FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0040923

Facility Name: Lexington Health Care Center of Wheeling, Inc.

Address: 730 W. Hintz Road (Number) Wheeling (City) 60090 (Zip Code)

County: Cook

Telephone Number: (847) 537-7474 **Fax #** (847) 537-7599

HFS ID Number:

Date of Initial License for Current Owners: 5/12/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' PREPERATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			10,973	10,973	8
9	SNF/PED					9
10	ICF	53,837	5,577		59,414	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,837	5,577	10,973	70,387	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.69%

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 [X] 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 [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 215 and days of care provided 5,979

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, I # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	389,388	37,790	21,068	448,246		448,246		448,246			1
2	Food Purchase		384,162		384,162		384,162	(18,153)	366,009			2
3	Housekeeping	362,626	38,828		401,454		401,454	392	401,846			3
4	Laundry	106,056	23,158		129,214		129,214		129,214			4
5	Heat and Other Utilities			239,078	239,078		239,078	10,748	249,826			5
6	Maintenance	32,280		190,008	222,288		222,288	79,129	301,417			6
7	Other (specify):* Alloc. From Mgmt Co							9,693	9,693			7
8	TOTAL General Services	890,350	483,938	450,154	1,824,442		1,824,442	81,809	1,906,251			8
	B. Health Care and Programs											
9	Medical Director			39,500	39,500		39,500		39,500			9
10	Nursing and Medical Records	4,576,632	433,792	94,524	5,104,948		5,104,948	66,460	5,171,408			10
10a	Therapy			1,040,575	1,040,575		1,040,575		1,040,575			10a
11	Activities	256,088	27,806	13,584	297,478		297,478		297,478			11
12	Social Services	145,182		7,286	152,468		152,468		152,468			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt Co							9,192	9,192			15
16	TOTAL Health Care and Programs	4,977,902	461,598	1,195,469	6,634,969		6,634,969	75,652	6,710,621			16
	C. General Administration											
17	Administrative	111,940		1,535,857	1,647,797		1,647,797	(1,507,058)	140,739			17
18	Directors Fees											18
19	Professional Services			178,033	178,033		178,033	23,060	201,093			19
20	Dues, Fees, Subscriptions & Promotions			75,423	75,423		75,423	7,801	83,224			20
21	Clerical & General Office Expenses	213,861	38,954	46,227	299,042		299,042	640,283	939,325			21
22	Employee Benefits & Payroll Taxes			930,057	930,057		930,057	17,468	947,525			22
23	Inservice Training & Education			17,911	17,911		17,911	1,714	19,625			23
24	Travel and Seminar			1,948	1,948		1,948	1,004	2,952			24
25	Other Admin. Staff Transportation			3,360	3,360		3,360	20,792	24,152			25
26	Insurance-Prop.Liab.Malpractice			399,815	399,815		399,815	7,186	407,001			26
27	Other (specify):* Alloc. From Mgmt Co							92,365	92,365			27
28	TOTAL General Administration	325,801	38,954	3,188,631	3,553,386		3,553,386	(695,385)	2,858,001			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,194,053	984,490	4,834,254	12,012,797		12,012,797	(537,924)	11,474,873			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 Health Care Center of Wheeling, Inc. #0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			148,475	148,475		148,475	419,524	567,999			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,109	40,109		40,109	432,134	472,243			32
33	Real Estate Taxes							406,791	406,791			33
34	Rent-Facility & Grounds			1,792,319	1,792,319		1,792,319	(1,787,961)	4,358			34
35	Rent-Equipment & Vehicles			69,548	69,548		69,548	3,516	73,064			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,050,451	2,050,451		2,050,451	(525,996)	1,524,455			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		302,502	37	302,539		302,539		302,539			39
40	Barber and Beauty Shops			19,709	19,709		19,709		19,709			40
41	Coffee and Gift Shops			3,476	3,476		3,476		3,476			41
42	Provider Participation Fee			313,458	313,458		313,458		313,458			42
43	Other (specify):* **Non-Allow Costs**	92,261		127,427	219,688		219,688	(219,688)				43
44	**TOTAL Special Cost Centers**	92,261	302,502	464,107	858,870		858,870	(219,688)	639,182			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,286,314	1,286,992	7,348,813	14,922,119		14,922,119	(1,283,608)	13,638,511			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: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(685)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,542)	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	128	30		9
10	Interest and Other Investment Income	(31,074)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,358)	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	(1,527)	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	(60,229)	43		24
25	Fund Raising, Advertising and Promotional	(37,883)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(932)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(384,833)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (525,935)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(757,673)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (757,673)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,283,608)		37

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

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

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

STATE OF ILLINOIS

Lexington Health Care Center of Wheeling, Inc.

ID# 0040923

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (1,804)	43	1
2	Labs-Part A	(2,631)	43	2
3	X-Rays Part A	(12,223)	43	3
4	Marketing Salary	(92,261)	43	4
5	Dues & Subscriptions Marketing	(1,298)	20	5
6	Trust Fees	(135)	43	6
7	Collections	(2,266)	19	7
8	Reclass LHI to maintenance	6,879	6	8
9	Education and Seminar Marketing	(1,948)	24	9
10	Unrealized loss on FMV swap	(277,146)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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**	(384,833)		49

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 supplemental schedule 6		See supplemental schedule 6		See supplemental schedule 6		

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. [X] 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	21	Office Supplies		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	42	42	2
3	V	30	Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	369,139	369,139	3
4	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	1,397	1,397	4
5	V	32	Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	444,714	444,714	5
6	V	33	Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	400,319	400,319	6
7	V	34	Rental expense	1,792,319	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,792,319)	7
8	V	43	Trust Fees		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	135	135	8
9	V	43	Unrealized loss on FMV swap		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	277,146	277,146	9
10	V								10
11	V								11
12	V								12
13	V		**The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Lexington Health Care Systems of Wheeling Ltd. Ptsp.						13
14	Total			$ 1,792,319			$ 1,493,092	$ * (299,227)	14

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 392	$ 392	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	9,353	9,353	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	213	213	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	1,182	1,182	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	65,866	65,866	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	6,026	6,026	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	358	358	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	9,693	9,693	22
23	V	10	Medical consultant		Royal Management Corp.	**	4,002	4,002	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	62,458	62,458	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	9,192	9,192	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	28,799	28,799	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	18,248	18,248	27
28	V	19	Professional fees		Royal Management Corp.	**	6,878	6,878	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,412	1,412	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	6,389	6,389	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	598,825	598,825	31
32	V	21	Bank charges		Royal Management Corp.	**	11,455	11,455	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	13,262	13,262	33
34	V	21	Postage		Royal Management Corp.	**	4,291	4,291	34
35	V	23	Inservice Training		Royal Management Corp.	**	1,714	1,714	35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 860,008	$ * 860,008	39

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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)	
15	V	21	Telephone	$	Royal Management Corp.	**	$ 12,408	$ 12,408	15
16	V	24	Travel & seminar		Royal Management Corp.	**	2,952	2,952	16
17	V	25	Auto expense		Royal Management Corp.	**	20,792	20,792	17
18	V	26	Insurance general		Royal Management Corp.	**	7,186	7,186	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	92,365	92,365	19
20	V	30	Depreciation		Royal Management Corp.	**	50,257	50,257	20
21	V	32	Interest		Royal Management Corp.	**	17,059	17,059	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	38	38	22
23	V	33	Property taxes		Royal Management Corp.	**	6,472	6,472	23
24	V	34	Rent expense		Royal Management Corp.	**	4,358	4,358	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,258	1,258	25
26	V	17	Management fees	1,535,857	Royal Management Corp.	**	2,258	(1,533,599)	26
27	V	35	Auto Lease		Royal Management Corp.	**			27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 1,535,857			$ 217,403	$ * (1,318,454)	39

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.	Bloomingdale	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	Sambell of	Wheeling	Real Estate	5
6			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Wheeling Ltd. Ptsp.		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					Samvest of	Lombard	Lessor	17
18					Lombard II, LLC			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

Facility Name & ID Number Lexington Health Care Center of Wheeling, # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 10,562	L17, C7	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,910	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,327	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,076	L21, C7	4
5											5
6											6
7											7
8				Certain Individuals work in excess of 40 hours per week.							8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,875		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: 01/01/2011 Ending: 2/31/2011

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days Available	722,420	10	$ 3,612	$	78,475	$ 392	1
2	5	Utilities - gas & electric	Bed Days Available	722,420	10	86,099		78,475	9,353	2
3	5	Utilities - water & sewer	Bed Days Available	722,420	10	1,961		78,475	213	3
4	5	Utilities - maintenance office	Bed Days Available	722,420	10	10,885		78,475	1,182	4
5	6	Management allocation - salaries	Bed Days Available	722,420	10	606,344	606,344	78,475	65,866	5
6	6	Repairs & maintenance	Bed Days Available	722,420	10	55,471		78,475	6,026	6
7	6	Scavenger & exterminating	Bed Days Available	722,420	10	3,293		78,475	358	7
8	7	Management allocation - employee	Bed Days Available	722,420	10	89,234		78,475	9,693	8
9	10	Medical consultant	Bed Days Available	722,420	10	36,843		78,475	4,002	9
10	10	Management allocation - salaries	Bed Days Available	722,420	10	574,970	574,970	78,475	62,458	10
11	15	Management allocation - employee	Bed Days Available	722,420	10	84,616		78,475	9,192	11
12	17	Management allocation - salaries	Bed Days Available	722,420	10	265,116	265,116	78,475	28,799	12
13	19	Computer consultant & supplies	Bed Days Available	722,420	10	167,987		78,475	18,248	13
14	19	Professional fees	Bed Days Available	722,420	10	63,319		78,475	6,878	14
15	20	Dues & subscriptions	Bed Days Available	722,420	10	13,000		78,475	1,412	15
16	20	Advertising - help wanted	Bed Days Available	722,420	10	58,818		78,475	6,389	16
17	21	Management allocation - salaries	Bed Days Available	722,420	10	5,512,623	5,512,623	78,475	598,825	17
18	21	Bank charges	Bed Days Available	722,420	10	105,454		78,475	11,455	18
19	21	Office supplies & printing	Bed Days Available	722,420	10	122,091		78,475	13,262	19
20	21	Postage	Bed Days Available	722,420	10	39,500		78,475	4,291	20
21	21	Telephone	Bed Days Available	722,420	10	114,221		78,475	12,408	21
22	24	Travel and Seminar	Bed Days Available	722,420	10	27,173		78,475	2,952	22
23	23	Inservice Training	Bed Days Available	722,420	10	15,778		78,475	1,714	23
24										24
25	TOTALS					$ 8,058,408	$ 6,959,053		$ 875,368	25

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] 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 Ave.
City / State / Zip Code: Lombard, IL 60148
Phone Number: ((630) 478-4700
Fax Number: ((630) 478-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days Available	722,420	10	$ 191,407	$	78,475	$ 20,792	1
2	26	Insurance general	Bed Days Available	722,420	10	66,156		78,475	7,186	2
3	27	Management allocation - employee	Bed Days Available	722,420	10	850,290		78,475	92,365	3
4	30	Depreciation	Bed Days Available	722,420	10	462,650		78,475	50,257	4
5	32	Interest	Bed Days Available	722,420	10	157,045		78,475	17,059	5
6	32	Amortization of mortgage costs	Bed Days Available	722,420	10	354		78,475	38	6
7	33	Property taxes	Bed Days Available	722,420	10	59,576		78,475	6,472	7
8	34	Rent expense	Bed Days Available	722,420	10	40,122		78,475	4,358	8
9	35	Equipment rental	Bed Days Available	722,420	10	11,581		78,475	1,258	9
10	35	Auto Lease	Bed Days Available	722,420	10	20,791		78,475	2,258	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,859,972	$		$ 202,043	25

Facility Name & ID Number Lexington Health Care Center of Wheeling, Ir # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	6,952,177	5/1/2017	0.0625	444,714	2
3												3
4												4
5								Interest on financing insurance premium			958	5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	675,000	3,081,153	Demand	Prime +1	30,506	6
7	JP Morgan Chase N.A.		X	Line of Credit	Varies	4/30/07	2,200,000	1,600,000	6/30/12	Libor + 2.25%	8,645	7
8												8
9	TOTAL Facility Related						$ 10,448,000	$ 11,633,330			$ 484,823	9
	B. Non-Facility Related*											
10								Amortization of loan costs			1,397	10
11								Interest income offset			(568)	11
12								Allocated from management co.			17,097	12
13								Less: Interest to shareholders			(30,506)	13
14	TOTAL Non-Facility Related						$	$			$ (12,580)	14
15	TOTALS (line 9+line14)						$ 10,448,000	$ 11,633,330			$ 472,243	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 & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 354,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010	$ 379,566	2
3. Under or (over) accrual (line 2 minus line 1).		$ 25,566	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 391,200	4
	Allocated Mgmt. Co.	6,472	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		$ 5,705	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 22,151 **For** 2008 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ (22,151)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 406,791	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	417,477	8
2007	433,316	9
2008	451,429	10
2009	343,531	11
2010	379,566	12

See attached accrual worksheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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.

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-10-401-027-0000	Land & Building	$ 379,565.96	$ 379,565.96
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-021	Land & Building	$ 229,415.60	$ 6,472.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 608,981.56	$ 386,037.96

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 01/01/2011 Ending: 12/31/2011

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	137,650	1993	$ 595,000	1
2	Allocation Mgmt. Co.			21,740	2
3	TOTALS	137,650		$ 616,740	3

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	205		1995	1995	$ 6,537,447	$	10-40	$ 163,223	$ 163,223	$ 2,728,907	4
5	10		2000	2000	98,710	2,468	40	2,468		28,380	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvement			1995	3,587		15			3,587	9
10	Land improvement - sidewalk replacement			1996	1,927	65	15	65		1,927	10
11	Leasehold improvement - pines & sod			1996	3,431	113	15	113		3,431	11
12	Basement rehab			1997	18,611		10			18,611	12
13	Building improvement - curtains/track			1997	1,936		35	55	55	801	13
14	Landscaping			1997	2,002	134	15	134		1,938	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		4,301	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	108	10	108		2,177	22
23	Infrared curtain units for 3 elevators			2001	4,500		5			4,500	23
24	Boiler vent repairs			2001	3,084	155	10	155		3,084	24
25	Kitchen wall rebuild			2003	22,500	1,125	20	1,125		9,375	25
26	Elevator upgrade			2004	11,077	554	20	554		4,247	26
27	Landscaping			2005	450	23	20	23		148	27
28	HVAC system			2005	27,711	1,386	20	1,386		8,661	28
29	Lobby, lounge, and reception rehab			2005	22,731	1,137	20	1,137		6,821	29
30	Lower level therapy room rehab			2005	8,100	405	20	405		2,801	30
31	First floor therapy room addition			2005	32,167	1,608	20	1,608		11,257	31
32	Transitional unit addition			2005	18,758	938	20	938		5,862	32
33	Basement rehab			2005	13,105	655	20	655		4,258	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 Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
37	Landscaping Enhancement	2006	$ 4,558	$ 304	15	$ 304	$	$ 1,646	37
38	HVAC	2006	10,034	1,003	10	1,003		5,099	38
39	Emergency A/C	2006	8,110	811	10	811		4,258	39
40	Administration HVAC	2006	6,058	606	10	606		3,181	40
41	Modular units attached to wall	2006	11,010	1,101	10	1,101		5,964	41
42	Transitional Unit	2006	8,017	401	10	401		2,005	42
43	Employee lunch room rehab	2006	2,361	236	10	236		1,318	43
44	Alzheimers Remodel	2007	606	15	40	15		60	44
45	Alzheimers Remodel	2007	10,535	263	40	263		1,052	45
46	Install wirelless LAN	2006	5,307	531	10	531		2,655	46
47	Automatic Doors Patio	2006	2,232	223	10	223		1,227	47
48	Parking Lot	2007	3,777	189	20	189		819	48
49	HVAC	2007	4,842	242	20	242		968	49
50	First Floor Remodel-carpentry, flooring, door frames, plumbing	2007	646,028		40	16,151	16,151	80,754	50
51	First Floor Remodel-painting, carpentry, flooring, plumbing	2007			40				51
52	Landscaping	2008	14,600	973	15	973		3,649	52
53	Second Floor Remodel-carpentry, flooring, electrical, painting	2008	485,694		27	17,662	17,662	55,930	53
54	Special care unit-carpentry, electrical, painting, alarm systems	2008	40,930		27	1,488	1,488	4,712	54
55	Irrigation System	2009	15,185	1,012	15	1,012		2,446	55
56	Landscaping Enhancements	2009	21,445	1,430	15	1,430		3,575	56
57	Roof repairs	2009	137,000	6,850	20	6,850		15,413	57
58	Stamped Concrete	2009	10,512	382	27	382		828	58
59	Quick connects	2009	9,678	484	20	484		1,210	59
60									60
61	2nd Floor remodel-Carpentry	2009	8,116	295	27	295		836	61
62	Patio Fence	2009	4,824	241	20	241		502	62
63	Patio Pergola	2009	8,299	415	20	415		1,141	63
64	3rd floor remodel-Carpentry,flooring,electrical,wallpaper	2009	443,781		27	16,137	16,137	40,343	64
65	alarms sytem,painting.								65
66	Brick panel replacement	2010	164,474	5,981	27	5,981		7,476	66
67	Office carpentry,flooring,electrical,painting,plumbing,signs	2010	40,017	2,808	27	2,808		2,808	67
68	Landscaping	2010	3,124	208	15	208		260	68
69	Parking lot signs and flagpole	2010	2,870	231	27	231		309	69
70	TOTAL (lines 4 thru 69)		$ 9,003,057	$ 38,483		$ 253,199	$ 214,716	$ 3,135,060	70

**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: 01/01/2011 Ending: 12/31/2011

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 12A, Carried Forward		$ 9,003,057	$ 38,483		$ 253,199	$ 214,716	$ 3,135,060	1
2	Remove and replace asphalt	2010	17,500	636	27	636		901	2
3	Spot cooler	2010	3,456	126	27	126		136	3
4	Admin office HVAC	2010	8,400	305	27	305		483	4
5	Holding tank	2010	13,000	473	27	473		591	5
6	Floor sink	2010	13,177	479	27	479		798	6
7	Remodel pantry-shelves	2010	8,880	323	27	323		377	7
8	Paint over bed lights	2010	5,770	210	27	210		210	8
9	Remodel library/lounge-flooring,carpentry	2010	10,114	368	27	368		429	9
10	Office carpentry,flooring,electrical,painting,plumbing,signs	2011	2,541	54	27	54		54	10
11	Office doors, keys	2011	16,375	198	27	198		198	11
12	HVAC repair, fire dampers	2011	21,469	88	27	88		88	12
13	Laundry room-tile, painting, electrical	2011	8,717	158	27	158		158	13
14	Common area doors	2011	30,333	92	27	92		92	14
15									15
16	Reconcile to book depreciation			(129)			129		16
17									17
18	Land improvements - management company	2002	300,834		40	8,888	8,888	88,739	18
19	HVAC, electrical, security system - management company	2003	2,642		30	509	509	1,538	19
20	Key card system - management company	2004	415		20	21	21	154	20
21	VAV TX controls - management company	2005	126		20	6	6	43	21
22	Interior Signs-management company	2006	92		5	6	6	32	22
23	Building improvements - management company	2008	14,577		5	759	759	3,013	23
24	Building improvements - management company	2009	2,721		5	50	50	360	24
25	Building improvements - management company	2010	2,652		5	109	109	275	25
26	Building improvements - management company	2011	1,872		5	41	41	42	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,488,720	$ 41,864		$ 267,098	$ 225,234	$ 3,233,771	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: 01/01/2011 Ending: 12/31/2011

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	$ 1,447,392	$ 96,785	$ 251,207	$ 154,422	5	$ 819,760	71
72	Current Year Purchases	138,928	9,826	9,826		5	9,826	72
73	Fully Depreciated Assets	55,986					55,986	73
74	Alloc. From Mgmt Co.	350,454		34,871	34,871	5	273,230	74
75	TOTALS	$ 1,992,760	$ 106,611	$ 295,904	$ 189,293		$ 1,158,802	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	Alloc. From Mgmt Co.			49,300		4,997	4,997	5	38,197	79
80	TOTALS			$ 49,300	$	$ 4,997	$ 4,997		$ 38,197	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)	$ 12,147,520	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,475	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 567,999	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 419,524	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,430,770	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Allocated from Mgmt Co.				4,358			6
7	TOTAL				$ 4,358 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 70,806 Description: Copier-$8,907; Fax Mach-$1,064;Mailing System-$247;Oxy-$25,990;Med Eq-$33,340 Alloc. Mgmt Co.-$1258
(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	Allocated from Mgmt Co.			2,258	18
19					19
20					20
21	TOTAL		$	$ 2,258	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 Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	7,015	$ 341,041	$	7,015	$ 341,041	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,170	125,334		2,170	125,334	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,845	574,200		8,845	574,200	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				302,502		302,502	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)					37		37	12
13	Other (specify):									13
14	TOTAL			$	18,030	$ 1,040,575	$ 302,539	18,030	$ 1,343,114	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.

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 172,112	$ 212,837	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 538,822)	3,704,057	3,704,057	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		37,990	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,876,169	$ 3,954,884	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,867	8,867	12
13	Land		616,740	13
14	Buildings, at Historical Cost		6,537,447	14
15	Leasehold Improvements, at Historical Cost	1,006,329	2,951,273	15
16	Equipment, at Historical Cost	767,307	2,042,060	16
17	Accumulated Depreciation (book methods)	(585,055)	(4,430,770)	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): Mortgage net cost		28,760	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,197,448	$ 7,754,377	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,073,617	$ 11,709,261	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 488,460	$ 488,460	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,681,153	4,681,153	29
30	Accrued Salaries Payable	441,080	441,080	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,728	10,728	31
32	Accrued Real Estate Taxes(Sch.IX-B)		391,200	32
33	Accrued Interest Payable		38,766	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	6,902,588	2,320,653	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,524,009	$ 8,372,040	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,952,177	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)**	$	$ 6,952,177	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,524,009	$ 15,324,217	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,450,392)	$ (3,614,956)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,073,617	$ 11,709,261	48

*(See instructions.)

Lexington Health Care Center of Wheeling
1/1/11-12/31/11
Provider # 0040923

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Due from remodeling	15,839	15,839
Due to/from rehab care therapy	42,161	42,161
Due to Republic Construction of Illinois, Inc	(27,671)	(27,671)
Due from Lexington Fin Serv LLC	2,198	2,198
Accrued Resident Tax	195,745	195,745
Accrued Expenses	48,710	48,710
Accrued Rent	5,974,889	
Accrued Insurance	120,065	120,065
Due to patient trust fund	(14,780)	(14,780)
Deferred Income	313,429	313,429
Due to Royal Operations	35,450	35,450
Due to Lake Zurich	685	685
Advance Bi-weekly Part A Payments	(35,821)	(35,821)
Uncollectible Part A Co. Pvts	(33,644)	(33,644)
Interest Rate Swap Liability		1,392,954
Prepaid Insurance	50,690	50,690
Escrow Insurance	79,037	79,037
Accrued Royal/Vesta Mgmt. Fees	135,606	135,606
	6,902,588	2,320,653

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,216,592)	1
2	Restatements (describe):		2
3	**Post closing adjustment**	(125,395)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,341,987)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,106,664)	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	(1,741)	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)**	$ (1,108,405)	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)**	$ (7,450,392)	24 *

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

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,069,526	1
2	Discounts and Allowances for all Levels	(6,951,198)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,118,328	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,216,273	6
7	Oxygen	5,137	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,221,410	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	7,087	12
13	Barber and Beauty Care	25,132	13
14	Non-Patient Meals	685	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,248	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	86,045	19
20	Radiology and X-Ray		20
21	Other Medical Services	120,478	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 474,675	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,042	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,042	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,815,455	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,824,442	31
32	Health Care	6,634,969	32
33	General Administration	3,553,386	33
	B. Capital Expense		
34	Ownership	2,050,451	34
	C. Ancillary Expense		
35	Special Cost Centers	545,412	35
36	Provider Participation Fee	313,458	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,922,119	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,106,664)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,106,664)	43

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

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

*** **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.**

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,314	1,672	$ 93,247	$ 55.77	1
2	Assistant Director of Nursing	24,881	29,898	799,569	26.74	2
3	Registered Nurses	31,354	37,731	1,166,681	30.92	3
4	Licensed Practical Nurses	24,180	28,643	721,573	25.19	4
5	CNAs & Orderlies	118,475	139,926	1,653,504	11.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,812	8,261	108,557	13.14	8
9	Activity Director					9
10	Activity Assistants	16,249	19,388	256,088	13.21	10
11	Social Service Workers	7,428	8,303	145,182	17.49	11
12	Dietician	256	281	4,694	16.70	12
13	Food Service Supervisor	1,646	1,936	36,808	19.01	13
14	Head Cook	1,794	1,993	30,745	15.43	14
15	Cook Helpers/Assistants	14,376	16,747	166,609	9.95	15
16	Dishwashers	15,452	17,735	150,532	8.49	16
17	Maintenance Workers	1,441	1,872	32,280	17.24	17
18	Housekeepers	32,331	38,256	362,626	9.48	18
19	Laundry	9,319	11,093	106,056	9.56	19
20	Administrator	1,488	2,266	111,940	49.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,495	15,028	213,861	14.23	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	1,695	2,041	33,501	16.41	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	2,508	2,951	92,261	31.26	33
34	TOTAL (lines 1 - 33)	322,494	386,021	$ 6,286,314 *	$ 16.28	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 20,933	1(3)	35
36	Medical Director	Monthly	39,500	9(3)	36
37	Medical Records Consultant	19	1,162	10(3)	37
38	Nurse Consultant	Monthly	41,311	10(3)	38
39	Pharmacist Consultant	Monthly	12,766	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	111	10,163	11(3)	44
45	Social Service Consultant	96	4,982	12(3)	45
46	Other(specify) Psychosocial	12	2,304	12(3)	46
47	Pulmonary	Monthly	39,285	10(3)	47
48	Medical Consultant	Monthly	4,002	10(7)	48
49	TOTAL (lines 35 - 48)	238	$ 176,408		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lynette Rugg	Administrator	0%	$ 83,570
Catherine Jenkins	Administrator	0%	28,370
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 111,940

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 1,061,819
Management Fees-Vest Mgmt.	407,794
Royal Capital MGMT Fees	66,244
Removed in column 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,535,857
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center, LLC	Collections	$ 2,259
Cassiday Schade	Legal	33,572
Lexington Financial Servs LLC	Financial	1,055
North Heron Insurance	Insurance	34,528
McGladrey & Pullen, LLP	Accounting	25,432
Personnel Planners	U/C Consulting	1,140
RSM McGladrey, INC.	Accounting	6,236
Much Shelist	Legal	6,158
Pension Administrators	Pension Administration	612
Real Med	Workers Compensation	113
Secretary of State	Filing Fees	100
See Schedule 21C		66,829
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 178,033

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,897
Unemployment Compensation Insurance	56,469
FICA Taxes	463,453
Employee Health Insurance	227,353
Employee Meals	17,468
Illinois Municipal Retirement Fund (IMRF)*	
401K	8,932
Uniform Allowance	2,331
Other Employee Benefits	32,510
Tuition Reimbursement	5,112
TOTAL (agree to Schedule V, line 22, col.8)	$ 947,525

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	56,002
Health Care Worker Background Check	
(Indicate # of checks performed 260)	3,120
Patient Background Checks 922.7	11,072
Miscellaneous Licenses & Fees	1,168
Miscellaneous Dues & Subscriptions	81
Alloc. From Mgmt Co.	7,801
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 83,224

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Alloc. From Mgmt Co.	2,952
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,952

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Wheeling
1/1/11-12/31/11
Section XIX.

C. Professional Fees Schedule 21C

Vendor/Payee	Type	Amount
Serpico, Petrosino & Dipiero, LTD	Legal	2,750
Ability Network	Computer Consulting	767.92
BSKLIVE INC. (Staffknex)	Computer Consulting	1,151.06
Efax Corporate	Computer Consulting	2,137.27
E-Health Data Solutions	Computer Consulting	2,400.00
Elton Designs Inc	Computer Consulting	2,175.05
Information Control	Computer Consulting	1,336.09
Lintech L LC	Computer Consulting	5,049.89
Micro Center A/R	Computer Consulting	53.52
My Innerview	Computer Consulting	6,141.23
National Datacare	Computer Consulting	3,105.00
On Shift	Computer Consulting	3,967.60
Paragon	Computer Consulting	1,100.00
Question Pro	Computer Consulting	66.70
SilverChair Learning Systems	Computer Consulting	8,610.00
Softchoice	Computer Consulting	1,193.44
Telemedicine Solutions	Computer Consulting	7,200.00
Vision Share, Inc.	Computer Consulting	84.56
XO Communications	Computer Consulting	1,046.23
Microsoft License	Computer Consulting	3,831
Right now technologies	Computer Consulting	8,927
Ace Action Computer Enterprises	Computer Consulting	523
Brook Electric	Computer Consulting	156
Kronos	Computer Consulting	1,400
Tympani	Computer Consulting	115
Avtech	Computer Consulting	883
Facility Wizard Software	Computer Consulting	358
Survey Analytics LLC	Computer Consulting	300
		66,829

Schedule V, line 19, column 3	178,033
Less collections	(2,259)
Less out of period	(7)
Sambell of Wheeling	
Secretary of State	200

Samvest of Lombard

Legal	244
Accounting	264
	508

Allocated from Mgmt. Co.

Katten, Muchin, Rosenman	Legal	455
Much Shelist	Legal	411
Laner Muchin	Legal	17
Seyfarth Shaw LLP	Legal	311
McGladrey & Pullen LLP	Accounting	1,549
Illinois Secretary of State	Filing Fees	43
LaSalle Network	Recruiting/Finance	1,904
Gilson Labus & Silverman	KEP	211
Pension Administrators, Inc.	401K Administration	293
Susan Parker	Social Service Consulting	32
M Werner Consulting	Financial Consultant	4
Christine Toolan	Social Service Consulting	7
Gene Whitehorn	Medicaid Reimb Specialist	1,133
Computer Services	Computer Consulting	18,248
		24,618

Schedule V, line 18, column 8	201,093

Facility Name & ID Number Lexington Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Amount of Expense Amortized Per Year								
					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 Health Care Center of Wheeling, Inc. # 0040923 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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? **N/A**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **65,479** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **313,458**
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. $ **17,468** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **685**

(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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.