

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: 0037002

Facility Name: Lexington of Streamwood

Address: 815 East Irving Park Road Streamwood 60107
Number City Zip Code

County: Cook

Telephone Number: (630) 837-5300 Fax # (630) 213-9076

HFS ID Number:

Date of Initial License for Current Owners: 7/8/91

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
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 01/01/2012 to 12/31/2012 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) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey 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 of Streamwood# 0037002 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 bedsN/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>214</u>	Skilled (SNF)	<u>214</u>	<u>78,324</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>214</u>	TOTALS	<u>214</u>	<u>78,324</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>12,771</u>	<u>12,771</u>	8
9	SNF/PED					9
10	ICF	<u>45,625</u>	<u>6,769</u>		<u>52,394</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>45,625</u>	<u>6,769</u>	<u>12,771</u>	<u>65,165</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.20%

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?

YesG. 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 7/8/91

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

YES ☐Date New ConstructionNO ☒

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

YES ☒NO ☐If YES, enter number
of beds certified 214 and days of care provided 11,213Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	381,191	44,634	10,624	436,449		436,449		436,449		1
2	Food Purchase		402,181		402,181		402,181	(20,536)	381,645		2
3	Housekeeping	318,438	38,817		357,255		357,255	400	357,655		3
4	Laundry	81,689	23,238		104,927		104,927		104,927		4
5	Heat and Other Utilities			221,589	221,589		221,589	7,894	229,483		5
6	Maintenance	34,296		154,226	188,522		188,522	91,729	280,251		6
7	Other (specify):* Alloc. From Mgmt Cd							11,976	11,976		7
8	TOTAL General Services	815,614	508,870	386,439	1,710,923		1,710,923	91,463	1,802,386		8
	B. Health Care and Programs										
9	Medical Director			63,525	63,525		63,525		63,525		9
10	Nursing and Medical Records	4,544,832	333,943	224,728	5,103,503		5,103,503	42,876	5,146,379		10
10a	Therapy										10a
11	Activities	251,350	27,697	6,711	285,758		285,758		285,758		11
12	Social Services	135,637		5,007	140,644		140,644		140,644		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. From Mgmt Cd							6,145	6,145		15
16	TOTAL Health Care and Programs	4,931,819	361,640	299,971	5,593,430		5,593,430	49,021	5,642,451		16
	C. General Administration										
17	Administrative	114,766		1,519,681	1,634,447		1,634,447	(1,479,578)	154,869		17
18	Directors Fees										18
19	Professional Services			308,825	308,825		308,825	17,140	325,965		19
20	Dues, Fees, Subscriptions & Promotions			169,787	169,787		169,787	15,725	185,512		20
21	Clerical & General Office Expenses	181,002	33,615	47,805	262,422		262,422	658,814	921,236		21
22	Employee Benefits & Payroll Taxes			971,829	971,829		971,829	18,611	990,440		22
23	Inservice Training & Education			10,702	10,702		10,702	1,057	11,759		23
24	Travel and Seminar							3,137	3,137		24
25	Other Admin. Staff Transportation			5,515	5,515		5,515	19,987	25,502		25
26	Insurance-Prop.Liab.Malpractice			387,072	387,072		387,072	4,334	391,406		26
27	Other (specify):* Alloc. From Mgmt Cd							105,968	105,968		27
28	TOTAL General Administration	295,768	33,615	3,421,216	3,750,599		3,750,599	(634,805)	3,115,794		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,043,201	904,125	4,107,626	11,054,952		11,054,952	(494,321)	10,560,631		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			196,462	196,462		196,462	401,782	598,244			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,392	127,392		127,392	297,177	424,569			32
33	Real Estate Taxes							490,454	490,454			33
34	Rent-Facility & Grounds			1,875,771	1,875,771		1,875,771	(1,871,441)	4,330			34
35	Rent-Equipment & Vehicles			86,920	86,920		86,920	3,737	90,657			35
36	Other (specify):*											36
37	TOTAL Ownership			2,286,545	2,286,545		2,286,545	(678,291)	1,608,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		654,282	1,617,325	2,271,607		2,271,607		2,271,607			39
40	Barber and Beauty Shops			17,943	17,943		17,943		17,943			40
41	Coffee and Gift Shops			10,438	10,438		10,438		10,438			41
42	Provider Participation Fee			444,902	444,902		444,902		444,902			42
43	Other (specify):* Non-Allowable Co	128,692		244,904	373,596		373,596	(373,596)				43
44	TOTAL Special Cost Centers	128,692	654,282	2,335,512	3,118,486		3,118,486	(373,596)	2,744,890			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,171,893	1,558,407	8,729,683	16,459,983		16,459,983	(1,546,208)	14,913,775			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 of Streamwood # 0037002 Report Period Beginning: 01/01/2012 Ending: 12/31/2012
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	(1,925)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,548)	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	(331)	30		9
10	Interest and Other Investment Income	(94,074)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,182)	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)	43		18
19	Entertainment				19
20	Contributions	(6,099)	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	(97,884)	43		24
25	Fund Raising, Advertising and Promotional	(56,448)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(656)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(173,988)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (449,136)		\$	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)	(1,097,072)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,097,072)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,546,208)		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

Lexington of Streamwood

ID# 0037002

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (4,105)	43	1
2	Labs-Part A	(19,601)	43	2
3	X-Rays-Part A	(37,419)	43	3
4	Trust fees	(100)	43	4
5	Unrealized loss on FMV swap	23,666	43	5
6	Reclass to Repairs & Maintenance	7,549	6	6
7	Collections	(2,400)	19	7
8	Out of period legal	(6,552)	19	8
9	Marketing Salary	(128,692)	43	9
10	Dues & Subscriptions Marketing	(1,023)	20	10
11	Chamber of commerce dues	(350)	20	11
12	Development Expense	(4,961)	43	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(173,988)		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.

[illegible]

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	\$	Sambell of Streamwood Limited Partnership	**	\$ 200	\$ 200	1
2	V	30	Depreciation		Sambell of Streamwood Limited Partnership	**	344,048	344,048	2
3	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	369,595	369,595	3
4	V	32	Amortization of mortgage costs		Sambell of Streamwood Limited Partnership	**	2,293	2,293	4
5	V	33	Property taxes		Sambell of Streamwood Limited Partnership	**	483,773	483,773	5
6	V	34	Rental expense	1,875,771	Sambell of Streamwood Limited Partnership	**		(1,875,771)	6
7	V	43	Trust fees		Sambell of Streamwood Limited Partnership	**	100	100	7
8	V	43	Unrealized loss on interest rate swap	23,666	Sambell of Streamwood Limited Partnership	**		(23,666)	8
9	V								9
10	V								10
11	V				Lexington Health Care Center of Streamwood,Inc.				11
12	V				own 100% of Sambell of Streamwood Limited Partnership.				12
13	V								13
14	Total			\$ 1,899,437			\$ 1,200,009	\$ * (699,428)	14

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

Facility Name & ID Number Lexington of Streamwood# 0037002Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.	**	\$ 400	\$ 400 15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	6,688	6,688 16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	296	296 17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	910	910 18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	75,372	75,372 19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	8,415	8,415 20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	393	393 21
22	V	6 Security service		Royal Management Corp.	**		
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	11,976	11,976 23
24	V	10 Medical consultant		Royal Management Corp.	**	4,202	4,202 24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	38,674	38,674 25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	6,145	6,145 26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	40,103	40,103 27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	18,895	18,895 28
29	V	19 Professional fees		Royal Management Corp.	**	6,997	6,997 29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	1,283	1,283 30
31	V	23 Inservice Training		Royal Management Corp.	**	1,057	1,057 31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	15,815	15,815 32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	626,787	626,787 33
34	V	21 Bank charges		Royal Management Corp.	**	3,470	3,470 34
35	V	21 Office supplies & printing		Royal Management Corp.	**	11,040	11,040 35
36	V	21 Postage		Royal Management Corp.	**	4,472	4,472 36
37	V						
38	V	** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% or Royal Management Corp.					
39	Total		\$			\$ 883,390	\$ * 883,390 39

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

Facility Name & ID Number	Lexington of Streamwood	#	0037002	Report Period Beginning:	01/01/2012	Ending:	12/31/2012
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VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Telephone	\$	Royal Management Corp.	**	\$ 13,045	\$ 13,045	15
16	V	24	Travel & seminar		Royal Management Corp.	**	3,137	3,137	16
17	V	25	Auto expense		Royal Management Corp.	**	19,987	19,987	17
18	V	26	Insurance general		Royal Management Corp.	**	4,334	4,334	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	105,968	105,968	19
20	V	30	Depreciation		Royal Management Corp.	**	58,065	58,065	20
21	V	32	Interest		Royal Management Corp.	**	17,711	17,711	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	1,652	1,652	22
23	V	33	Property taxes		Royal Management Corp.	**	6,681	6,681	23
24	V	34	Rent expense		Royal Management Corp.	**	4,330	4,330	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,766	1,766	25
26	V	17	Management fees	1,519,681	Royal Management Corp.	**		(1,519,681)	26
27	V	35	Auto Lease Expense		Royal Management Corp.	**	1,971	1,971	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 Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total			\$ 1,519,681			\$ 238,647	\$ * (1,281,034)	39

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

Facility Name & ID Number

Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	22.33%	Lexington HC Ctr. of Lombard, Inc.	Lombard	Sambell of	Streamwood	Real Estate	1
2	John Samatas Discretionary Trust	22.33%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Streamwood		Property	2
3	Cynthia Thiem Discretionary Trust	22.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Limited Partnership			3
4	Jeffrey J. Bell Revocable Trust	8.25%	Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Eastgate Manor	Algonquin	Supportive	4
5	Lawrence W. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	of Algonquin, LLC		Living Facility	5
6	David S. Bell Revocable Trust	8.25%	Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Vesta Management	Lombard	Mgmt. Company	6
7	David S. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	Group, LLC			7
8	Jeffrey J. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Royal Management	Lombard	Mgmt. Company	8
9	Lawrence W. Bell 2001 Trust	2.75%	Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Corporation			9
10					Lexington Financial	Lombard	Finance Company	10
11					Services, LLC			11
12					Lexington Square	Lombard	Independent	12
13					Life Care of		and Assisted	13
14					Lombard, LLC		Living	14
15					Lexington Square	Elmhurst	Independent	15
16					Life Care of		Living Facility	16
17					Elmhurst, LLC			17
18					Samvest of Lombard	Lombard	Lessor	18
19					II, LLC			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 of Streamwood # 0037002 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	23.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 11,170	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,180	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,902	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,425	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,426	L17, C7	5
6		Member									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	\$ 40,103		13

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

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

Facility Name & ID Number Lexington of Streamwood# 0037002

Report Period Beginning:

01/01/2012Ending: 2/31/2012

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 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	725,412	10	\$ 3,707	\$	78,324	\$ 400	1
2	5	Utilities - gas & electric	Bed Days	725,412	10	61,939		78,324	6,688	2
3	5	Utilities - water & sewer	Bed Days	725,412	10	2,741		78,324	296	3
4	5	Utilities - maintenance office	Bed Days	725,412	10	8,424		78,324	910	4
5	6	Management allocation - salaries	Bed Days	725,412	10	698,068	698,068	78,324	75,372	5
6	6	Repairs & maintenance	Bed Days	725,412	10	77,933		78,324	8,415	6
7	6	Scavenger & exterminating	Bed Days	725,412	10	3,642		78,324	393	7
8	6	Security service	Bed Days	725,412	10			78,324	0	8
9	7	Management allocation - employee	Bed Days	725,412	10	110,922		78,324	11,976	9
10	10	Medical consultant	Bed Days	725,412	10	38,914		78,324	4,202	10
11	10	Management allocation - salaries	Bed Days	725,412	10	358,188	358,188	78,324	38,674	11
12	15	Management allocation - employee	Bed Days	725,412	10	56,916		78,324	6,145	12
13	17	Management allocation - salaries	Bed Days	725,412	10	371,421	371,421	78,324	40,103	13
14	19	Computer consultant & supplies	Bed Days	725,412	10	174,999		78,324	18,895	14
15	19	Professional fees	Bed Days	725,412	10	64,806		78,324	6,997	15
16	20	Dues & subscriptions	Bed Days	725,412	10	11,884		78,324	1,283	16
17	23	Inservice Training	Bed Days	725,412	10	9,785		78,324	1,057	17
18	20	Advertising - help wanted	Bed Days	725,412	10	146,469		78,324	15,815	18
19	21	Management allocation - salaries	Bed Days	725,412	10	5,805,098	5,805,098	78,324	626,787	19
20	21	Bank charges	Bed Days	725,412	10	32,134		78,324	3,470	20
21	21	Office supplies & printing	Bed Days	725,412	10	102,249		78,324	11,040	21
22	21	Postage	Bed Days	725,412	10	41,415		78,324	4,472	22
23	21	Telephone	Bed Days	725,412	10	120,819		78,324	13,045	23
24	24	Travel and Seminar	Bed Days	725,412	10	29,058		78,324	3,137	24
25	TOTALS					\$ 8,331,531	\$ 7,232,775		\$ 899,572	25

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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	25	Auto expense	Bed Days	725,412	10	\$ 185,111	\$	78,324	\$ 19,987	1
2	26	Insurance general	Bed Days	725,412	10	40,142		78,324	4,334	2
3	27	Management allocation - employee	Bed Days	725,412	10	981,440		78,324	105,968	3
4	30	Depreciation - leasehold improv.	Bed Days	725,412	10	537,783		78,324	58,065	4
5	32	Interest	Bed Days	725,412	10	164,037		78,324	17,711	5
6	32	Amortization of mortgage costs	Bed Days	725,412	10	15,301		78,324	1,652	6
7	33	Property taxes	Bed Days	725,412	10	61,875		78,324	6,681	7
8	34	Rent expense	Bed Days	725,412	10	40,101		78,324	4,330	8
9	35	Equipment rental	Bed Days	725,412	10	16,356		78,324	1,766	9
10	35	Auto lease	Bed Days	725,412	10	18,252		78,324	1,971	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					\$ 2,060,398	\$		\$ 222,465	25

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				
	A. Directly Facility Related Long-Term											
1	Lexington Financial						\$				\$	1
2	Services, L.L.C		X	Mortgage	Varies	5/22/08	6,734,000	6,078,951	1/1/33	Variable	369,595	2
3												3
4												4
5							Interest on financing insurance premium				1,388	5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	1,154,048	8,466,042	Demand	Prime +1	92,965	6
7	Bank of America		X	Working Capital	None	9/30/12	13,700,000	1,270,000	9/30/13	Prime/Libor	33,039	7
8												8
9	TOTAL Facility Related						\$ 21,588,048	\$ 15,814,993			\$ 496,987	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			2,293	10
11								Interest income offset			(1,109)	11
12								Allocated from management company			19,363	12
13								Less: Shareholder interest			(92,965)	13
14	TOTAL Non-Facility Related						\$	\$			\$ (72,418)	14
15	TOTALS (line 9+line14)						\$ 21,588,048	\$ 15,814,993			\$ 424,569	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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	507,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011		\$	478,154	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(29,446)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	493,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		Allocated from Mgmt. Co.			6,681	
				\$	29,341	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 \$ 1,045 For 2002 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(9,322)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	490,454	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007	492,792	8
2008	500,084	9
2009	368,079	10
2010	492,260	11
2011	478,154	12

See attached real estate accrual sheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Lexington of Streamwood

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0037002

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 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 06-25-300-006-0000	Land & Building	\$ 478,154.22	\$ 478,154.22
2. Royal Management Corp(Samvest of Lombard II)		\$ 230,165.98	\$ 6,681.00
3. 05-01-202-019	Land & Building	\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 708,320.20	\$ 484,835.22

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942

B. General Construction Type: Exterior Concrete Block

Frame Steel

Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1991	\$ 211,400	1
2	Management Company Allocation		2002	22,023	2
3	TOTALS	30,000		\$ 233,423	3

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

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	214		1991	1991	\$ 5,248,322	\$	35	\$ 149,952	\$ 149,952	\$ 3,223,969	4
5			1993	1993	105,236		35	3,007	3,007	58,632	5
6			1995	1995	82,650	2,361	35	2,361		41,323	6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	7,336		35	210	210	4,089	9
10	Land Improvements			1995	7,000		15			7,000	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		5,807	11
12	Piping			1996	3,139	90	35	90		1,481	12
13	Basement remodeling			1997	20,204		10			20,204	13
14	Floor repairs			1997	555		10			555	14
15	Corner Guards			1997	998		10			998	15
16	Corner Guards			1998	3,563		10			3,563	16
17	Wiring			1998	2,050		10			2,050	17
18	Tile			1998	11,697		10			11,697	18
19	Patio			1999	12,012	801	15	801		10,478	19
20	Parking lot			2000	1,773		10			1,773	20
21	110-ton A/C unit			2000	6,923		10			6,922	21
22	Rods for bedside curtains			2000	5,872		10			5,872	22
23	Automatic doors			2000	1,300		10			1,300	23
24	Rehab project: carpeting, wallcovering, handrails, painting			2000	85,195		10			85,194	24
25	Compressor/tube bundles-cooling system			2001	12,921		10			12,921	25
26	Rehab project: resident rooms, corridors, dining room			2001	212,217	10,611	20	10,611		122,026	26
27	Parking lot			2002	29,288	1,464	10	1,464		29,288	27
28	Office area rehab			2002	26,991	1,350	20	1,350		14,173	28
29	Elevator interior upgrade			2002	1,120	46	10	46		1,120	29
30	Gazebo			2002	3,393	171	10	171		3,393	30
31	Elevator electronic curtains			2002	4,500	37	10	37		4,500	31
32	Door frame protector			2003	5,276	528	10	528		5,234	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring			2003	9,392	939	10	939		8,843	33
34	Roof			2003	29,950	1,498	20	1,498		13,605	34
35	Kitchen Sewer/Dishroom			2004	6,224	622	10	622		5,185	35
36	Compressor/tube bundles-cooling system			2004	14,737	737	20	737		6,141	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	Kitchen fire protection upgrade	2004	\$ 1,427	\$ 143	10	\$ 143	\$	\$ 1,250	37
38	Landscaping	2005	8,495	425	20	425		3,081	38
39	Kitchen renovation	2005	12,034	602	20	602		4,213	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		13,104	40
41	Therapy room renovation	2005	11,628	581	20	581		4,262	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		17,912	42
43	Dialysis units	2005	66,426	3,535	20	3,535		26,513	43
44	Create transitional unit	2005	14,490	725	20	725		5,074	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		2,367	45
46	Basement renovation	2005	46,561	2,328	20	2,328		16,684	46
47	Landscaping enhancement	2006	3,414	228	15	228		1,481	47
48	HVAC	2006	17,125	856	20	856		5,208	48
49	Door closer	2006	4,446	222	20	222		1,499	49
50	Blinds	2006	1,566		5			1,566	50
51	Employee lunch room rehab	2006	2,883	144	20	144		960	51
52	Storeroom door lock	2006	2,843	142	20	142		923	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		20,684	53
54	Fine dining	2006	7,650	382	20	382		2,516	54
55	Automatic door	2006	2,259	113	20	113		706	55
56	Landscaping	2007	10,606	530	20	530		2,694	56
57	Parking lot	2007	2,777	139	20	139		730	57
58	HVAC	2007	1,501	75	20	75		431	58
59	Painting Building	2007	16,150	808	20	808		4,376	59
60	Landscaping	2008	33,747	2,250	15	2,250		9,187	60
61	Common areas-metal doors	2008	7,055	353	20	353		1,677	61
62	Wanderguard	2008	3,882	194	20	194		970	62
63	Lawn Irrigation	2009	18,125	1,208	15	1,208		3,926	63
64	Landscaping	2009	3,138	209	15	209		766	64
65	Quick connectors	2009	9,375	469	20	469		1,720	65
66	1st floor admin office-heating,plumbing	2009	13,598	767	20	767		2,344	66
67	Fire alarm system	2009	5,271	264	20	264		792	67
68	Metal Doors-painting	2009	4,650	232	20	232		851	68
69	2nd Floor Remodel-carpentry	2009	33,503	838	40	838		3,142	69
70	TOTAL (lines 4 thru 69)		\$ 6,491,737	\$ 47,918		\$ 201,087	\$ 153,169	\$ 3,882,945	70

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,491,737	\$ 47,918		\$ 201,087	\$ 153,169	\$ 3,882,945	1
2	Patio Pergola	2009	7,930	793	10	793		2,643	2
3	Landscaping	2010	5,785	386	15	386		965	3
4	HVAC Quick connectors, admin office	2010	15,373	561	27	561		1,187	4
5	Lockers and Pantry-plumbing, tile	2010	14,809	540	27	540		1,187	5
6	Director of Nursing office painting	2010	7,887	288	27	288		576	6
7	Ramp repair	2010	3,240	216	15	216		468	7
8	Library/Lounge update-art,flooring	2010	8,356	305	27	305		661	8
9	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	48,949	3,009	27	3,009		6,018	9
10	Office carpentry,flooring,electrical,painting,signs,HVAC	2011	4,714	171	27	171		271	10
11	Office-Doors, ADON, Locks	2011	26,169	952	27	952		1,111	11
12	HVAC Chiller	2011	95,360	3,468	27	3,468		4,913	12
13	Laundry Room-Painting, Tile	2011	7,686	279	27	279		395	13
14	2nd floor doors	2011	26,317	957	27	957		1,276	14
15									15
16	Install cast iron pipe sprinkler	2012	4,550	138	27	138		138	16
17	Shower room-tile-painting,plumbing	2012	87,763	266	27	266		266	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	Reconcile to book depreciation			332			(332)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,856,625	\$ 60,579		\$ 213,416	\$ 152,837	\$ 3,905,020	34

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

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,856,625	\$ 60,579		\$ 213,416	\$ 152,837	\$ 3,905,020	1
2	Real Estate Entity								2
3	1st floor remodel-Carpentry,flooring,electrical,painting	2008	531,230		27	19,317	19,317	96,586	3
4	2nd Floor Remodel-Carpentry,Flooring,Electrical,painting	2008	487,332		27	17,721	17,721	70,885	4
5	Remodel special care units-carpentry,electrical,painting	2008	32,914		27	1,197	1,197	4,788	5
6	3rd floor remodel-carpentry,flooring,electrical,painting	2009	667,142		27	24,260	24,260	88,953	6
7	Parking lot seal and stripe	2011	3,600		27	131	131	164	7
8	Remodel LL Flooring-Carpentry,flooring, electrical	2011	27,575		27	1,003	1,003	1,087	8
9	Kitchen holding tank	2011	11,665		27	424	424	777	9
10	Drain tile and pits	2011	8,000		27	291	291	388	10
11									11
12									12
13									13
14									14
15	Mgmt Co.								15
16									16
17	Building-management company	2002	304,761		40	8,831	8,831	98,963	17
18	HVAC, electrical, security system-management company	2003	2,677		30	650	650	1,744	18
19	Key card system-management company	2004	421		20	20	20	177	19
20	VAC TX controls-management company	2005	128		20	6	6	50	20
21	Build Imp-management company	2006	93		5	6	6	38	21
22	Building Improvement Management Co.	2008	14,769		5	754	754	3,995	22
23	Building Improvement Management Co.	2009	2,757		15	50	50	515	23
24	Building Improvement Management Co.	2010	2,687		15	108	108	453	24
25	Building Improvement Management Co.	2011	1,896		15	86	86	131	25
26	Building Improvement Management Co.	2012	6,551		15	3	3	151	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,962,823	\$ 60,579		\$ 288,274	\$ 227,695	\$ 4,274,865	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,503,539	\$ 126,275	\$ 252,811	\$ 126,536	5	\$ 966,595	71
72	Current Year Purchases	74,755	9,608	9,608		5	9,608	72
73	Fully Depreciated Assets	156,167					156,167	73
74	Allocated from Mgmt. Co.	536,042		42,739	42,739	5	309,474	74
75	TOTALS	\$ 2,270,503	\$ 135,883	\$ 305,158	\$ 169,275		\$ 1,441,844	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.			52,317		4,812	4,812	5	41,650	79
80	TOTALS			\$ 52,317	\$	\$ 4,812	\$ 4,812		\$ 41,650	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)	\$ 11,519,066	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 196,462	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 598,244	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 401,782	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,758,359	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	Allocated from Management Company				4,330			6
7	TOTAL				\$ 4,330			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: *

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: \$ 88,686Description: Copier-\$10,441;Postage-\$90;Printer-\$1,090;Med Equip-\$33,312;Oxy-\$41,556;Dietary-\$432;Mgmt Co.-\$1,766
(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	Allocated from Management Company			1,971	20
21	TOTAL		\$	\$ 1,971	21

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	39(3)	hrs	\$	6,273	\$ 582,906	\$	6,273	\$ 582,906	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,772	307,031		4,772	307,031	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		11,868	729,193		11,868	729,193	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				654,282		654,282	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Ambulance Refund	39(3)				(1,806)			(1,806)	13
14	TOTAL			\$	22,913	\$ 1,617,325	\$ 654,282	22,913	\$ 2,271,607	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
This report must be completed even if financial statements are attached.				
		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 424,598	\$ 466,058	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (467,234))	2,893,831	2,893,831	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,610	1,610	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,862,588	1,862,588	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,182,627	\$ 5,224,087	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,884	67,884	12
13	Land		233,423	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,494,714	3,609,265	15
16	Equipment, at Historical Cost	931,475	2,322,820	16
17	Accumulated Depreciation (book methods)	(1,118,371)	(5,758,359)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage cost</u>		46,753	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,375,702	\$ 5,875,344	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,558,329	\$ 11,099,431	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 706,353	\$ 706,353	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	9,736,042	9,736,042	29
30	Accrued Salaries Payable	384,397	384,397	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,300	6,300	31
32	Accrued Real Estate Taxes(Sch.IX-B)		493,200	32
33	Accrued Interest Payable		25,917	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	12,907,781	5,297,053	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 23,740,873	\$ 16,649,262	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,078,951	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)	\$	\$ 6,078,951	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 23,740,873	\$ 22,728,213	46
47	TOTAL EQUITY(page 18, line 24)	\$ (17,182,544)	\$ (11,628,782)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,558,329	\$ 11,099,431	48

*(See instructions.)

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/12-12/31/12

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other current liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
401K Withholdings	2,456	2,456
Due to merit hospice	65,000	65,000
Sambel Due from LLC 1		1,568
Interest rate swap		1,307,934
Escrow insurance	618,050	618,050
Accrued Expenses	65,680	65,680
Accrued Resident tax	104,732	104,732
Accrued Royl/Vesta MGMT	503,494	503,494
Due to patient trust fund	30,616	30,616
Accrued Rent	8,920,230	
Accrued Insurance	118,067	118,067
Deferred Income	413,907	413,907
Professional liabilities claims	2,105,542	2,105,542
Due to-Royal Operations	39,720	39,720
Due to Republic Construction of Illinois, Inc	(9,235)	(9,235)
Advance biweekly Part A payments	(47,448)	(47,448)
Uncollectible Part A Co. Pvts	(63,687)	(63,687)
Prepaid Insurance	40,657	40,657
	<u>12,907,781</u>	<u>5,297,053</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (14,924,845)	1
2	Restatements (describe):		2
3	Post closing adjustment	(235,554)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (15,160,399)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,022,145)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,022,145)	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)	\$ (17,182,544)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Streamwood# 0037002Report Period Beginning: 01/01/2012Ending: 12/31/2012**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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,572,827	1
2	Discounts and Allowances for all Levels	(9,248,189)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,324,638	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,908,646	6
7	Oxygen	49,013	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,957,659	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	11,824	12
13	Barber and Beauty Care	22,580	13
14	Non-Patient Meals	1,925	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	577,439	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	261,416	19
20	Radiology and X-Ray		20
21	Other Medical Services	279,248	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,154,432	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,109	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,109	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)	\$ 14,437,838	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,710,923	31
32	Health Care	5,593,430	32
33	General Administration	3,750,599	33
	B. Capital Expense		
34	Ownership	2,286,545	34
	C. Ancillary Expense		
35	Special Cost Centers	2,673,584	35
36	Provider Participation Fee	444,902	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,459,983	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,022,145)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,022,145)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,183,369	44
45	Private Pay - Net Inpatient Revenue	1,127,934	45
46	Medicare - Net Inpatient Revenue	1,351,731	46
47	Other-(specify) <u>Managed Care</u>	661,604	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,324,638	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? No^ If not, please attach a reconciliation.

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

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

^ - Entity is a cash basis tax payer.

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	1,859	2,297	\$ 113,653	\$ 49.48	1
2	Assistant Director of Nursing	26,890	33,217	931,272	28.04	2
3	Registered Nurses	16,454	20,896	650,792	31.14	3
4	Licensed Practical Nurses	41,541	50,781	1,312,666	25.85	4
5	CNAs & Orderlies	108,810	129,824	1,498,195	11.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,546	15,536	172,853	11.13	10
11	Social Service Workers	6,052	7,228	135,637	18.77	11
12	Dietician	1,556	1,817	32,238	17.74	12
13	Food Service Supervisor	1,507	1,690	37,821	22.38	13
14	Head Cook	1,557	1,785	31,763	17.79	14
15	Cook Helpers/Assistants	11,475	13,494	134,421	9.96	15
16	Dishwashers	14,843	16,939	144,948	8.56	16
17	Maintenance Workers	2,054	2,233	34,296	15.36	17
18	Housekeepers	27,835	33,541	318,438	9.49	18
19	Laundry	7,720	9,089	81,689	8.99	19
20	Administrator	1,670	2,222	114,766	51.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,412	11,099	181,002	16.31	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	1,861	2,345	38,254	16.31	31
32	Other Health Care Memory Care	3,714	4,411	78,497	17.80	32
33	Other(specify) Marketing	4,184	4,649	128,692	27.68	33
34	TOTAL (lines 1 - 33)	303,540	365,093	\$ 6,171,893 *	\$ 16.90	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	123	\$ 7,925	1(3)	35
36	Medical Director	Monthly	63,525	9(3)	36
37	Medical Records Consultant	18	963	10(3)	37
38	Nurse Consultant	Monthly	129,824	10(3)	38
39	Pharmacist Consultant	Monthly	13,410	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	105	5,546	11(3)	44
45	Social Service Consultant	96	4,869	12(3)	45
46	Other(specify) CARF	Monthly	20,094	10(3)	46
47	Pulmonary	Monthly	60,437	10(3)	47
48	Medical Consultant	Monthly	4,202	10(7)	48
49	TOTAL (lines 35 - 48)	342	\$ 310,795		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

STATE OF ILLINOIS

0037002

Report Period Beginning:

01/01/2012

Page 21

Ending: 12/31/2012

Facility Name & ID Number

Lexington of Streamwood

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	
Kalsang Youtso	Administrator	0	\$ 113,512	Workers' Compensation Insurance	\$ 127,112	IDPH License Fee	\$	
Gina McCarthy	Administrator	0	1,254	Unemployment Compensation Insurance	102,056	Advertising: Employee Recruitment	26,969	
				FICA Taxes	453,726	Health Care Worker Background Check		
				Employee Health Insurance	218,497	(Indicate # of checks performed 172)	2,066	
				Employee Meals	18,611	Patient Background Checks	336 4,029	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	4,951	
				401K	28,433	Miscellaneous Dues & Subscriptions	3,337	
				Other Employee Benefits	34,563	Employment Fees	128,435	
				Tuition Reimbursement	5,780	Less: Chamber of Commerce Dues & Mkt	(1,373)	
				Uniform Allowance	1,662	Management Company Allocation	17,098	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)						TOTAL (agree to Sch. V,		
(List each licensed administrator separately.) \$ 114,766						line 20, col. 8) \$ 185,512		
B. Administrative - Other								
Description			Amount					
Management Fees-Royal Operating			\$ 1,089,720					
Management Fees-Vesta Mgmt.			429,961					
Management Fees (Eliminated in Column 7)								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,519,681	TOTAL (agree to Schedule V,				
(Attach a copy of any management service agreement)				line 22, col.8)				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Grabowski Law Center, LLC	Collections	\$ 2,400				Out-of-State Travel	\$	
Cassiday Schade LLP	Legal	84,667	N/A					
Illinois Secretary of State	Filing Fees	40						
Amalgamated Bank of Chicago	Financial	483				In-State Travel		
McGladrey LLP	Accounting	36,668						
Much Shelist	Legal	6,466						
North Heron Insurance	Insurance Company	8,157						
Personnel Planners	U/C Consulting	1,440				Seminar Expense		
Standard and Poor	Financial	563						
McCracken and Frank	Legal	351						
Petrosino Serpico	Legal	3,570				Management Company Allocation	3,137	
See Schedule 21C		164,020				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)			TOTAL		\$	(agree to Sch. V,		
(If total legal fees exceed \$5,000, attach copy of invoices.) \$ 308,825						line 24, col. 8)	\$ 3,137	

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/12-12/31/12
Professional Fees

Schedule 21C

XIX. Support Schedules

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Pension Administrators	Pension Administration	883
Duane Morris	Legal	7,648
ABILITY NETWORK INC	Computer Services	1,448
American Finan / Vocollect	Computer Services	1,168
Americorp Financial	Computer Services	76,652
BOA	Computer Services	122
EFAX Corporate	Computer Services	931
E-Health Data Solutions	Computer Services	2,400
Elton Designs, Inc.	Computer Services	260
Facility Wizard	Computer Services	358
Health MedX LLC	Computer Services	14,584
ICI Time	Computer Services	160
Information Control	Computer Services	1,147
Kronos	Computer Services	1,392
Lanac / Tech Support	Computer Services	318
Lintech LLC	Computer Services	4,391
MS Licensing, GP	Computer Services	5,939
My Innerview	Computer Services	6,335
National Datacare	Computer Services	2,599
OnShift	Computer Services	8,017
Oracle	Computer Services	8,927
Paragon Clinical	Computer Services	1,100
Real Med	Computer Services	155
Relias Learning	Computer Services	3,864
Silver Chair Learning Systems	Computer Services	3,864
Softchoice Email Security Subscripti	Computer Services	533

Telemedicine Solutions	Computer Services	7,200
TOPNOTCH	Computer Services	109
TRISYS INC	Computer Services	140
TYMPANI	Computer Services	1,237
VIRTUAL RABBIT	Computer Services	10
VOCOLLECT HEALTH	Computer Services	11
XO Communications	Computer Services	118
		<u>164,020</u>
Schedule V, line 19, column 3		<u>308,825</u>
Collection fees		(2,400)
Out of period legal		(6,552)
Sambell of Streamwood		
Secretary of State		<u>200</u>
Samvest of Lombard		
Accounting		<u>277</u>

Lexington Health Care Center of Streamwood, Inc.

Provider # 0037002

1/1/12-12/31/12

Professional Fees

Allocated from Mgmt Co.		
Much Shelist	Legal	600
Duane Morris	Legal	40
Cassiday Schade	Legal	2
McGladrey LLP	Accounting	1,431
Illinois Secretary of State	Filing Fees	34
Gilson Labus & Silverman	KEP	401
Tam Kaiden	Investigative Services	51
Bank of America Leasing	UCC Search & Filing	21
Versight Inc.	Annual Report-Health Ins	118
Personnel Planners	U/C Consultant	21
LaSalle Network	Recruiting/Finance	1,516
Pension Administrators, Inc.	401K Administration	292
Gene Whitehorn	Medicaid Reimb Specialist	1,159
Christine Toolan	Social Service Consulting	19
M Werner Consulting	Financial Consultant	1,015
Computer Services	Computer Consulting	18,895

Schedule V, line 19, column 8	<u><u>325,965</u></u>
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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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,163 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. \$ 444,902
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. \$ 18,611 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 925

(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? N/A 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? N/A
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 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.