



Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc.

# 0040923 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>215</u>	Skilled (SNF)	<u>215</u>	<u>78,475</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>215</u>	TOTALS	<u>215</u>	<u>78,475</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			<u>5,212</u>	<u>5,212</u>	8
9	SNF/PED					9
10	ICF	<u>42,913</u>	<u>11,698</u>	<u>4,937</u>	<u>59,548</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,913</u>	<u>11,698</u>	<u>10,149</u>	<u>64,760</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.52%

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

None (Do not include bed reserve 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 215 and days of care provided 4,694

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, L # 0040923 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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
	<b>A. General Services</b>										
1	Dietary	400,729	31,257	2,674	434,660		434,660	-	434,660		1
2	Food Purchase		384,636		384,636		384,636	(1,437)	383,199		2
3	Housekeeping	509,226	41,298	-	550,524		550,524	319	550,843		3
4	Laundry	-	23,575	-	23,575	-	23,575	-	23,575		4
5	Heat and Other Utilities			202,912	202,912		202,912	9,151	212,063		5
6	Maintenance	39,694	-	179,357	219,051		219,051	133,638	352,689		6
7	Other (specify):* <b>Alloc. From Mgmt Co</b>	-	-	-	-		-	16,643	16,643		7
8	<b>TOTAL General Services</b>	<b>949,649</b>	<b>480,766</b>	<b>384,943</b>	<b>1,815,358</b>	<b>-</b>	<b>1,815,358</b>	<b>158,314</b>	<b>1,973,672</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	-	-	34,500	34,500		34,500	-	34,500		9
10	Nursing and Medical Records	5,251,564	276,374	47,105	5,575,043		5,575,043	27,184	5,602,227		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	153,181	19,909	1,527	174,617		174,617	-	174,617		11
12	Social Services	163,754	-	3,302	167,056		167,056	-	167,056		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):* <b>Alloc. From Mgmt Co</b>	-	-	-	-		-	3,612	3,612		15
16	<b>TOTAL Health Care and Programs</b>	<b>5,568,499</b>	<b>296,283</b>	<b>86,434</b>	<b>5,951,216</b>	<b>-</b>	<b>5,951,216</b>	<b>30,796</b>	<b>5,982,012</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	138,776	-	1,698,786	1,837,562		1,837,562	(1,634,351)	203,211		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			200,668	200,668		200,668	36,523	237,191		19
20	Dues, Fees, Subscriptions & Promotions			38,505	38,505		38,505	8,509	47,014		20
21	Clerical & General Office Expenses	189,639	27,095	41,748	258,482		258,482	874,026	1,132,508		21
22	Employee Benefits & Payroll Taxes			1,258,019	1,258,019		1,258,019	-	1,258,019		22
23	Inservice Training & Education			7,923	7,923		7,923	547	8,470		23
24	Travel and Seminar			111	111		111	961	1,072		24
25	Other Admin. Staff Transportation		-	5,137	5,137		5,137	15,311	20,448		25
26	Insurance-Prop.Liab.Malpractice			515,857	515,857		515,857	9,693	525,550		26
27	Other (specify):* <b>Alloc. From Mgmt Co</b>	-	-	-	-		-	120,187	120,187		27
28	<b>TOTAL General Administration</b>	<b>328,415</b>	<b>27,095</b>	<b>3,766,754</b>	<b>4,122,264</b>	<b>-</b>	<b>4,122,264</b>	<b>(568,594)</b>	<b>3,553,670</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>6,846,563</b>	<b>804,144</b>	<b>4,238,131</b>	<b>11,888,838</b>	<b>-</b>	<b>11,888,838</b>	<b>(379,484)</b>	<b>11,509,354</b>		<b>29</b>

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	<b>D. Ownership</b>											
30	Depreciation			73,665	73,665		73,665	284,480	358,145			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			230,080	230,080		230,080	159,330	389,410			32
33	Real Estate Taxes			-	-		-	564,408	564,408			33
34	Rent-Facility & Grounds			1,960,340	1,960,340		1,960,340	(1,955,188)	5,152			34
35	Rent-Equipment & Vehicles			37,642	37,642		37,642	2,228	39,870			35
36	Other (specify):*			-	-		-	-	-			36
37	<b>TOTAL Ownership</b>			2,301,727	2,301,727	-	2,301,727	(944,742)	1,356,985			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	191,230	835,310	1,026,540		1,026,540	-	1,026,540			39
40	Barber and Beauty Shops	-	-	12,711	12,711		12,711	(12,711)	-			40
41	Coffee and Gift Shops	-	-	1,746	1,746		1,746	(1,430)	316			41
42	Provider Participation Fee			487,666	487,666		487,666	-	487,666			42
43	Other (specify):* <b>Non-Allowable Cos</b>	104,371	-	443,877	548,248		548,248	(548,248)	-			43
44	<b>TOTAL Special Cost Centers</b>	104,371	191,230	1,781,310	2,076,911	-	2,076,911	(562,389)	1,514,522			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,950,934	995,374	8,321,168	16,267,476	-	16,267,476	(1,886,615)	14,380,861			45

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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	(1,437)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,766)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,585	30		9
10	Interest and Other Investment Income	(161,338)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,309)	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	(3,151)	43		18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(390,792)	43		24
25	Fund Raising, Advertising and Promotional	(12,955)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(253)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(77,052)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (669,568)		\$	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)	(1,217,047)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,217,047)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,886,615)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

Lexington Health Care Center of Wheeling, Inc.

ID# 0040923

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (925)	43	1
2	Labs-Part A	(3,482)	43	2
3	X-Rays Part A	(8,144)	43	3
4	Marketing Salary	(104,371)	43	4
5	Gift Shop Income	(1,430)	41	5
6	Trust Fees	(75)	43	6
7	Collections	(23,775)	19	7
8	Out of period & nonallowable legal	(4,336)	19	8
9	Unrealized loss on FMV swap	112,723	43	9
10	Salesforce.com Offset	(2,641)	19	10
11	Nonallowable Dues	(5,177)	20	11
12	Non allowable finance charge	(1,866)	32	12
13	Loss on Disposal	(20,842)	43	13
14	Barber and beauty shop income	(12,711)	40	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(77,052)		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.	**	\$ 199	\$ 199	1	
2	V	30 Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	214,925	214,925	2	
3	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	23,716	23,716	3	
4	V	32 Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	277,403	277,403	4	
5	V	33 Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	557,340	557,340	5	
6	V	34 Rental Income	1,960,340	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,960,340)	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	112,723	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(112,723)	8	
9	V	43 Gain/Loss on disposal of assets		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	20,842	20,842	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		\$ 2,073,063			\$ 1,094,500	\$ * (978,563)	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.	**	\$ 319	\$	319	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	8,172		8,172	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	341		341	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	638		638	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	125,259		125,259	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	8,042		8,042	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	337		337	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	16,643		16,643	22
23	V	10 Management allocation - salaries		Royal Management Corp.	**	27,184		27,184	23
24	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,612		3,612	24
25	V	17 Management allocation - salaries		Royal Management Corp.	**	64,435		64,435	25
26	V	19 Computer consultant & supplies		Royal Management Corp.	**	38,510		38,510	26
27	V	19 Professional fees		Royal Management Corp.	**	28,566		28,566	27
28	V	20 Dues & subscriptions		Royal Management Corp.	**	1,566		1,566	28
29	V	20 Advertising - help wanted		Royal Management Corp.	**	12,120		12,120	29
30	V	21 Management allocation - salaries		Royal Management Corp.	**	840,105		840,105	30
31	V	21 Bank charges		Royal Management Corp.	**	3,393		3,393	31
32	V	21 Office supplies & printing		Royal Management Corp.	**	13,712		13,712	32
33	V	21 Postage		Royal Management Corp.	**	4,059		4,059	33
34	V	21 Telephone		Royal Management Corp.	**	12,757		12,757	34
35	V								35
36	V								36
37	V								37
38	V	** The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.							38
39	Total		\$			\$ 1,209,770	\$ *	1,209,770	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>	**	\$ 547	\$	547	15
16	V	24 <u>Travel &amp; seminar</u>		<u>Royal Management Corp.</u>	**	961		961	16
17	V	25 <u>Auto expense</u>		<u>Royal Management Corp.</u>	**	15,311		15,311	17
18	V	26 <u>Insurance general</u>		<u>Royal Management Corp.</u>	**	9,693		9,693	18
19	V	27 <u>Management allocation - employee benefits</u>		<u>Royal Management Corp.</u>	**	120,187		120,187	19
20	V	30 <u>Depreciation</u>		<u>Royal Management Corp.</u>	**	67,970		67,970	20
21	V	32 <u>Interest</u>		<u>Royal Management Corp.</u>	**	18,930		18,930	21
22	V	32 <u>Amortization of mortgage costs</u>		<u>Royal Management Corp.</u>	**	2,485		2,485	22
23	V	33 <u>Property taxes</u>		<u>Royal Management Corp.</u>	**	7,068		7,068	23
24	V	34 <u>Rent expense</u>		<u>Royal Management Corp.</u>	**	5,152		5,152	24
25	V	35 <u>Equipment rental</u>		<u>Royal Management Corp.</u>	**	1,574		1,574	25
26	V	17 <u>Management fees</u>	1,698,786	<u>Royal Management Corp.</u>	**			(1,698,786)	26
27	V	35 <u>Auto Lease</u>		<u>Royal Management Corp.</u>	**	654		654	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	<b>Total</b>		\$ 1,698,786			\$ 250,532	\$ *	(1,448,254)	39

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

Facility Name &amp; ID Number

Lexington Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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 Bloomingdale, Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Lexington Square	Lombard	Independent and	3
4			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Life Care		Assisted Living	4
5			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	of Lombard, LLC		Facility	5
6			Lexington HC Ctr. of Lombard, Inc.	Lombard	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Life Care		Living Facility	7
8			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	of Elmhurst, LLC			8
9			Lexington HC Ctr. of Streamwood, Inc.	Streamwood	Vesta Management	Lombard	Mgmt. Company	9
10					Group LLC			10
11					Lexington Health	Wheeling	Real Estate	11
12					Care Systems of		Property	12
13					Wheeling Ltd. Ptsp.			13
14					Royal Management	Lombard	Mgmt. Company	14
15					Corporation			15
16					Lexington Financial	Lombard	Finance Company	16
17					Services II, LLC			17
18					Heron Point	Lombard	Mgmt. Company	18
19					Management Corp			19
20					Samvest of Lombard	Lombard	Lessor	20
21					II, LLC			21
22					North Heron	Lombard	Finance Company	22
23					Investments, LLC			23
24					Lexington Home	Lombard	Home Health	24
25					Health Care, Inc.			25
26					Lexington Hospice	Lombard	Hospice	26
27					Services, LLC			27
28					Lexington Private	Lombard	Healthcare	28
29		0			Home Care			29
30		0						30



Facility Name & ID Number Lexington Health Care Center of Wheeling, # 0040923 Report Period Beginning: 01/01/17 Ending: 12/31/17

## 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	\$ 10,124	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,032	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,376	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	13,150	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	17,337	L17, C7	5
6	Phil Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,716	L17, C7	6
7	Jeremy Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,699	L17, C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,435		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 Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	722,335	10	\$ 2,937	\$ 78,475	\$ 319	1	
2	5	Utilities - gas & electric	Bed Days Available	722,335	10	75,222	78,475	8,172	2	
3	5	Utilities - water & sewer	Bed Days Available	722,335	10	3,135	78,475	341	3	
4	5	Utilities - maintenance office	Bed Days Available	722,335	10	5,869	78,475	638	4	
5	6	Management allocation - salaries	Bed Days Available	722,335	10	1,152,969	1,152,969	78,475	125,259	5
6	6	Repairs & maintenance	Bed Days Available	722,335	10	74,022	78,475	8,042	6	
7	6	Scavenger & exterminating	Bed Days Available	722,335	10	3,102	78,475	337	7	
8	7	Management allocation - employees	Bed Days Available	722,335	10	153,196	78,475	16,643	8	
9	10	Management allocation - salaries	Bed Days Available	722,335	10	250,218	250,218	78,475	27,184	9
10	15	Management allocation - employees	Bed Days Available	722,335	10	33,247	78,475	3,612	10	
11	17	Management allocation - salaries	Bed Days Available	722,335	10	593,100	593,100	78,475	64,435	11
12	19	Computer consultant & supplies	Bed Days Available	722,335	10	354,473	78,475	38,510	12	
13	19	Professional fees	Bed Days Available	722,335	10	262,937	78,475	28,566	13	
14	20	Dues & subscriptions	Bed Days Available	722,335	10	14,411	78,475	1,566	14	
15	20	Advertising - help wanted	Bed Days Available	722,335	10	111,560	78,475	12,120	15	
16	21	Management allocation - salaries	Bed Days Available	722,335	10	7,732,875	7,732,875	78,475	840,105	16
17	21	Bank charges	Bed Days Available	722,335	10	31,229	78,475	3,393	17	
18	21	Office supplies & printing	Bed Days Available	722,335	10	126,211	78,475	13,712	18	
19	21	Postage	Bed Days Available	722,335	10	37,365	78,475	4,059	19	
20	21	Telephone	Bed Days Available	722,335	10	117,421	78,475	12,757	20	
21	23	Inservice Training	Bed Days Available	722,335	10	5,038	78,475	547	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 11,140,537	\$ 9,729,162	\$ 1,210,317	25	

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	24	Travel and Seminar	Bed Days Available	722,335	10	\$ 8,850	\$ 78,475	\$ 961	1
2	25	Auto expense	Bed Days Available	722,335	10	140,934	78,475	15,311	2
3	26	Insurance general	Bed Days Available	722,335	10	89,225	78,475	9,693	3
4	27	Management allocation - employees	Bed Days Available	722,335	10	1,106,283	78,475	120,187	4
5	30	Depreciation	Bed Days Available	722,335	10	625,643	78,475	67,970	5
6	32	Interest	Bed Days Available	722,335	10	174,244	78,475	18,930	6
7	32	Amortization of mortgage costs	Bed Days Available	722,335	10	22,869	78,475	2,485	7
8	33	Property taxes	Bed Days Available	722,335	10	65,056	78,475	7,068	8
9	34	Rent expense	Bed Days Available	722,335	10	47,418	78,475	5,152	9
10	35	Equipment rental	Bed Days Available	722,335	10	14,486	78,475	1,574	10
11	35	Auto Lease	Bed Days Available	722,335	10	6,017	78,475	654	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					\$ 2,301,025	\$	\$ 249,985	25

Facility Name & ID Number Lexington Health Care Center of Wheeling, I # 0040923 Report Period Beginning: 01/01/17 Ending: 12/31/17

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Lexington Financial					\$	\$			\$	1									
2	Services II, L.L.C	X		Mortgage	Varies	4/30/07	7,573,000		9/15/2017	Libor +3.5%	186,565	2								
3	MB Financial		X	Mortgage	Fix Prin Var Int	9/15/2017	4,527,000	4,481,730	9/15/2019	Libor + 3.5%	67,695	3								
4												4								
5						Sch 9A	1,536,723				25,009	5								
<b>Working Capital</b>																				
6	Shareholders	X		Working Capital	None	Various	675,000	3,238,324	Demand	0.0150	88,000	6								
7	Shareholders	X		Working Capital	Varies	Various	2,000,000	2,000,000	Demand	0.0800	72,000	7								
8						Sch 9A	600,000				19,947	8								
9	<b>TOTAL Facility Related</b>					\$	14,775,000	\$ 11,856,777			\$ 459,216	9								
<b>B. Non-Facility Related*</b>																				
10								Amortization of loan costs			23,716	10								
11								Less: Interest to shareholders			(160,000)	11								
12								Interest Income			(1,338)	12								
13								See Sch 9A			67,816	13								
14	<b>TOTAL Non-Facility Related</b>					\$		\$			\$ (69,806)	14								
15	<b>TOTALS (line 9+line14)</b>					\$	14,775,000	\$ 11,856,777			\$ 389,410	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 Health Care Center of Wheeling, Inc.  
 IDPH License# 0040923  
 Fiscal Year E 12/31/17

**Schedule 9A**

**IX. Interest Expense and Real Estate Tax Expense**

	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				
		<b>A. Directly Facility Related</b>										
<b>Long-Term</b>												
1	Sambell of Elmhurst II LP		X	Mortgage	Varies	9/15/2017	\$ 1,252,410	\$ 1,252,410	9/15/2019	Libor + 3.5%	\$ 18,861	1
2	LHCS Lake Zurich LP		X	Mortgage	Varies	9/15/2017	284,313	284,313	9/15/2019	Libor + 3.5%	4,282	2
3												3
4												4
5										Finance Charge - Insurance Policy	1,866	5
<b>Working Capital</b>												
6	American Chartered Bank		X	Line of Credit	Varies	3/25/2016	5,600,000		9/15/2017	Libor + 2.5%	11,664	6
7	MB Financial		X	Line of Credit	Varies	9/15/2017	2,000,000	600,000	9/15/2019	Libor + 2.5%	8,283	7
8												8
9	<b>TOTAL Facility Related</b>						\$ 9,136,723	\$ 2,136,723			\$ 44,956	9
<b>B. Non-Facility Related*</b>												
10										Imputed Interest	47,857	10
11										Non Allowable Finance Charge	(1,866)	11
12										Microsoft Software Interest	411	12
13										Allocated from Mgmt Co.	21,414	13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 67,816	14
15	<b>TOTALS (line 9+line14)</b>						\$ 9,136,723	\$ 2,136,723			\$ 112,772	15

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2016 report.			\$ <b>598,000</b>	<b>1</b>	
	2016				
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.)			\$ <b>559,959</b>	<b>2</b>	
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(38,041)</b>	<b>3</b>	
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>577,000</b>	<b>4</b>	
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$ <b>18,381</b>	<b>5</b>	
		Alloc Fr. Mgmt Co.	<b>7,068</b>		
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$ _____	<b>6</b>	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>564,408</b>	<b>7</b>	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	<u>388,015</u>	<u>8</u>		
	2013	<u>551,608</u>	<u>9</u>		
	2014	<u>478,292</u>	<u>10</u>		
	2015	<u>531,065</u>	<u>11</u>		
	2016	<u>559,959</u>	<u>12</u>		
<a href="#">See attached real estate accrual sheet</a>					
				<b>FOR BHF USE ONLY</b>	
				<b>13</b>	
			FROM R. E. TAX STATEMENT FOR 2016 \$	<b>13</b>	
			PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>	
			LESS REFUND FROM LINE 6 \$	<b>15</b>	
			AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>	

**NOTES:**

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

# 2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Wheeling, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040923

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>03-10-401-027-0000</u>	<u>Land &amp; Building</u>	\$ <u>559,959.11</u>	\$ <u>559,959.11</u>
2.	<u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-021</u>	<u>Land &amp; Building</u>	\$ <u>257,787.00</u>	\$ <u>7,068.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ <u><u>817,746.11</u></u>	\$ <u><u>567,027.11</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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 Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning:

01/01/17

Ending:

12/31/17

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.

Table with 6 columns: Line Item, Use, Square Feet, Year Acquired, Cost, and Line Item. Rows include Resident Care, Management Company Allocation, and TOTALS.

Facility Name &amp; ID Number Lexington Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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	\$ 3,708,245	4
5	1		2000	2000	98,710	2,468	40	2,468		43,188	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Building improvement	1995		3,587		15			3,587	9
10		Land improvement - sidewalk replacement	1996		1,927		15			1,927	10
11		Leasehold improvement - pines & sod	1996		3,431		15			3,431	11
12		Basement rehab	1997		18,611		10			18,611	12
13		Building improvement - curtains/track	1997		1,936		35	55	55	1,076	13
14		Landscaping	1997		2,002		15			2,002	14
15		Wiring for MDS	1998		3,552		10			3,552	15
16		Parking Lot	1998		2,952		10			2,952	16
17		Roof repair	2000		1,980		10			1,980	17
18		Remodel HVAC/exhaust system - office area	2000		7,480	374	20	374		6,545	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		16,125.4	25
26		Elevator upgrade	2004		11,077	554	20	554		7,571	26
27		Landscaping	2005		450	23	20	23		286	27
28		HVAC system	2005		27,711	1,386	20	1,386		16,977	28
29		Lobby, lounge, and reception rehab	2005		22,731	1,137	20	1,137		13,643	29
30		Lower level therapy room rehab	2005		8,100	405	20	405		5,231	30
31		First floor therapy room addition	2005		32,167	1,608	20	1,608		20,905	31
32		Transitional unit addition	2005		18,758	938	20	938		11,490	32
33		Basement rehab	2005		13,105	655	20	655		8,188	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 &amp; ID Number Lexington Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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		\$ 3470	37
38	HVAC	2006	10,034		10			10,034	38
39	Emergency A/C	2006	8,110		10			8110	39
40	Administration HVAC	2006	6,058		10			6058	40
41	Modular units attached to wall	2006	11,010		10			11010	41
42	Transitional Unit	2006	8,017	401	10	401		4411	42
43	Employee lunch room rehab	2006	2,361		10			2361	43
44	Alzheimers Remodel	2007	606	15	40	15		150	44
45	Alzheimers Remodel	2007	10,535	263	40	263		2630	45
46	Install wireless LAN	2006	5,307		10			5307	46
47	Automatic Doors Patio	2006	2,232		10			2232	47
48	Parking Lot	2007	3,777	189	20	189		1953	48
49	HVAC	2007	4,842	242	20	242		2420	49
50	First Floor Remodel-carpentry, flooring, door frames, plumbing	2007	646,028		40	16,151	16,151	177660	50
51									51
52	Landscaping	2008	14,600	973	15	973		9487	52
53	Second Floor Remodel-carpentry, flooring, electrical, painting	2008	485,694		27	17,662	17,662	161902	53
54	Special care unit-carpentry, electrical, painting, alarm systems	2008	40,930		27	1,488	1,488	13640	54
55	Irrigation System	2009	15,185	1,012	15	1,012		8518	55
56	Landscaping Enhancements	2009	21,445	1,430	15	1,430		12323	56
57	Roof repairs	2009	137,000	6,850	20	6,850		56513	57
58	Stamped Concrete	2009	10,512	382	27	382		3120	58
59	Quick connects	2009	9,678	484	20	484		4114	59
60									60
61	2nd Floor remodel-Carpentry	2009	8,116	295	27	295		2606	61
62	Patio Fence	2009	4,824	241	20	241		1948	62
63	Patio Pergola	2009	8,299	415	20	415		3631	63
64	3rd floor remodel-Carpentry, flooring, electrical, wallpaper	2009	443,781		27	16,137	16,137	137165	64
65	alarms sytem, painting.								65
66	Brick panel replacement	2010	164,474	5,981	27	5,981		43362.4	66
67	Office carpentry, flooring, electrical, painting, plumbing, signs	2010	40,017	2,808	27	2,808		19656.4	67
68	Landscaping	2010	3,124	208	15	208		1341.4	68
69	Parking lot signs and flagpole	2010	2,870	231	27	231		1695.4	69
70	TOTAL (lines 4 thru 69)		\$ 9,003,057	\$ 33,399		\$ 248,115	\$ 214,716	\$ 4,645,160	70

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

Facility Name &amp; ID Number Lexington Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 9,003,057	\$ 33,399		\$ 248,115	\$ 214,716	\$ 4,645,160	1
2	Remove and replace asphalt	2010	17500	636	27	636		4717	2
3	Spot cooler	2010	3456	126	27	126		892	3
4	Admin office HVAC	2010	8400	305	27	305		2313	4
5	Holding tank	2010	13000	473	27	473		3429	5
6	Floor sink	2010	13177	479	27	479		3672	6
7	Remodel pantry-shelves	2010	8880	323	27	323		2315	7
8	Paint over bed lights	2010	5770	210	27	210		1470	8
9	Remodel library/lounge-flooring,carpentry	2010	10114	368	27	368		2637	9
10	Office carpentry,flooring,electrical,painting,plumbing,signs	2011	2541	92	27	92		606	10
11	Office doors, keys	2011	16375	595	27	595		3768	11
12	HVAC repair, fire dampers	2011	21469	780	27	780		4768	12
13	Laundry room-tile, painting, electrical	2011	8717	317	27	317		2061	13
14	Common area doors	2011	30333	1,103	27	1,103		6710	14
15									15
16	Sprinkler Replacement	2012	10441	380	27	380		1931	16
17	Electrical thru out home	2012	8728	317	27	317		1638	17
18									18
19	EMR Wiring- Entire Facility	2013	18523	674	27	674		2920	19
20									20
21	Install Trees - Main Entrance	2014	10320	229	15	229		916	21
22	Remove and replace asphalt parking lot	2014	17400	264	27	264		1056	22
23	Install french drain - kitchen	2014	2750	33	27	33		132	23
24	R/M Reclass: Replace pistons, rods, and fans - Mechanical Room	2014	2585		27	96	96	336	24
25									25
26	Building Wiring - Entire Facility	2015	5243	191	27	191		493	26
27	R&M - Asphalt work in the parking lot	2015	5000		20	250	250	625	27
28									28
29	Room Renovations - 1st floor chair rails	2016	13770	501	27	501		668	29
30	Chliier replacement	2017	106,058	3,535	15	3,535		3,535	30
31									31
32	Reconcile to book depreciation			-1,240			1,240		32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,363,607	\$ 44,090		\$ 260,392	\$ 216,302	\$ 4,698,768	34

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	<b>Totals from Page 12B, Carried Forward</b>	\$ 9,363,607	\$ 44,090		\$ 260,392	\$ 216,302	\$ 4,698,768	1	
2								2	
3	Land improvements - management company	2002 312,638		40	7,077	7,077	145,843	3	
4	HVAC, electrical, security system - management company	2003 2,746		30	675	675	2,264	4	
5	Key card system - management company	2004 432		20	21	21	289	5	
6	VAV TX controls - management company	2005 131		20	7	7	84	6	
7	Interior Signs-management company	2006 96		20	6	6	71	7	
8	Building improvements - management company	2008 14,165		20	168	168	6,047	8	
9	Building improvements - management company	2009 2,783		20	52	52	1,283	9	
10	Building improvements - management company	2010 2,716		20	51	51	1,166	10	
11	Building improvements - management company	2011 1,946		20	90	90	589	11	
12	Building improvements - management company	2012 6,580		20	13	13	1,368	12	
13	Building improvements - management company	2013 5,079		20	368	368	1,578	13	
14	Building improvements - management company	2014 2,749		20	273	273	965	14	
15	Building improvements - management company	2015 483		20	59	59	148	15	
16	Building improvements - management company	2016 7,976		20	588	588	821	16	
17	Building improvements - management company	2017 5,186		20	65	65	98	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	<b>TOTAL (lines 1 thru 33)</b>	\$ 9,729,313	\$ 44,090		\$ 269,905	\$ 225,816	\$ 4,861,382	34	

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	\$ 232,182	\$ 28,866	\$ 29,074	\$ 208	5-10	\$ 174,696	71
72	Current Year Purchases	7,774	709	709		5-7	709	72
73	Fully Depreciated Assets	1,176,983				5-7	1,176,983	73
74	Allocated from Mgmt. Co.	635,752		56,039	56,039	5	571,777	74
75	TOTALS	\$ 2,052,691	\$ 29,575	\$ 85,822	\$ 56,247		\$ 1,924,165	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.			57,188	-	2,418	2,418	5	53,214	79
80	TOTALS			\$ 57,188	\$	\$ 2,418	\$ 2,418		\$ 53,214	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)	\$ 12,456,785	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,665	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 358,145	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 284,481	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,838,761	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from Management Company</u>				<u>5,152</u>			6
7	TOTAL				\$ <u>5,152</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. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2020                      \$ \_\_\_\_\_

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: \$ 39,216 Description: See Sch 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocated from Management Company</u>			<u>654</u>	20
21	TOTAL		\$	\$ <u>654</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:** Lexington Health Care Center of Wheeling, Inc.  
**IDPH License ID Number:** 0040923  
**Fiscal Year End:** 12/31/17

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Copier	8,445
Printer	2,470
Postage	805
Medical Equipment	25,922
Management company	1,574
<b>Total - Line 16</b>	<b><u><u>39,216</u></u></b>

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

**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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	5,608	\$ 301,764	\$	5,608	\$ 301,764	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,307	109,276		2,307	109,276	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		10,251	416,662		10,251	416,662	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 prescripts				155,760		155,760	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39(3)				7,608			7,608	12
13	Other (specify): <u>Sch 16A</u>	39(2)					35,470		35,470	13
14	<b>TOTAL</b>			\$	18,166	\$ 835,310	\$ 191,230	18,166	\$ 1,026,540	14

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

Facility Name: Lexington Health Care Center of Wheeling, Inc.  
IDPH License ID Number: 0040923  
Fiscal Year End: 12/31/17

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 13 Other (specify)**

<b>Description</b>	<b>Amount</b>
DME	5,289
Oxygen	30,181
<b>Total - Line 12</b>	<b><u>35,470</u></b>

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc.# 0040923Report Period Beginning: 01/01/17Ending: 12/31/17

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 176,878	\$ 208,999	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>2,754,454</u> )	2,101,232	2,101,232	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	42,226	42,226	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,320,336	\$ 2,352,457	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,867	8,867	12
13	Land		617,593	13
14	Buildings, at Historical Cost		6,537,447	14
15	Leasehold Improvements, at Historical Cost	1,157,514	3,191,866	15
16	Equipment, at Historical Cost	558,059	2,109,879	16
17	Accumulated Depreciation (book methods)	(962,825)	(6,838,761)	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 <u>Rec. from Insurance</u> )	125,001	125,001	22
23	Other(specify): <u>Mortgage Cost, Net</u>		133,450	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 886,616	\$ 5,885,342	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,206,952	\$ 8,237,799	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 373,586	\$ 373,586	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	600,000	600,000	29
30	Accrued Salaries Payable	444,344	444,344	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,388	15,388	31
32	Accrued Real Estate Taxes(Sch.IX-B)		577,000	32
33	Accrued Interest Payable		41,802	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	13,968,331	2,864,306	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 15,401,649	\$ 4,916,426	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	5,238,324	6,775,047	39
40	Mortgage Payable		4,481,730	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,238,324	\$ 11,256,777	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 20,639,973	\$ 16,173,203	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (17,433,021)	\$ (7,935,404)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,206,952	\$ 8,237,799	48

\*(See instructions.)

**Facility Name:** Lexington Health Care Center of Wheeling, Inc.  
**IDPH License ID Number:** 0040923  
**Fiscal Year End:** 12/31/17

**Schedule 17A**

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

<b>Description</b>	<b>Operating</b>	<b>After Consolidation</b>
Cash Patient Trust	(51,790)	(51,790)
Sambel Rent Receivable	-	(11,104,025)
Due To / From Rehab Care Therapy	18,854	18,854
Due From Elmhurst Square-Ar	(371)	(371)
Prepaid Insurance	45,795	45,795
Escrow - Insurance	106,089	106,089
Cobra	3,965	3,965
Withholding - Dental Insurance	(2,014)	(2,014)
Withholding - Ep/Ci/Wl	5,250	5,250
401K Withholding	2,863	2,863
Accrued Expenses	99,044	99,044
Accrued Resident Tax	61,626	61,626
Accrued Vesta 3% Management Fees	2,268,521	2,268,521
Accrued Royal Management Fees	(57,955)	(57,955)
Accrued Rent	11,104,025	11,104,025
Accrued Insurance	109,805	109,805
Due To Patient Trust Fund	51,789	51,789
Advance - Biweekly Part A Paym	322	322
Uncollectible Part A Co Pvts	(1)	(1)
Due To - Royal Operations	32,919	32,919
Due To Republic	6,147	6,147
Due To Chicago Ridge	(371)	(371)
Due To Lhcc Elmhurst	(54)	(54)
Due To Lagrange	21,148	21,148
Due To Lake Zurich	(977)	(977)
Due To Schaumburg	1,049	1,049
Due To/From Lex Fincl Svcs Ii Llc	181	181
Professional Liabilities Claims	142,472	142,472
<b>Total - Line 36</b>	<b>13,968,331</b>	<b>2,864,306</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(15,905,610)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post closing adjustment</b>	<b>27,141</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(15,878,469)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,554,552)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,554,552)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(17,433,021)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Lexington Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning: 01/01/17

Ending:

12/31/17

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 20,778,049	1
2	Discounts and Allowances for all Levels	(9,282,231)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,495,818	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,343,084	6
7	Oxygen	9,226	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,352,310	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,430	12
13	Barber and Beauty Care	14,402	13
14	Non-Patient Meals	1,437	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	213,644	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	67,012	19
20	Radiology and X-Ray	11,812	20
21	Other Medical Services	553,721	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 863,458	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,338	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,338	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,712,924	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,815,358	31
32	Health Care	5,951,216	32
33	General Administration	4,122,264	33
<b>B. Capital Expense</b>			
34	Ownership	2,301,727	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,589,245	35
36	Provider Participation Fee	487,666	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 16,267,476	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,554,552)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,554,552)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,836,160	44
45	Private Pay - Net Inpatient Revenue	2,159,113	45
46	Medicare - Net Inpatient Revenue	343,398	46
47	Other-(specify) <b>Managed Care</b>	4,157,147	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 11,495,818	49

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

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

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

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

^ - Entity is a cash basis taxpayer

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc.

# 0040923

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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	1,973	2,266	\$ 144,537	\$ 63.79	1
2	Assistant Director of Nursing	485	536	22,435	41.83	2
3	Registered Nurses	27,427	33,293	1,175,757	35.31	3
4	Licensed Practical Nurses	30,703	36,957	993,349	26.88	4
5	CNAs & Orderlies	125,250	147,297	2,257,380	15.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,980	2,178	41,079	18.86	9
10	Activity Assistants	8,728	9,891	112,102	11.33	10
11	Social Service Workers	5,997	7,135	163,754	22.95	11
12	Dietician					12
13	Food Service Supervisor	1,978	2,297	54,807	23.86	13
14	Head Cook	2,026	2,317	42,119	18.18	14
15	Cook Helpers/Assistants	24,295	28,199	303,802	10.77	15
16	Dishwashers					16
17	Maintenance Workers	1,753	2,110	39,694	18.81	17
18	Housekeepers	37,860	45,183	509,226	11.27	18
19	Laundry					19
20	Administrator	1,643	2,185	138,776	63.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,743	9,501	189,638	19.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,066	2,527	51,594	20.42	31
32	Other Health Care(specify)	21,439	25,858	619,533	23.96	32
33	Other(specify) <u>Marketing</u>	2,343	2,535	91,353	36.03	33
34	TOTAL (lines 1 - 33)	304,687	362,264	\$ 6,950,934 *	\$ 19.19	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	Monthly 34,500	9(3)	36
37	Medical Records Consultant	Monthly 796	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 18,813	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly 4,721	11(3)	44
45	Social Service Consultant	Monthly 3,302	12(3)	45
46	Other(specify) <u>Pulmonary</u>	Monthly 16,911	10(3)	46
47	<u>Post Acute Consultant</u>	Monthly 1,398	10(3)	47
48	<u>Telemedicine Consulting</u>	Monthly 9,187	10(3)	48
49	TOTAL (lines 35 - 48)	\$ 89,628		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 Health Care Center of Wheeling, Inc.  
**IDPH License ID Number:** 0040923  
**Fiscal Year End:** 12/31/17

**Schedule 20A**

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Staffing Coordinator	1,989	2,455	39,598	\$ 16.13
Unit Secretary	5,481	6,640	142,564	\$ 21.47
Accounts Coordinator	2,093	2,446	34,721	\$ 14.20
Admissions	1,543	1,890	38,310	\$ 20.27
MDS	3,592	4,264	143,815	\$ 33.73
Clinical Coordinator	616	774	28,174	\$ 36.40
Dietetic Technician	2,184	2,606	44,486	\$ 17.07
Wound Care Coordinator	3,941	4,784	147,866	\$ 30.91
<b>Total - Line 32 Other Health Care (specify):</b>	<b>21,439</b>	<b>25,858</b>	<b>619,533</b>	<b>\$ 23.96</b>

**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	
Amy Saltzman	Administrator	0	\$ 138,776	Workers' Compensation Insurance	\$ 142,677	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	38,395	Advertising: Employee Recruitment	5,623	
				FICA Taxes	509,527	Health Care Worker Background Check		
				Employee Health Insurance	511,991	(Indicate # of checks performed <u>93</u> )	1,119	
				Employee Meals		Patient Background Checks	331 3,971	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	5,978	
				401K	20,292	Miscellaneous Dues & Subscriptions	4,644	
				Uniform Allowance	1,743	Non Allowable Dues	(5,177)	
				Other Employee Benefits	33,394	Management Company Allocation	13,686	
						IHCA Dues	15,180	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 1,258,019	\$ 47,014		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-Royal Operating			\$ 1,482,041	N/A			Out-of-State Travel	\$
Management Fees-Vest Mgmt.			216,745					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	111
							Allocated from Home Office	961
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,072	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Facility Name:** Lexington Health Care Center of Wheeling, Inc.  
**IDPH License ID Number:** 0040923  
**Fiscal Year End:** 12/31/17

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
Cash Receipts	Collections	23,775
ICIMS	Computer expenses	3,694
Info Controls	Computer expenses	724
MB	Computer expenses	50
MHC	Computer expenses	738
Naitional Datacare Corp	Computer expenses	5,373
Microsoft	Computer expenses	9,688
Netsmart	Computer expenses	12,048
Health Medx	Computer expenses	(3,012)
RSM US LLP	Computer expenses	5,116
Much Shelist	Legal	35,207
Royal Management Ops	Legal	1,926
Goldstine, Skrodzki, Russian, Nemac And Hoff, Ltd	Legal	850
Generation Law Ltd	Legal	3,282
Serpico, Petrosino, Dipiero & O'Shea, Ltd	Legal	69
Hughes Socol Piers Resnick And Dym Ltd	Legal	369
Duane Morris	Legal	1,224
Lexington Financial Services Llc	Legal	487

**Total (agree to Schedule V, line 19, column 3)** 200,668

Legal Allocated from Real Estate	199
Less: Non-Allowable Legal Fees	(4,336)
Less: Non-Allowable Computer Services	(2,641)
Less: Non-Allowable Collections	(23,775)

**Allocated from SV of Lombard II**

Friedman & Huey	Accounting	144
Illinois Secretary of State	Filing Fees	17
		<u>142</u>

**Allocated from Management Company**

Much Shelist	Legal	1,814
Hinshaw & Culbertson LLP	Legal	249
Duane Morris	Legal	2,139
Serpico, Petrosino	Legal	13
Golan and Christie	Legal	22
RSM	Accounting	1,485
Friedman & Huey	Accounting	794
IL Secretary of State	Filing Fees	52
Gilson Labus & Silverman LLC	Accounting	705
Marcum LLP	Accounting	347
LaSalle Network	Recruiting / Finance	1,248
Pension Administrators, Inc.	401K Administration	(128)
Gene Whitehorn	Medicaid Reimb Specialist	2,026
M Werner Consulting	Financial Consulting	1,039
Eisen Alliance LLC	Workplace Consultant	324
Barry Lazarus	Health Care Consultant	277
Mark Rodeghier	Survey Preparation Consultant	717
Pathway Health Services	Operational & Financial Consulti	2,489
IMEC	Operational & Financial Consulti	6,051
Forest Performance	Performance Consulting	1,853
Reputation.com	Performance Consulting	1,110
Devree Molnar	Strategy/Operations Consulting	156
Steven Wood	Strategy/Operations Consulting	320
Susan Parker	Social Service Consultant	18
Focus Pointe Global	Strategic Planning	1,291
CLIN-SCIENCE RESEARCH	General Business Consulting	419
Provinet Solutions	Technical Consulting	16
ANDRZJ STANKIEWIC	General Business Consulting	100
DLC	Financial Planning & Analysis	1,478
Computer Services	Computer Consulting	38,510

**Total (agree to Schedule V, line 19, column 8)** 237,191

**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 - \$15,180
- (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? 5-7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 57,484 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. \$ 487,666  
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. \$ - Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,437
- (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