	Academic Education		hrs								
12	Other (specify): <u>DME</u>	39(2)						511		511	
13	Other (specify): <u>Oxygen</u>	39(3)						5,483		5,483	
14	TOTAL			\$		\$		\$ 5,994		\$ 5,994	

1
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Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/14 Ending: 12/31/14
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 302,275	\$ 321,967	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,658,071</u>)	2,353,073	2,353,073	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,400	4,400	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>COBRA</u>	59	59	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,659,807	\$ 2,679,499	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,867	8,867	12
13	Land		617,098	13
14	Buildings, at Historical Cost		6,528,926	14
15	Leasehold Improvements, at Historical Cost	1,060,616	3,049,980	15
16	Equipment, at Historical Cost	728,905	2,363,947	16
17	Accumulated Depreciation (book methods)	(873,275)	(5,760,936)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify): <u>Mortgage cost, net</u>		24,568	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 925,113	\$ 6,832,450	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,584,920	\$ 9,511,949	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 473,987	\$ 473,987	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	5,143,162	5,143,162	29
30	Accrued Salaries Payable	612,833	612,833	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,854	8,854	31
32	Accrued Real Estate Taxes(Sch.IX-B)		514,800	32
33	Accrued Interest Payable		36,756	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	10,404,946	2,545,804	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 16,643,782	\$ 9,336,196	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,417,768	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,417,768	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,643,782	\$ 15,753,964	46
47	TOTAL EQUITY(page 18, line 24)	\$ (13,058,862)	\$ (6,242,015)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,584,920	\$ 9,511,949	48

*(See instructions.)

Facility Name: Lexington of Wheeling
IDPH License ID Number: 0040923
Fiscal Year End: 12/31/14

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
DUE TO / FROM REHAB CARE THERAPY	42,161	42,161
RENT RECEIVABLE	-	(8,516,134)
DUE TO/FROM REPUBLIC CONSTRUCTION	(35,011)	(35,011)
PREPAID INSURANCE	19,694	19,694
ESCROW - INSURANCE	39,489	39,489
FEDERAL U/C	888	888
ACCRUED EXPENSES	30,135	30,135
ACCRUED RESIDENT TAX	63,905	63,905
ACCRUED ROYL / VESTA MGMT FEES	1,440,953	1,440,953
ACCRUED RENT	8,516,134	8,516,134
ACCRUED INSURANCE	37,661	37,661
DUE TO PATIENT TRUST FUND	(28,759)	(28,759)
ADVANCE - BIWEEKLY PART A PAYM	(24,294)	(24,294)
UNCOLLECTIBLE PART A CO PVTS	198	198
DUE TO - ROYAL OPERATIONS	26,572	26,572
DUE TO REPUBLIC	80	80
DUE TO CHICAGO RIDGE	1,343	1,343
SAMBEL INTEREST RATE SWAP LIABILITY	-	656,992
PROFESSIONAL LIABILITIES CLAIMS	273,797	273,797
Total - Line 36	10,404,946	2,545,804
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (11,518,460)	1
2	Restatements (describe):		2
3	Post closing adjustment	(190,786)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (11,709,246)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,349,616)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,349,616)	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)	\$ (13,058,862)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 21,012,823	1
2	Discounts and Allowances for all Levels	(10,644,639)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,368,184	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,849,371	6
7	Oxygen	20,826	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,870,197	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	8,119	12
13	Barber and Beauty Care	14,842	13
14	Non-Patient Meals	1,887	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	348,072	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	101,588	19
20	Radiology and X-Ray	15,302	20
21	Other Medical Services	140,494	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 630,304	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,930	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,930	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	3,395	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,395	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,874,010	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,840,189	31
32	Health Care	5,836,280	32
33	General Administration	3,970,295	33
B. Capital Expense			
34	Ownership	2,313,645	34
C. Ancillary Expense			
35	Special Cost Centers	1,760,642	35
36	Provider Participation Fee	502,575	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,223,626	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,349,616)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,349,616)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,699,220	44
45	Private Pay - Net Inpatient Revenue	824,534	45
46	Medicare - Net Inpatient Revenue	556,451	46
47	Other-(specify) <u>Managed Care</u>	287,979	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,368,184	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

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

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

^ - Entity is a cash basis tax payer.

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	1,832	2,253	\$ 123,127	\$ 54.65	1
2	Assistant Director of Nursing	27,652	32,408	893,290	27.56	2
3	Registered Nurses	20,397	24,146	770,518	31.91	3
4	Licensed Practical Nurses	40,694	48,144	1,252,580	26.02	4
5	CNAs & Orderlies	131,783	151,772	1,975,453	13.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,132	13,737	155,353	11.31	10
11	Social Service Workers	5,551	6,363	120,883	19.00	11
12	Dietician	1,676	1,917	33,740	17.60	12
13	Food Service Supervisor	1,534	1,779	37,672	21.18	13
14	Head Cook	1,683	1,969	31,198	15.84	14
15	Cook Helpers/Assistants	20,986	24,176	245,366	10.15	15
16	Dishwashers	3,301	3,789	32,657	8.62	16
17	Maintenance Workers	1,940	2,185	39,505	18.08	17
18	Housekeepers	33,767	40,242	409,790	10.18	18
19	Laundry	7,185	8,526	88,639	10.40	19
20	Administrator	1,424	1,895	74,911	39.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,337	12,643	221,314	17.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,760	2,265	36,619	16.17	31
32	Other Health C: <u>Memory Care</u>	3,175	3,679	74,539	20.26	32
33	Other(specify) <u>See Sch 20A</u>	3,731	4,177	138,417	33.14	33
34	TOTAL (lines 1 - 33)	331,540	388,065	\$ 6,755,571 *	\$ 17.41	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	128	34,625	9(3) 36
37	Medical Records Consultant	14	748	10(3) 37
38	Nurse Consultant	15	15,972	10(3) 38
39	Pharmacist Consultant	Monthly	15,532	10(3) 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	96	4,651	11(3) 44
45	Social Service Consultant	89	3,817	12(3) 45
46	Other(specify)			46
47	<u>Pulmonary</u>	Monthly	18,136	10(3) 47
48	<u>Medical Consultant</u>	Monthly	2,587	10(7) 48
49	TOTAL (lines 35 - 48)	342	\$ 96,068	49

C. CONTRACT NURSES

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

Facility Name: Lexington of Wheeling
IDPH License ID Number: 0040923
Fiscal Year End: 12/31/14

Schedule 20A

XVIII. Staffing and Salary Costs

Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Barber Beauty	483	568	6,250	\$ 11.00
Marketing	3,248	3,609	132,167	\$ 36.62
Total - Line 33 Other (specify):	3,731	4,177	138,417	\$ 33.14

Facility Name & ID Number Lexington of Wheeling

0040923

Report Period Beginning: 01/01/14

Ending: 12/31/14

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		
Tremaine Brown	Administrator	0	\$ 74,911	Workers' Compensation Insurance	\$ 222,337	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	101,909	Advertising: Employee Recruitment	18,908		
				FICA Taxes	518,132	Health Care Worker Background Check			
				Employee Health Insurance	345,698	(Indicate # of checks performed <u>193</u>)	2,321		
				Employee Meals	19,648	Patient Background Checks	8,237		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	4,276		
Secretary of State				401K	16,347	Miscellaneous Dues & Subscriptions	2,558		
TOTAL (agree to Schedule V, line 17, col. 1)				Uniform Allowance	8,101	Non Allowable Dues	(121)		
(List each licensed administrator separately.)			\$ 74,911	Other Employee Benefits	37,353	Management Company Allocation	4,634		
B. Administrative - Other									
Description			Amount						
Management Fees-Royal Operating			\$ 1,218,139				Less: Public Relations Expense ()		
Management Fees-Vesta Mgmt.			442,928				Non-allowable advertising ()		
Management Fees (Eliminated in Column 7)							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,661,067	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,269,525	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 42,804
(Attach a copy of any management service agreement)									
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	
Appraisal Research Counselors	Appraisers		\$ 4,000	N/A			Out-of-State Travel	\$	
Duane Morris	Legal		907						
Cassiday Schade	Legal		23,693						
Grabowski Law Center	Collections		5,655				In-State Travel		
McGladrey, LLP	Accounting		33,806						
Much Shelist	Legal		8,326						
Pension Administrators	Pension Administration		795				Seminar Expense		
Personnel Planners	U/C Consulting		1,403				Management Company Allocation	1,739	
Rocio Gaytan Robles	Worker's Compensation		100						
Scott & Kraus	Legal		1,459						
Serpico, Petrosino, & Dupiero	Legal		360						
See Schedule 21C			77,518				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 158,022				TOTAL	\$ 1,739	

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Lexington of Wheeling
IDPH License ID Number: 0040923
Fiscal Year End: 12/31/14

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Secretary of State	Filing Fees	144
Gilson Labus & Silverman	Accounting	1,135
Ability Network	Computer Services	1,513
Avalere Health	Computer Services	2,000
Availity	Computer Services	139
Centino	Computer Services	750
Corepoint	Computer Services	945
Citrix	Computer Services	348
E-Health Data Solutions	Computer Services	3,450
Health MedX	Computer Services	15,454
Information Controls	Computer Services	9,866
HP Commercial Repair	Computer Services	5
Lintec	Computer Services	73
MS Licensing	Computer Services	8,374
National Datacare	Computer Services	3,551
On Shift	Computer Services	7,912
National Research	Computer Services	513
Relias	Computer Services	8,041
Relias Learning	Computer Services	-
Salesforce.com	Computer Services	5,594
Soft choice Corporation	Computer Services	3,224
Telemedicine Solutions	Computer Services	1,200
Trisis	Computer Services	1,716
Scott & Kraus	Computer Services	371
Symbria	Computer Services	1,200
		<u>77,518</u>

	Total (agree to Schedule V, line 19, column 3)	<u>158,022</u>
To disallow collection fees		(5,655)
Salesforce.com		(5,594)
Out of period legal		<u>(201)</u>
Reclassified Insurance		<u>(11,450)</u>
<i>Legal allocated from Real Estate</i>		200
Secretary of State		
<i>Samvest of Lombard</i>		
Accounting		109
Filing Fees		<u>17</u>
		<u>125</u>
<i>Allocated from Mgmt Co.</i>		
Much Shelist	Legal	174
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	56
Duane Morris	Legal	300
McGladrey LLP	Accounting	1,567
Frost, Ruttenberg & Rothblatt, P.C	Accounting	108
Gilson Labus & Silverman	Accounting	1,154
Illinois Secretary of State	Filing Fees	43
LaSalle Network	Recruiting/Finance	5,774
Pension Administrators, Inc.	401K Administration	359
Gene Whitehorn	Medicaid Reimb Specialist	1,556
M. Werner Consulting	Financial Consultant	2,040
McNamara & Associates	SNF Consultants	298
Healthcents	Managed Care Consultants	396
Computer Services	Computer Consulting	<u>16,828</u>
		<u>30,653</u>
	Total (agree to Schedule V, line 19, column 8)	<u>177,550</u>

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

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

Facility Name & ID Number Lexington of Wheeling# 0040923

Report Period Beginning:

01/01/14

Ending:

12/31/14**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? Yes
If YES, give association name and amount. IHCA - \$245
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 69,441 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 502,575
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. \$ 19,648 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,887
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.