

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 E Irving Park Rd Streamwood 60107 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 X PROPRIETARY Individual Partnership Corporation X "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 01/01/2016 to 12/31/2016 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) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) 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
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Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	408,013	35,331	8,471	451,815		451,815		451,815			1
2	Food Purchase		389,166		389,166		389,166	(657)	388,509			2
3	Housekeeping	424,118	44,038		468,156		468,156	353	468,509			3
4	Laundry		20,675		20,675		20,675		20,675			4
5	Heat and Other Utilities			273,126	273,126		273,126	8,637	281,763			5
6	Maintenance	31,301		182,576	213,877		213,877	87,899	301,776			6
7	Other (specify):* Alloc. From Mgmt Co							11,301	11,301			7
8	TOTAL General Services	863,432	489,210	464,173	1,816,815		1,816,815	107,533	1,924,348			8
	B. Health Care and Programs											
9	Medical Director			47,850	47,850		47,850		47,850			9
10	Nursing and Medical Records	5,247,521	421,783	86,531	5,755,835		5,755,835	39,223	5,795,058			10
10a	Therapy											10a
11	Activities	161,243	25,088	22,074	208,405		208,405		208,405			11
12	Social Services	160,196		3,052	163,248		163,248		163,248			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt Co							5,117	5,117			15
16	TOTAL Health Care and Programs	5,568,960	446,871	159,507	6,175,338		6,175,338	44,340	6,219,678			16
	C. General Administration											
17	Administrative	109,927		1,746,640	1,856,567		1,856,567	(1,686,188)	170,379			17
18	Directors Fees											18
19	Professional Services			254,074	254,074		254,074	19,194	273,268			19
20	Dues, Fees, Subscriptions & Promotions			146,910	146,910		146,910	13,520	160,430			20
21	Clerical & General Office Expenses	169,789	27,196	37,986	234,971		234,971	771,819	1,006,790			21
22	Employee Benefits & Payroll Taxes			1,292,312	1,292,312		1,292,312		1,292,312			22
23	Inservice Training & Education			10,737	10,737		10,737	392	11,129			23
24	Travel and Seminar							1,184	1,184			24
25	Other Admin. Staff Transportation			1,811	1,811		1,811	12,905	14,716			25
26	Insurance-Prop.Liab.Malpractice			385,726	385,726		385,726	3,196	388,922			26
27	Other (specify):* Alloc. From Mgmt Co							113,348	113,348			27
28	TOTAL General Administration	279,716	27,196	3,876,196	4,183,108		4,183,108	(750,630)	3,432,478			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,712,108	963,277	4,499,876	12,175,261		12,175,261	(598,757)	11,576,504			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			138,708	138,708		138,708	338,820	477,528			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			162,364	162,364		162,364	314,838	477,202			32
33	Real Estate Taxes							673,004	673,004			33
34	Rent-Facility & Grounds			2,057,946	2,057,946		2,057,946	(2,052,759)	5,187			34
35	Rent-Equipment & Vehicles			110,016	110,016		110,016	2,460	112,476			35
36	Other (specify):*											36
37	TOTAL Ownership			2,469,034	2,469,034		2,469,034	(723,637)	1,745,397			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		527,316	1,392,007	1,919,323		1,919,323		1,919,323			39
40	Barber and Beauty Shops			16,371	16,371		16,371		16,371			40
41	Coffee and Gift Shops			2,295	2,295		2,295		2,295			41
42	Provider Participation Fee			432,178	432,178		432,178		432,178			42
43	Other (specify):* Non-Allowable Cos	67,285		385,319	452,604		452,604	(452,604)				43
44	TOTAL Special Cost Centers	67,285	527,316	2,228,170	2,822,771		2,822,771	(452,604)	2,370,167			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,779,393	1,490,593	9,197,080	17,467,066		17,467,066	(1,774,998)	15,692,068			45

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

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 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(657)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,233)	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	2,211	30		9
10	Interest and Other Investment Income	(42,809)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,597)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,030)	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	(296,432)	43		24
25	Fund Raising, Advertising and Promotional	(17,989)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,571)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	90,383	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (298,724)		\$	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)	(1,476,274)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,476,274)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,774,998)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (3,885)	43	1
2	Labs-Part A	(16,217)	43	2
3	X-Rays-Part A	(17,365)	43	3
4	Collections	(3,037)	19	4
5	Marketing Salary	(67,285)	43	5
6	Trust fees	(85)	43	6
7	Unrealized loss on FMV swap	218,993	43	7
8	Salesforce.com	(6,648)	19	8
9	Disallow Lobbying	(2,861)	20	9
10	Non-Allowable Professional Fees	(1,395)	19	10
11	Non-Allowable Legal	(9,832)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	90,383		49

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		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	**	228,697	228,697	2
3	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	335,732	335,732	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	**	665,946	665,946	5
6	V	34	Rental expense	2,057,946	Sambell of Streamwood Limited Partnership	**		(2,057,946)	6
7	V	43	Trust fees		Sambell of Streamwood Limited Partnership	**	85	85	7
8	V	43	Unrealized loss on interest rate swap	218,993	Sambell of Streamwood Limited Partnership	**		(218,993)	8
9	V								9
10	V								10
11	V				The owners of Lexington Health Care Center of Streamwood, Inc.				11
12	V				own 100% of Sambell of Streamwood Limited Partnership.				12
13	V								13
14	Total			\$ 2,276,939			\$ 1,232,953	\$ * (1,043,986)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	\$	Royal Management Corp.	**	\$ 353	\$ 353	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	7,786	7,786	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	328	328	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	523	523	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	80,159	80,159	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	7,405	7,405	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	335	335	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	11,301	11,301	22
23	V	10	Medical consultant		Royal Management Corp.	**	2,925	2,925	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	36,298	36,298	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	5,117	5,117	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	60,452	60,452	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	16,183	16,183	27
28	V	19	Professional fees		Royal Management Corp.	**	23,723	23,723	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	2,410	2,410	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	13,971	13,971	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	743,570	743,570	31
32	V	21	Bank charges		Royal Management Corp.	**	2,976	2,976	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	10,055	10,055	33
34	V	21	Postage		Royal Management Corp.	**	3,742	3,742	34
35	V	21	Telephone		Royal Management Corp.	**	11,476	11,476	35
36	V								36
37	V								37
38	V		** The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total		\$				\$ 1,041,088	\$ * 1,041,088	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	23 Inservice Training	\$	Royal Management Corp.	**	\$ 392	\$ 392	15
16	V	24 Travel & seminar		Royal Management Corp.	**	1,184	1,184	16
17	V	25 Auto expense		Royal Management Corp.	**	12,905	12,905	17
18	V	26 Insurance general		Royal Management Corp.	**	3,196	3,196	18
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	113,348	113,348	19
20	V	30 Depreciation		Royal Management Corp.	**	107,912	107,912	20
21	V	32 Interest		Royal Management Corp.	**	17,193	17,193	21
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	2,429	2,429	22
23	V	33 Property taxes		Royal Management Corp.	**	7,058	7,058	23
24	V	34 Rent expense		Royal Management Corp.	**	5,187	5,187	24
25	V	35 Equipment rental		Royal Management Corp.	**	1,509	1,509	25
26	V	17 Management fees	1,746,640	Royal Management Corp.	**		(1,746,640)	26
27	V	35 Auto Lease		Royal Management Corp.	**	951	951	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	** The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total		\$ 1,746,640			\$ 273,264	\$ * (1,473,376)	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:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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					North Heron	Lombard	Finance Company	1
2					Investments, LLC			2
3								3
4					Lexington Home	Lombard	Home Health	4
5					Health Care, Inc.			5
6								6
7					Lexington Hospice	Lombard	Hospice	7
8					Services, LLC			8
9								9
10					Lexington Private	Lombard	Healthcare	10
11					Home Care			11
12								12
13					Merit Sleep	Lombard	Management	13
14					Management, LLC		Company	14
15								15
16					Samvest of	Algonquin	Real Estate	16
17					Algonquin Ltd. Ptsp		Property	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

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 10,080	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,012	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,350	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	14,004	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	20,005	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,452		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

Ending: 2/31/2016

((630) 458-4796

Facility Name & ID Number Lexington of Streamwood# 0037002

Report Period Beginning:

01/01/2016Ending: 2/31/2016

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	23	Inservice Training	Bed Days Available	724,314	10	\$ 3,621	\$	78,324	\$ 392	1
2	24	Travel and Seminar	Bed Days Available	724,314	10	10,947		78,324	1,184	2
3	25	Auto expense	Bed Days Available	724,314	10	119,337		78,324	12,905	3
4	26	Insurance general	Bed Days Available	724,314	10	29,556		78,324	3,196	4
5	27	Management allocation - employee	Bed Days Available	724,314	10	1,048,208		78,324	113,348	5
6	30	Depreciation	Bed Days Available	724,314	10	997,930		78,324	107,912	6
7	32	Interest	Bed Days Available	724,314	10	158,994		78,324	17,193	7
8	32	Amortization of mortgage costs	Bed Days Available	724,314	10	22,462		78,324	2,429	8
9	33	Property taxes	Bed Days Available	724,314	10	65,273		78,324	7,058	9
10	34	Rent expense	Bed Days Available	724,314	10	47,968		78,324	5,187	10
11	35	Equipment rental	Bed Days Available	724,314	10	13,953		78,324	1,509	11
12	35	Auto Lease	Bed Days Available	724,314	10	8,793		78,324	951	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					\$ 2,527,042	\$		\$ 273,264	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	5,348,254	1/1/33	Variable	335,732	2
3												3
4												4
5								Finance Charge - Insurance Policy			1,754	5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	1,154,048	9,244,097	Demand	Prime +1	120,580	6
7	Bank of America		X	Working Capital	None	9/30/14	13,700,000	1,356,000	4/30/2017	Prime/Libor	40,030	7
8												8
9	TOTAL Facility Related						\$ 21,588,048	\$ 15,948,351			\$ 498,096	9
	B. Non-Facility Related*											
10								Amortization of loan cost			2,293	10
11								Allocated from Mgmt Co.			19,622	11
12								Interest Income offset			(5,367)	12
13								See Sch 9A			(37,442)	13
14	TOTAL Non-Facility Related						\$				\$ (20,894)	14
15	TOTALS (line 9+line14)						\$ 21,588,048	\$ 15,948,351			\$ 477,202	15

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

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

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

Facility Name: Lexington of Streamwood
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/2016

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$		\$			1		
2												2		
3												3		
4												4		
5												5		
	Working Capital													
6												6		
7												7		
8												8		
9	TOTAL Facility Related				\$0.00		\$	0	\$	0		\$	0	9
	B. Non-Facility Related*													
10							Non Allowable Shareholder Interest					(35,688)	10	
11							Non Allowable Finance Charge					(1,754)	11	
12													12	
13													13	
14	TOTAL Non-Facility Related				\$0.00		\$	0	\$	0		\$	(37,442)	14

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center of Streamwood, Inc. 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 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>06-25-300-006-0000</u>	<u>Land & Building</u>	\$ <u>612,375.00</u>	\$ <u>612,375.00</u>
2. <u>Royal Management Corp(Samvest o</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>249,002.30</u>	\$ <u>7,058.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>861,377.30</u></u>	\$ <u><u>619,433.00</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 83,942

B. General Construction Type: Exterior Concrete BlockFrame SteelNumber of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	30,000	1991	\$ 211,400	1
2	Management Company Allocation		2002	22,198	2
3	TOTALS	30,000		\$ 233,598	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	214		1991	1991	\$ 5,248,322	\$	35	\$ 149,952	\$ 149,952	\$ 3,823,777	4
5			1993	1993	105,236		35	3,007	3,007	70,660	5
6			1995	1995	82,650	2,361	35	2,361		50,767	6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	7,336		35	210	210	4,929	9
10	Land Improvements			1995	7,000		15			7,000	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		7,215	11
12	Piping			1996	3,139	90	35	90		1,841	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		15			12,012	19
20	Parking lot			2000	1,773		10			1,773	20
21	110-ton A/C unit			2000	6,923		10			6,923	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			85,195	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		164,470	26
27	Parking lot			2002	29,288		10			29,288	27
28	Office area rehab			2002	26,991	1,350	20	1,350		19,573	28
29	Elevator interior upgrade			2002	1,120		10			1,120	29
30	Gazebo			2002	3,393		10			3,393	30
31	Elevator electronic curtains			2002	4,500		10			4,500	31
32	Door frame protector			2003	5,276		10			5,276	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring			2003	9,392		10			9,392	33
34	Roof			2003	29,950	1,498	20	1,498		19,597	34
35	Kitchen Sewer/Dishroom			2004	6,224		10			6,224	35
36	Compressor/tube bundles-cooling system			2004	14,737	737	20	737		9,088	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:

01/01/2016 Ending: 12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Kitchen fire protection upgrade	2004	\$ 1,427	\$	10	\$	\$	\$ 1,427	37
38 Landscaping	2005	8,495	425	20	425		4,781	38
39 Kitchen renovation	2005	12,034	602	20	602		6,621	39
40 Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		20,592	40
41 Therapy room renovation	2005	11,628	581	20	581		6,586	41
42 Create first floor therapy room	2005	44,781	2,239	20	2,239		26,868	42
43 Dialysis units	2005	66,426	3,535	20	3,535		40,653	43
44 Create transitional unit	2005	14,490	725	20	725		7,974	44
45 Alzheimers unit renovation	2005	5,910	296	20	296		3,551	45
46 Basement renovation	2005	46,561	2,328	20	2,328		25,996	46
47 Landscaping enhancement	2006	3,414	228	15	228		2,393	47
48 HVAC	2006	17,125	856	20	856		8,632	48
49 Door closer	2006	4,446	222	20	222		2,387	49
50 Blinds	2006	1,566		5			1,566	50
51 Employee lunch room rehab	2006	2,883	144	20	144		1,536	51
52 Storeroom door lock	2006	2,843	142	20	142		1,491	52
53 Dialysis Stations	2006	62,832	3,142	20	3,142		33,252	53
54 Fine dining	2006	7,650	382	20	382		4,044	54
55 Automatic door	2006	2,259	113	20	113		1,158	55
56 Landscaping	2007	10,606	530	20	530		4,814	56
57 Parking lot	2007	2,777	139	20	139		1,286	57
58 HVAC	2007	1,501	75	20	75		731	58
59 Painting Building	2007	16,150	808	20	808		7,608	59
60 Landscaping	2008	33,747	2,250	15	2,250		18,187	60
61 Common areas-metal doors	2008	7,055	353	20	353		3,089	61
62 Wanderguard	2008	3,882	194	20	194		1,746	62
63 Lawn Irrigation	2009	18,125	1,208	15	1,208		8,758	63
64 Landscaping	2009	3,138	209	15	209		1,602	64
65 Quick connectors	2009	9,375	469	20	469		3,596	65
66 1st floor admin office-heating,plumbing	2009	13,598	767	20	767		5,412	66
67 Fire alarm system	2009	5,271	264	20	264		1,848	67
68 Metal Doors-painting	2009	4,650	232	20	232		1,779	68
69 2nd Floor Remodel-carpentry	2009	33,503	838	40	838		6,494	69
70 TOTAL (lines 4 thru 69)		\$ 6,491,737	\$ 43,167		\$ 196,336	\$ 153,169	\$ 4,671,631	70

**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:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,491,737	\$ 43,167		\$ 196,336	\$ 153,169	\$ 4,671,631	1
2	Patio Pergola	2009	7,930	793	10	793		5,815	2
3	Landscaping	2010	5,785	386	15	386		2,509	3
4	HVAC Quick connectors, admin office	2010	15,373	561	27	561		3,431	4
5	Lockers and Pantry-plumbing, tile	2010	14,809	540	27	540		3,347	5
6	Director of Nursing office painting	2010	7,887	288	27	288		1,728	6
7	Ramp repair	2010	3,240	216	15	216		1,332	7
8	Library/Lounge update-art,flooring	2010	8,356	305	27	305		1,881	8
9	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	48,949	1,958	27	1,958		11,748	9
10	Office carpentry,flooring,electrical,painting,signs,HVAC	2011	4,714	171	27	171		955	10
11	Office-Doors, ADON, Locks	2011	26,169	952	27	952		4,919	11
12	HVAC Chiller	2011	95,360	3,468	27	3,468		18,785	12
13	Laundry Room-Painting, Tile	2011	7,686	279	27	279		1,511	13
14	2nd floor doors	2011	26,317	957	27	957		5,104	14
15									15
16	Install cast iron pipe sprinkler	2012	4,550	165	27	165		798	16
17	Shower room-tile-painting,plumbing	2012	87,763	3,191	27	3,191		13,030	17
18									18
19	Update Sprinkler Heads- Entire Facility	2013	28,070	1,021	27	1,021		3,573	19
20	EMR Building Wire- Entire Facility	2013	16,538	601	27	601		1,904	20
21									21
22	R/M Reclass: Intstallation of Kitchen Countertop	2014	2,800		15	187	187	467	22
23	R/M Reclass: Install Elevator Door Restrictor	2014	5,250		10	525	525	1,313	23
24	R/M Reclass: Cracked Pavement Sealing (Parking Lot)	2014	3,500		15	233	233	583	24
25						-			25
26	R/M Reclass: Decorating and Tiling- Service entrance ramp doors	2015	3,328		15	221	221	443	26
27	R/M Reclass: Cast iron piping and concrete bottom loading ramp	2015	4,825		20	241	241	483	27
28	R/M Reclass: Paving on outside parking lot	2015	4,600		20	230	230	460	28
29	R/M Reclass: Replace four sprinkler heads in outside canopy	2015	2,663		20	133	133	266	29
30	R/M Reclass: Cut out bad turf along curb of back driveway	2015	3,535		15	235	235	471	30
31	Update Shower Room in Facility	2015	6,100	222	27	222		277	31
32	EMR Building Wire- Entire Facility	2015	3,472	126	27	126		200	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,941,306	\$ 59,367		\$ 214,541	\$ 155,174	\$ 4,758,964	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:

01/01/2016 Ending: 12/31/2016

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		\$ 6,941,306	\$ 59,367		\$ 214,541	\$ 155,174	\$ 4,758,964	1
2									2
3									3
4	Update HVAC - Mechanical Room	2016	106,947	2,917	27	2,917		2,917	4
5	Room Renovations - 1st floor chair rails	2016	13,423		27				5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18	Real Estate Entity								18
19	1st floor remodel-Carpentry,flooring,electrical,painting	2008	531,230		27	19,317	19,317	173,855	19
20	2nd Floor Remodel-Carpentry,Flooring,Electrical,painting	2008	487,333		27	17,721	17,721	141,770	20
21	Remodel special care units-carpentry,electrical,painting	2008	32,914		27	1,197	1,197	9,577	21
22	3rd floor remodel-carpentry,flooring,electrical,painting	2009	667,142		27	24,260	24,260	185,994	22
23	Parking lot seal and stripe	2011	3,600		27	131	131	689	23
24	Remodel LL Flooring-Carpentry,flooring, electrical	2011	27,575		27	1,003	1,003	5,100	24
25	Kitchen holding tank	2011	11,666		27	424	424	2,473	25
26	Drain tile and pits	2011	8,000		27	291	291	1,552	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,831,135	\$ 62,284		\$ 281,804	\$ 219,520	\$ 5,282,890	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:

01/01/2016 Ending: 12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 8,831,135	\$ 62,284		\$ 281,804	\$ 219,520	\$ 5,282,890	1
2								2
3 Mgmt Co.								3
4								4
5 Building-management company	2002	307,173		40	8,914	8,914	136,294	5
6 HVAC, electrical, security system-management company	2003	2,698		30	633	633	2,143	6
7 Key card system-management company	2004	424		20	21	21	263	7
8 VAC TX controls-management company	2005	129		20	6	6	76	8
9 Build Imp-management company	2006	94		20	6	6	64	9
10 Building Improvement Management Co.	2008	14,885		20	162	162	6,505	10
11 Building Improvement Management Co.	2009	2,779		20	50	50	1,128	11
12 Building Improvement Management Co.	2010	2,708		20	49	49	1,041	12
13 Building Improvement Management Co.	2011	1,911		20	87	87	489	13
14 Building Improvement Management Co.	2012	6,604		20	12	12	1,129	14
15 Building Improvement Management Co.	2013	4,990		20	355	355	1,187	15
16 Building Improvement Management Co.	2014	2,701		20	263	263	678	16
17 Building Improvement Management Co.	2015	475		20	57	57	87	17
18 Building Improvement Management Co.	2016	7,836		20	225	225	225	18
19								19
20 Reconcile to book depreciation			(204)			204		20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 9,186,542	\$ 62,080		\$ 292,644	\$ 230,564	\$ 5,434,199	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	\$ 1,118,542	\$ 74,583	\$ 85,767	\$ 11,184	5-10	\$ 996,353	71
72	Current Year Purchases	36,098	2,045	2,045	-	7	2,045	72
73	Fully Depreciated Assets	622,464			-	5-10	622,464	73
74	Allocated from Mgmt. Co.	637,099		94,265	94,265	5-7	525,687	74
75	TOTALS	\$ 2,414,203	\$ 76,628	\$ 182,077	\$ 105,449		\$ 2,146,549	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				\$ -	\$ -	\$ -			\$ -
77					-	-	-		
78					-	-	-		
79	Allocated from Mgmt. Co.			57,433	-	2,807	2,807	5	50,999
80	TOTALS			\$ 57,433	\$ -	\$ 2,807	\$ 2,807		\$ 50,999

E. Summary of Care-Related Assets					1	2
		Reference				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)				\$ 11,891,776
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$ 138,708
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$ 477,528
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$ 338,820
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$ 7,631,747

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
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				5,187			6
7	TOTAL				\$ 5,187			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: \$ 111,525
- Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Management Company			951	20
21	TOTAL		\$	\$ 951	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

Facility Name:

Lexington of Streamwood

IDPH License ID Number:

0037002

Fiscal Year End:

12/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	6,806
Printer System	3,884
Postage	323
Equipment Rental	47,521
Oxygen	51,483
Allocated from Mgmt Co.	1,509
Total - Line 16	111,525

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

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.

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	\$	7,951	\$ 462,693	\$	7,951	\$ 462,693	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,703	146,937		4,703	146,937	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		17,415	766,250		17,415	766,250	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				515,627		515,627	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				16,127			16,127	12
13	Other (specify): See Sch 16A	39(2)					11,689		11,689	13
14	TOTAL			\$	30,069	\$ 1,392,007	\$ 527,316	30,069	\$ 1,919,323	14

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

Facility Name: Lexington Health Care Center of Streamwood, Inc.
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/2015

Schedule 16A

STATE OF ILLINOIS									
Page 16A									
Facility Name & ID Number		Lexington Health Care Center of Streamwood, Inc.		#	037002	Report Period Beginning:		1/01/2015	Ending: 12/31/2015
1	2	3	4	5	6	7	8		
Schedule V Line & Column Reference	Service	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	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	hrs							2
3	Licensed Recreational Therapist	hrs							3
4	Licensed Physical Therapist	hrs							4
5	Physician Care	visits							5
6	Dental Care	visits							6
7	Work Related Program	hrs							7
8	Habilitation	hrs							8
9	Pharmacy	# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	hrs							10
11	Academic Education	hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)				8,696		10,345	12
13	Other (specify): <u>DME</u>	39(2)				2,993		18,496	13
14	TOTAL		\$		\$	\$ 11,689		\$ 28,841	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.

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	\$ 774,477	\$ 830,809	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,817,899)	2,216,116	2,216,116	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	18,226	18,226	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,008,819	\$ 3,065,151	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,884	67,884	12
13	Land		233,598	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,654,234	3,832,984	15
16	Equipment, at Historical Cost	624,673	2,471,636	16
17	Accumulated Depreciation (book methods)	(1,354,483)	(7,631,747)	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 cost, net		37,580	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 992,308	\$ 4,365,493	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,001,127	\$ 7,430,644	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 505,253	\$ 505,253	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,600,097	10,600,097	29
30	Accrued Salaries Payable	518,288	518,288	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,836	25,836	31
32	Accrued Real Estate Taxes(Sch.IX-B)		700,000	32
33	Accrued Interest Payable		25,230	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	17,425,115	5,192,759	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 29,074,589	\$ 17,567,463	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,348,254	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)	\$	\$ 5,348,254	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 29,074,589	\$ 22,915,717	46
47	TOTAL EQUITY(page 18, line 24)	\$ (25,073,462)	\$ (15,485,073)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,001,127	\$ 7,430,644	48

*(See instructions.)

Facility Name: Lexington of Streamwood
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet

Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
Total - Line 23	-	-

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

		After
Description	Operating	Consolidation
PA Audit Settlement	123,347	123,347
Cash Patient Trust	18,622	18,622
Rent Receivable	-	(12,546,596)
Due to Lex Fin Svcs	410	410
Sambell Due from LLC 1	-	1,410
Prepaid Insurance	44,561	44,561
Escrow-Insurance	886,885	886,885
Withholding - Dental Insurance	(128)	(128)
Withholding - EP/CI/WL	1,118	1,118
401K Withholding	(1,094)	(1,094)
Accrued Expenses	189,304	189,304
Accrues Resident Tax	81,497	81,497
Accrued Royal/Vesta Mgmt Fees	3,482,899	3,482,899
Accrued Rent	12,546,596	12,546,596
Accrued Insurance	29,436	29,436
Due to Patient Trust Fund	(20,052)	(20,052)
Advance - Biweekly Part A Payment	(211,018)	(211,018)
Uncollectible Part A Co Pvts	(86,926)	(86,926)
Due to - Royal Operations	17,406	17,406
Due to/from Republic	2,702	2,702
Due to/from Vesta Mgmt	214	214
Due to/from	55,977	55,977
Sambell Interest Rate Swap Liability	-	312,830
Professional Liabilities Claim	263,359	263,359
Total - Line 36	17,425,115	5,192,759

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (22,653,956)	1
2	Restatements (describe):		2
3	Post closing adjustment	(510,447)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (23,164,403)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,909,059)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,909,059)	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)	\$ (25,073,462)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 24,136,820	1
2	Discounts and Allowances for all Levels	(14,777,600)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,359,220	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,535,965	6
7	Oxygen	43,948	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,579,913	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	1,824	12
13	Barber and Beauty Care	18,190	13
14	Non-Patient Meals	657	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	777,826	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	235,255	19
20	Radiology and X-Ray	27,603	20
21	Other Medical Services	552,152	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,613,507	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,367	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,367	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)	\$ 15,558,007	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,816,815	31
32	Health Care	6,175,338	32
33	General Administration	4,183,108	33
	B. Capital Expense		
34	Ownership	2,469,034	34
	C. Ancillary Expense		
35	Special Cost Centers	2,390,593	35
36	Provider Participation Fee	432,178	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,467,066	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,909,059)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,909,059)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,477,730	44
45	Private Pay - Net Inpatient Revenue	712,302	45
46	Medicare - Net Inpatient Revenue	528,413	46
47	Other-(specify) <u>Managed Care</u>	640,775	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,359,220	49

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

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

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

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

^ - Entity is a cash basis taxpayer

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	1,863	2,185	\$ 120,733	\$ 55.26	1
2	Assistant Director of Nursing	1,695	2,164	97,486	45.05	2
3	Registered Nurses	22,368	29,693	972,637	32.76	3
4	Licensed Practical Nurses	36,215	48,155	1,292,144	26.83	4
5	CNAs & Orderlies	118,714	148,613	2,082,793	14.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,127	2,459	48,876	19.87	9
10	Activity Assistants	9,129	10,400	112,367	10.80	10
11	Social Service Workers	7,544	8,582	160,196	18.67	11
12	Dietician	1,881	2,246	57,029	25.40	12
13	Food Service Supervisor	864	1,062	22,039	20.76	13
14	Head Cook	1,437	1,620	31,217	19.27	14
15	Cook Helpers/Assistants	24,794	28,208	297,728	10.55	15
16	Dishwashers					16
17	Maintenance Workers	1,449	1,802	31,301	17.37	17
18	Housekeepers	33,272	40,374	424,118	10.50	18
19	Laundry					19
20	Administrator	1,439	1,772	109,927	62.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,769	9,778	169,789	17.36	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	1,817	2,282	41,851	18.34	31
32	Other Health Care See Sch 20A	19,761	25,063	639,877	25.53	32
33	Other(specify) Marketing	1,562	1,933	67,285	34.80	33
34	TOTAL (lines 1 - 33)	295,700	368,391	\$ 6,779,393 *	\$ 18.40	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	47,850	9(3)	36
37	Medical Records Consultant	Monthly	878	10(3)	37
38	Nurse Consultant	Monthly	812	10(3)	38
39	Pharmacist Consultant	Monthly	15,248	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,704	11(3)	44
45	Social Service Consultant	Monthly	3,052	12(3)	45
46	Other(specify) Pulmonary	Monthly	58,487	10(3)	46
47	Post Acute Consultant	Monthly	1,956	10(3)	47
48	See Sch 20B	Monthly	12,075	Var.	48
49	TOTAL (lines 35 - 48)		\$ 145,062		49

C. CONTRACT NURSES

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

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

IDPH License ID Number:0037002

Fiscal Year End:12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Staffing Coordinator	1,532	1,971	30,188	\$ 15.32
Unit Secretary	3,779	5,064	105,466	\$ 20.83
Accounts Coordinator	1,810	2,154	26,274	\$ 12.20
Admissions	3,280	3,937	91,038	\$ 23.13
MDS	5,085	6,664	221,651	\$ 33.26
Clinical Coordinator	1,826	2,143	74,907	\$ 34.95
Transitional Care Nurse	855	1,117	41,600	\$ 37.24
Wound Care Coordinator	1,595	2,013	48,753	\$ 24.21
Total - Line 32 Other Health Care (specify):	19,761	25,063	639,877	25.53

Facility Name: Lexington Health Care Center of Streamwood, Inc.
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/2016

Schedule 20B

XVIII. Staffing and Salary Costs
B. Consultant Services
Line 48

Description	# of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Sch V Line & Column Reference
Medical Consultant	Monthly	2,925	10(7)
Telemedicine Consultant	Monthly	9,150	10(3)
Total - Line 48		12,075	

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	\$ 109,927	Workers' Compensation Insurance		\$ 224,733	IDPH License Fee		\$ 1,990			
				Unemployment Compensation Insurance		63,635	Advertising: Employee Recruitment		3,062			
				FICA Taxes		505,648	Health Care Worker Background Check					
				Employee Health Insurance		420,939	(Indicate # of checks performed 324)		3,884			
				Employee Meals			Patient Background Checks	631	7,575			
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees		3,211			
				401K		26,728	Miscellaneous Dues & Subscriptions		11,549			
				Other Employee Benefits		38,469	Employment Fees		109,007			
				Tuition Reimbursement		5,794	Management Company Allocation		13,971			
				Uniform Allowance		6,366	IHCA Dues		6,181			
							Less: Public Relations Expense	()				
							Non-allowable advertising	()				
							Yellow page advertising	()				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 109,927	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 160,430		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				G. Schedule of Travel and Seminar**				
Description				Amount				Description				Amount
Management Fees-Royal Operating				\$ 1,281,408				Out-of-State Travel				\$
Management Fees-Vesta Mgmt.				465,232								
Management Fees (Eliminated in Column 7)								In-State Travel				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 1,746,640								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees								
Vendor/Payee	Type		Amount	Description	Line #	Amount						
Cassiday Schade LLP	Legal		\$ 96,950	N/A		\$						
Cook County Med	Storage		500									
Duane Morris	Legal		871									
Generation Law	Legal		7,068									
Grabowski	Collections		104									
RSM US LLP	Accounting		46,446									
Much Shelist	Legal		2,825									
Attadale	Operations Consulting		9,990									
Amalgamated Bank	Administrative Fee		483									
Cash Receipts	Collections		1,703									
See Schedule 21C	Various		87,134									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 254,074				TOTAL (agree to Sch. V, line 24, col. 8)				\$ 1,184

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Lexington of Streamwood
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Much Shelist	Collections	1,231
Pension Administrators	401K Administration	1,380
Personnel Planners	U/C Consulting	1,290
Filpi & Filpi	Legal	100
SB2	Computer Services	2,484
SNR Denton	Legal	2,116
Standard & Poor	Financial	563
Voya	Financial	3
Jefferies	Tax Consulting	1,395
Secretary of State	Filing Fees	80
Ability Network	Computer Services	5,981
APR	Computer Services	63
Availity	Computer Services	252
Avatier	Computer Services	177
Cinetec	Computer Services	851
Citrix	Computer Services	702
Corepoint	Computer Services	1,543
DocuSign Inc.	Computer Services	462
E-Health Data Solutions	Computer Services	863
HealthMedx	Computer Services	14,758
Information Controls	Computer Services	7,029
MHC Software	Computer Services	837
Microsoft Licensing	Computer Services	1,344
National Datacare	Computer Services	2,623
NTT Data	Computer Services	6,801
OnShift	Computer Services	1,579
Provinet	Computer Services	112
Relias	Computer Services	9,339
Salesforce.com	Computer Services	6,648
Shiftmation Control	Computer Services	7,471
Softchoice Corporation	Computer Services	10,212
Sophos	Computer Services	(5,766)
Symbria	Computer Services	2,200
Tableau Software, Inc.	Computer Services	411
Total (agree to Schedule V, line 19, column 3)		254,074
Allocated from Management Company Professional Services		200
Less: Non-Allowable Legal Fees		(12,869)
Less: Non-Allowable Professional Fees		(8,043)
Allocated from Mgmt Co.		
Gilson Labus & Silverman	Accounting	131
Illinois Secretary of State	Filing Fees	10
		141
Allocated from Mgmt Co.		
RSM US LLP	Accounting	3,589
Marcum LLP	Accounting	429
Gilson Labus & Silverman	Accounting	111
Illinois Secretary of State	Filing Fees	51
LaSalle Network	Recruiting/Finance	2,495
Callan Associates, Ltd.	Recruiting	13,363
Pension Administrators, Inc.	401K Administration	428
Voya Financial	401K Administration	18
Gene Whitehorn	Medicaid Reimb Specialist	1,927
M. Werner Consulting	Financial Consultant	1,025
M. Rodeghier Consulting	Process Improvement Consultant	78
Wordy.com	Proofreading	69
Computer Services	Computer Consulting	16,183
Total (agree to Schedule V, line 19, column 8)		273,268

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$6,181
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,478 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. \$ 432,178
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 benefit on Schedule V. \$ - Has any meal income been offset against related costs? Yes Indicate the amount. \$ 657
- (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 of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees