FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0037002

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

Address: 815 E. Irving Park Road (Number) Streamwood (City) 60107 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	214	Skilled (SNF)	214	78,110	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	214	TOTALS	214	78,110	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			14,661	14,661	8
9	SNF/PED					9
10	ICF	47,317	4,389		51,706	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,317	4,389	14,661	66,367	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.97%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/8/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New Construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 214 and days of care provided 9,130

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwoo # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	402,745	38,137	26,876	467,758		467,758		467,758			1
2	Food Purchase		360,299		360,299		360,299	(22,031)	338,268			2
3	Housekeeping	367,091	38,459		405,550		405,550	391	405,941			3
4	Laundry	72,845	22,397		95,242		95,242		95,242			4
5	Heat and Other Utilities			259,939	259,939		259,939	10,698	270,637			5
6	Maintenance	34,889		127,944	162,833		162,833	77,031	239,864			6
7	Other (specify):* Alloc. From Mgmt Co							9,648	9,648			7
8	**TOTAL General Services**	877,570	459,292	414,759	1,751,621		1,751,621	75,737	1,827,358			8
	B. Health Care and Programs											
9	Medical Director			48,450	48,450		48,450		48,450			9
10	Nursing and Medical Records	4,600,050	286,586	67,978	4,954,614		4,954,614	66,151	5,020,765			10
10a	Therapy			1,235,462	1,235,462		1,235,462		1,235,462			10a
11	Activities	296,997	35,509	10,755	343,261		343,261		343,261			11
12	Social Services	132,304		7,866	140,170		140,170		140,170			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt Co							9,149	9,149			15
16	**TOTAL Health Care and Programs**	5,029,351	322,095	1,370,511	6,721,957		6,721,957	75,300	6,797,257			16
	C. General Administration											
17	Administrative	107,846		1,479,424	1,587,270		1,587,270	(1,450,759)	136,511			17
18	Directors Fees											18
19	Professional Services			215,876	215,876		215,876	23,244	239,120			19
20	Dues, Fees, Subscriptions & Promotions			153,735	153,735		153,735	6,848	160,583			20
21	Clerical & General Office Expenses	239,410	38,756	40,635	318,801		318,801	637,264	956,065			21
22	Employee Benefits & Payroll Taxes			996,967	996,967		996,967	17,730	1,014,697			22
23	Inservice Training & Education			19,113	19,113		19,113	1,706	20,819			23
24	Travel and Seminar							2,938	2,938			24
25	Other Admin. Staff Transportation			650	650		650	20,695	21,345			25
26	Insurance-Prop.Liab.Malpractice			390,788	390,788		390,788	7,153	397,941			26
27	Other (specify):* Alloc. From Mgmt Co							91,936	91,936			27
28	**TOTAL General Administration**	347,256	38,756	3,297,188	3,683,200		3,683,200	(641,245)	3,041,955			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,254,177	820,143	5,082,458	12,156,778		12,156,778	(490,208)	11,666,570			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. #0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			183,661	183,661		183,661	392,521	576,182			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			94,213	94,213		94,213	293,199	387,412			32
33	Real Estate Taxes							645,749	645,749			33
34	Rent-Facility & Grounds			2,031,307	2,031,307		2,031,307	(2,026,969)	4,338			34
35	Rent-Equipment & Vehicles			68,186	68,186		68,186	3,500	71,686			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,377,367	2,377,367		2,377,367	(692,000)	1,685,367			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		582,513	6,199	588,712		588,712		588,712			39
40	Barber and Beauty Shops			19,051	19,051		19,051		19,051			40
41	Coffee and Gift Shops			10,851	10,851		10,851		10,851			41
42	Provider Participation Fee			292,922	292,922		292,922		292,922			42
43	Other (specify):* **Non-Allow Costs**	151,470		182,991	334,461		334,461	(334,461)				43
44	**TOTAL Special Cost Centers**	151,470	582,513	512,014	1,245,997		1,245,997	(334,461)	911,536			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,405,647	1,402,656	7,971,839	15,780,142		15,780,142	(1,516,669)	14,263,473			45

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,301)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,838)	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	(268)	30		9
10	Interest and Other Investment Income	(105,811)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9,541)	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	(2,550)	43		18
19	Entertainment				19
20	Contributions	(2,000)	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	(71,598)	43		24
25	Fund Raising, Advertising and Promotional	(42,679)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(202)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(570,608)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (816,396)		$	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)	(700,273)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (700,273)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,516,669)		37

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

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

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

STATE OF ILLINOIS

Lexington Health Care Center of Streamwood, Inc.

ID# 0037002

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (1,430)	43	1
2	Labs-Part A	(21,031)	43	2
3	X-Rays-Part A	(25,122)	43	3
4	Trust fees	(100)	43	4
5	Unrealized loss on FMV swap	(373,689)	43	5
6	Reclass to Repairs & Maintenance	5,117	6	6
7	Collections	(1,837)	19	7
8	Out of period legal	(128)	19	8
9	Marketing Salary	(151,470)	43	9
10	Dues & Subscriptions Marketing	(918)	20	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				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**	(570,608)		49

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Page 6 Supplemental		See attached Page 6 Supplemental		See attached 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Sambell of Streamwood Limited Partnership	**	$ 200	$ 200	1
2	V	30	Depreciation		Sambell of Streamwood Limited Partnership	**	342,766	342,766	2
3	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	379,699	379,699	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	**	639,307	639,307	5
6	V	34	Rental expense	2,031,307	Sambell of Streamwood Limited Partnership	**		(2,031,307)	6
7	V	43	Trust fees		Sambell of Streamwood Limited Partnership	**	100	100	7
8	V	43	Unrealized loss on interest rate swap		Sambell of Streamwood Limited Partnership	**	373,689	373,689	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			$ 2,031,307			$ 1,738,054	$ * (293,253)	14

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 391	$ 391	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	9,309	9,309	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	212	212	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	1,177	1,177	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	65,560	65,560	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	5,998	5,998	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	356	356	21
22	V	6	Security service		Royal Management Corp.	**			22
23	V	7	Management allocation - employee benefits		Royal Management Corp.	**	9,648	9,648	23
24	V	10	Medical consultant		Royal Management Corp.	**	3,984	3,984	24
25	V	10	Management allocation - salaries		Royal Management Corp.	**	62,167	62,167	25
26	V	15	Management allocation - employee benefits		Royal Management Corp.	**	9,149	9,149	26
27	V	17	Management allocation - salaries		Royal Management Corp.	**	28,665	28,665	27
28	V	19	Computer consultant & supplies		Royal Management Corp.	**	18,163	18,163	28
29	V	19	Professional fees		Royal Management Corp.	**	6,846	6,846	29
30	V	20	Dues & subscriptions		Royal Management Corp.	**	1,406	1,406	30
31	V	23	Inservice Training		Royal Management Corp.	**	1,706	1,706	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	6,360	6,360	32
33	V	21	Management allocation - salaries		Royal Management Corp.	**	596,040	596,040	33
34	V	21	Bank charges		Royal Management Corp.	**	11,402	11,402	34
35	V	21	Office supplies & printing		Royal Management Corp.	**	13,201	13,201	35
36	V	21	Postage		Royal Management Corp.	**	4,271	4,271	36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% or Royal Management Corp.						38
39	Total			$			$ 856,011	$ * 856,011	39

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Telephone	$	Royal Management Corp.	**	$ 12,350	$ 12,350	15
16	V	24	Travel & seminar		Royal Management Corp.	**	2,938	2,938	16
17	V	25	Auto expense		Royal Management Corp.	**	20,695	20,695	17
18	V	26	Insurance general		Royal Management Corp.	**	7,153	7,153	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	91,936	91,936	19
20	V	30	Depreciation		Royal Management Corp.	**	50,023	50,023	20
21	V	32	Interest		Royal Management Corp.	**	16,980	16,980	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	38	38	22
23	V	33	Property taxes		Royal Management Corp.	**	6,442	6,442	23
24	V	34	Rent expense		Royal Management Corp.	**	4,338	4,338	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,252	1,252	25
26	V	17	Management fees	1,479,424	Royal Management Corp.	**		(1,479,424)	26
27	V	35	Auto Lease Expense		Royal Management Corp.	**	2,248	2,248	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			$ 1,479,424			$ 216,393	$ * (1,263,031)	39

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	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 Health Care Center of Streamwoc # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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	$ 10,512	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	8,869	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,284	L17, C7	3
4	Daniel Thiem	Executive VP	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,053	L21, C7	4
5											5
6											6
7											7
8					Certain individuals work in excess of 40 hours per week						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,718		13

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	722,420	10	$ 3,612	$	78,110	$ 391	1
2	5	Utilities - gas & electric	Bed Days	722,420	10	86,099		78,110	9,309	2
3	5	Utilities - water & sewer	Bed Days	722,420	10	1,961		78,110	212	3
4	5	Utilities - maintenance office	Bed Days	722,420	10	10,885		78,110	1,177	4
5	6	Management allocation - salaries	Bed Days	722,420	10	606,344	606,344	78,110	65,560	5
6	6	Repairs & maintenance	Bed Days	722,420	10	55,471		78,110	5,998	6
7	6	Scavenger & exterminating	Bed Days	722,420	10	3,293		78,110	356	7
8	6	Security service	Bed Days	722,420	10			78,110	0	8
9	7	Management allocation - employee	Bed Days	722,420	10	89,234		78,110	9,648	9
10	10	Medical consultant	Bed Days	722,420	10	36,843		78,110	3,984	10
11	10	Management allocation - salaries	Bed Days	722,420	10	574,970	574,970	78,110	62,167	11
12	15	Management allocation - employee	Bed Days	722,420	10	84,616		78,110	9,149	12
13	17	Management allocation - salaries	Bed Days	722,420	10	265,116	265,116	78,110	28,665	13
14	19	Computer consultant & supplies	Bed Days	722,420	10	167,987		78,110	18,163	14
15	19	Professional fees	Bed Days	722,420	10	63,319		78,110	6,846	15
16	20	Dues & subscriptions	Bed Days	722,420	10	13,000		78,110	1,406	16
17	23	Inservice Training	Bed Days	722,420	10	15,778		78,110	1,706	17
18	20	Advertising - help wanted	Bed Days	722,420	10	58,818		78,110	6,360	18
19	21	Management allocation - salaries	Bed Days	722,420	10	5,512,623	5,512,623	78,110	596,040	19
20	21	Bank charges	Bed Days	722,420	10	105,454		78,110	11,402	20
21	21	Office supplies & printing	Bed Days	722,420	10	122,091		78,110	13,201	21
22	21	Postage	Bed Days	722,420	10	39,500		78,110	4,271	22
23	21	Telephone	Bed Days	722,420	10	114,221		78,110	12,350	23
24	24	Travel and Seminar	Bed Days	722,420	10	27,173		78,110	2,938	24
25	TOTALS					$ 8,058,408	$ 6,959,053		$ 871,299	25

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Royal Management Corp.
Street Address: 665 West 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	25	Auto expense	Bed Days	722,420	10	$ 191,407	$	78,110	$ 20,695	1
2	26	Insurance general	Bed Days	722,420	10	66,156		78,110	7,153	2
3	27	Management allocation - employee	Bed Days	722,420	10	850,290		78,110	91,936	3
4	30	Depreciation - leasehold improv.	Bed Days	722,420	10	462,650		78,110	50,023	4
5	32	Interest	Bed Days	722,420	10	157,045		78,110	16,980	5
6	32	Amortization of mortgage costs	Bed Days	722,420	10	354		78,110	38	6
7	33	Property taxes	Bed Days	722,420	10	59,576		78,110	6,442	7
8	34	Rent expense	Bed Days	722,420	10	40,122		78,110	4,338	8
9	35	Equipment rental	Bed Days	722,420	10	11,581		78,110	1,252	9
10	35	Auto lease	Bed Days	722,420	10	20,791		78,110	2,248	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,859,972	$		$ 201,105	25

Facility Name & ID Number Lexington Health Care Center of Streamwood # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C		X	Mortgage	Varies	5/22/08	6,734,000	6,270,075	1/1/33	Variable	379,700	2
3												3
4												4
5							Interest on financing insurance permium				1,005	5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	1,154,048	8,017,807	Demand	Prime +1	86,756	6
7	Bank of America		X	Working Capital	None	4/4/04	2,000,000	1,360,000	6/30/12	Prime/Libor	6,451	7
8												8
9	TOTAL Facility Related						$ 9,888,048	$ 15,647,882			$ 473,912	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			2,293	10
11								Interest income offset			(19,055)	11
12								Allocated from management company			17,018	12
13								Less: Shareholder interest			(86,756)	13
14	TOTAL Non-Facility Related						$	$			$ (86,500)	14
15	TOTALS (line 9+line14)						$ 9,888,048	$ 15,647,882			$ 387,412	15

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

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 379,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2010**	$ 492,260	2
3. Under or (over) accrual (line 2 minus line 1).		$ 113,060	3
	Allocated Mgmt. Co.	6,442	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 507,600	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.**		$ 34,625	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** $ 15,978 **For** 2008 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (15,978)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 645,749	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	443,467	8
	2007	492,792	9
	2008	500,084	10
	2009	368,079	11
	2010	492,260	12

See attached accrual worksheet

FOR BHF USE ONLY

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

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

TELEPHONE (630) 458-4700 FAX #: (630) 458-4796

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

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-25-300-006-0000	Land & Building	$ 492,259.93	$ 492,259.93
2.	Royal Management Corp(Samvest of Lombard II)		$	$
3.	05-01-202-019	Land & Building	$ 229,415.60	$ 6,442.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 721,675.53	$ 498,701.93

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization:
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	Allocated from Management Compnay		2002	22,035	2
3	TOTALS	30,000		$ 233,435	3

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	214		1991	1991	$ 5,248,322	$	35	$ 149,952	$ 149,952	$ 3,074,017	4
5			1993	1993	105,236		35	3,007	3,007	55,625	5
6			1995	1995	82,650	2,361	35	2,361		38,962	6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	7,336		35	210	210	3,879	9
10	Land Improvements			1995	7,000		15			7,000	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		5,455	11
12	Piping			1996	3,139	90	35	90		1,391	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		9,677	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	646	10	646		12,921	25
26	Rehab project: resident rooms, corridors, dining room			2001	212,217	10,611	20	10,611		111,415	26
27	Parking lot			2002	29,288	2,929	10	2,929		27,824	27
28	Office area rehab			2002	26,991	1,350	20	1,350		12,823	28
29	Elevator interior upgrade			2002	1,120	112	10	112		1,074	29
30	Gazebo			2002	3,393	339	10	339		3,222	30
31	Elevator electronic curtains			2002	4,500	450	10	450		4,463	31
32	Door frame protector			2003	5,276	528	10	528		4,706	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wirirng			2003	9,392	939	10	939		7,904	33
34	Roof			2003	29,950	1,498	20	1,498		12,107	34
35	Kitchen Sewer/Dishroom			2004	6,224	622	10	622		4,563	35
36	Compressor/tube bundles-cooling system			2004	14,737	737	20	737		5,404	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Kitchen fire protection upgrade	2004	$ 1,427	$ 143	10	$ 143	$	$ 1,107	37
38	Landscaping	2005	8,495	425	20	425		2,656	38
39	Kitchen renovation	2005	12,034	602	20	602		3,611	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		11,232	40
41	Therapy room renovation	2005	11,628	581	20	581		3,681	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		15,673	42
43	Dialysis units	2005	66,426	3,535	20	3,535		22,978	43
44	Create transitional unit	2005	14,490	725	20	725		4,349	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		2,071	45
46	Basement renovation	2005	46,561	2,328	20	2,328		14,356	46
47	Landscaping enhancement	2006	3,414	228	15	228		1,253	47
48	HVAC	2006	17,125	856	20	856		4,352	48
49	Door closer	2006	4,446	222	20	222		1,277	49
50	Blinds	2006	1,566	313	5	313		1,591	50
51	Employee lunch room rehab	2006	2,883	144	20	144		816	51
52	Storeroom door lock	2006	2,843	142	20	142		781	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		17,542	53
54	Fine dining	2006	7,650	382	20	382		2,134	54
55	Automatic door	2006	2,259	113	20	113		593	55
56	Landscaping	2007	10,606	530	20	530		2,164	56
57	Parking lot	2007	2,777	139	20	139		591	57
58	HVAC	2007	1,501	75	20	75		356	58
59	Painting Building	2007	16,150	808	20	808		3,568	59
60	Landscaping	2008	33,747	2,250	15	2,250		6,937	60
61	Common areas-metal doors	2008	7,055	353	20	353		1,324	61
62	Wanderguard	2008	3,882	194	20	194		776	62
63	Lawn Irrigation	2009	18,125	1,208	15	1,208		2,718	63
64	Landscaping	2009	3,138	209	15	209		557	64
65	Quick connectors	2009	9,375	469	20	469		1,251	65
66	1st floor admin office-heating,plumbing	2009	13,598	767	20	767		1,577	66
67	Fire alarm system	2009	5,271	264	20	264		528	67
68	Metal Doors-painting	2009	4,650	232	20	232		619	68
69	2nd Floor Remodel-carpentry	2009	33,503	838	40	838		2,304	69
70	TOTAL (lines 4 thru 69)		$ 6,491,737	$ 50,989		$ 204,158	$ 153,169	$ 3,681,883	70

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,491,737	$ 50,989		$ 204,158	$ 153,169	$ 3,681,883	1
2	Patio Pergola	2009	7,930	793	10	793		1,850	2
3	Landscaping	2010	5,785	386	15	386		579	3
4	HVAC Quick connectors, admin office	2010	15,373	561	27	561		626	4
5	Lockers and Pantry-plumbing, tile	2010	14,809	540	27	540		647	5
6	Director of Nursing office painting	2010	7,887	288	27	288		288	6
7	Ramp repair	2010	3,240	216	15	216		252	7
8	Library/Lounge update-art,flooring	2010	8,356	305	27	305		356	8
9	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	48,949	3,009	27	3,009		3,009	9
10	Office carpentry,flooring,electrical,painting,signs,HVAC	2011	4,714	100	27	100		100	10
11	Office-Doors, ADON, Locks	2011	26,169	159	27	159		159	11
12	HVAC Chiller	2011	95,360	1,445	27	1,445		1,445	12
13	Laundry Room-Painting, Tile	2011	7,686	116	27	116		116	13
14	2nd floor doors	2011	26,317	319	27	319		319	14
15									15
16									16
17	Reconcile to book depreciation			269			(269)		17
18									18
19									19
20									20
21									21
22									22
23	Real Estate Entity								23
24	1st floor remodel-Carpentry,flooring,electrical,painting	2008	531,230		27	19,317	19,317	77,269	24
25	2nd Floor Remodel-Carpentry,Flooring,Electrical,painting	2008	487,332		27	17,721	17,721	53,163	25
26	Remodel special care units-carpentry,electrical,painting	2008	32,914		27	1,197	1,197	3,591	26
27	3rd floor remodel-carpentry,flooring,electrical,painting	2009	667,142		27	24,260	24,260	64,693	27
28	Parking lot seal and stripe	2011	3,600		27	33	33	33	28
29	Remodel LL Flooring-Carpentry,flooring, electrical	2011	27,575		27	84	84	84	29
30	Kitchen holding tank	2011	11,665		27	353	353	353	30
31	Drain tile and pits	2011	8,000		27	97	97	97	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,533,770	$ 59,495		$ 275,457	$ 215,962	$ 3,890,912	34

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,533,770	$ 59,495		$ 275,457	$ 215,962	$ 3,890,912	1
2									2
3									3
4	Mgmt Co.								4
5									5
6	Building-management company	2002	304,917		40	8,847	8,847	89,944	6
7	HVAC, electrical, security system-management company	2003	2,678		30	507	507	1,559	7
8	Key card system-management company	2004	421		20	21	21	156	8
9	VAC TX controls-management company	2005	128		20	6	6	44	9
10	Build Imp-management company	2006	93		5	6	6	32	10
11	Building Improvement Management Co.	2008	14,775		5	756	756	3,054	11
12	Building Improvement Management Co.	2009	2,758		15	50	50	366	12
13	Building Improvement Management Co.	2010	2,688		15	108	108	278	13
14	Building Improvement Management Co.	2011	1,898		15	41	41	42	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,864,126	$ 59,495		$ 285,799	$ 226,304	$ 3,986,387	34

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,420,654	$ 109,381	$ 235,917	$ 126,536	5	$ 838,332	71
72	Current Year Purchases	218,251	14,785	14,785		5	14,785	72
73	Fully Depreciated Assets	64,558					64,558	73
74	Allocated from Mgmt Co.	355,211		34,707	34,707	5	276,938	74
75	TOTALS	$ 2,058,674	$ 124,166	$ 285,409	$ 161,243		$ 1,194,613	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.			49,970		4,974	4,974		38,716	79
80	TOTALS			$ 49,970	$	$ 4,974	$ 4,974		$ 38,716	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)	$ 11,206,205	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 183,661	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 576,182	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 392,521	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,219,716	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co.				4,338			6
7	TOTAL				$ 4,338 **			7

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

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

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 69,438 Description: Copier-$9,787;Mailing System-$183;Med Equp-$19,500;Oxygen-$37,230;Dietary-$1,486;Mgmt Co.-$1252
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	Allocated from Mgmt Co.			2,248	18
19					19
20					20
21	TOTAL		$	$ 2,248	21

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	9,705	$ 419,913	$	9,705	$ 419,913	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,781	208,569		3,781	208,569	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,121	606,980		9,121	606,980	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				582,513		582,513	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Ambulance	39(3)					6,199		6,199	13
14	TOTAL			$	22,607	$ 1,235,462	$ 588,712	22,607	$ 1,824,174	14

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

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (83,388)	$ (36,925)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 568,018)	3,398,947	3,398,947	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)		13,866	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,317,169	$ 3,377,498	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,884	67,884	12
13	Land		233,435	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,401,534	3,510,568	15
16	Equipment, at Historical Cost	932,543	2,108,644	16
17	Accumulated Depreciation (book methods)	(999,299)	(5,219,716)	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		49,046	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,402,662	$ 6,103,419	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,719,831	$ 9,480,917	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 522,824	$ 522,824	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	9,377,807	9,377,807	29
30	Accrued Salaries Payable	340,711	340,711	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,338	21,338	31
32	Accrued Real Estate Taxes(Sch.IX-B)		507,600	32
33	Accrued Interest Payable		26,747	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	9,361,500	2,609,057	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 19,624,180	$ 13,406,084	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,270,075	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)**	$	$ 6,270,075	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 19,624,180	$ 19,676,159	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (14,904,349)	$ (10,195,242)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,719,831	$ 9,480,917	48

*(See instructions.)

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/11-12/31/11

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other current liabilities

Description	Operating	After Consolidation
Due from LHCC Schaumburg		
Due from remodeling	13,866	13,866
Due to Lex Fin SVCS	452	452
Sambel Due from LLC 1		1,610
Interest rate swap		1,331,600
Escrow insurance	515,142	515,142
Accrued Expenses	55,093	55,093
Accrued Resident tax	175,757	175,757
Accrued Royl/Vesta MGMT	32,445	32,445
Due to patient trust fund	19,261	19,261
Accrued Rent	8,085,653	-
Accrued Insurance	120,149	120,149
Deferred Income	319,853	319,853
Due to/from LHCC Schaumburg	2,533	2,533
Due to-Royal Operations	47,065	47,065
Due to Republic Construction of Illinois, Inc	(7,589)	(7,589)
Advance biweekly Part A payments	(11,296)	(11,296)
Uncollectible Part A Co. Pvts	(49,112)	(49,112)
Prepaid Insurance	42,228	42,228
	9,361,500	2,609,057

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (12,798,642)	1
2	Restatements (describe):		2
3			3
4	Post closing adjustment	(187,450)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (12,986,092)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,916,492)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,765)	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)**	$ (1,918,257)	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)**	$ (14,904,349)	24 *

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 19,146,987	1
2	Discounts and Allowances for all Levels	(8,962,890)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,184,097	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,722,294	6
7	Oxygen	38,127	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,760,421	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	3,212	12
13	Barber and Beauty Care	22,404	13
14	Non-Patient Meals	4,301	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	508,724	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	163,536	19
20	Radiology and X-Ray		20
21	Other Medical Services	197,900	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 900,077	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,055	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,055	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,863,650	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,751,621	31
32	Health Care	6,721,957	32
33	General Administration	3,683,200	33
	B. Capital Expense		
34	Ownership	2,377,367	34
	C. Ancillary Expense		
35	Special Cost Centers	953,075	35
36	Provider Participation Fee	292,922	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,780,142	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,916,492)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,916,492)	43

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

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

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	857	1,143	$ 76,044	$ 66.53	1
2	Assistant Director of Nursing	21,099	27,537	1,007,606	36.59	2
3	Registered Nurses	20,064	24,644	760,155	30.85	3
4	Licensed Practical Nurses	49,925	50,324	1,276,129	25.36	4
5	CNAs & Orderlies	103,134	118,426	1,356,517	11.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,426	7,433	90,772	12.21	8
9	Activity Director					9
10	Activity Assistants	19,995	22,708	296,997	13.08	10
11	Social Service Workers	7,144	8,007	132,304	16.52	11
12	Dietician	1,012	1,090	19,626	18.01	12
13	Food Service Supervisor	1,942	2,184	42,790	19.59	13
14	Head Cook	1,724	1,933	35,367	18.30	14
15	Cook Helpers/Assistants	13,597	15,457	150,309	9.72	15
16	Dishwashers	16,213	18,169	154,653	8.51	16
17	Maintenance Workers	1,926	2,210	34,889	15.79	17
18	Housekeepers	33,991	39,521	367,091	9.29	18
19	Laundry	6,892	8,159	72,845	8.93	19
20	Administrator	1,258	1,482	107,846	72.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,310	13,875	239,410	17.25	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	1,930	2,235	32,827	14.69	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	3,295	3,787	151,470	40.00	33
34	TOTAL (lines 1 - 33)	322,734	370,324	$ 6,405,647 *	$ 17.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	435	$ 23,570	1(3)	35
36	Medical Director	Monthly	48,450	9(3)	36
37	Medical Records Consultant	27	1,605	10(3)	37
38	Nurse Consultant	62	23,588	10(3)	38
39	Pharmacist Consultant	Monthly	12,559	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	104	8,865	11(3)	44
45	Social Service Consultant	103	5,178	12(3)	45
46	Other(specify) Psychosocial	56	2,688	12(3)	46
47	Pulmonary	Monthly	30,225	10(3)	47
48	Medical Consultant	Monthly	3,984	10(7)	48
49	TOTAL (lines 35 - 48)	787	$ 160,712		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gina McCarthy	Administrator	0	$ 107,846
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,846

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 1,010,017
Management Fees-Vesta Mgmt.	406,395
Royal Capital MGMT Fees	63,012
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,479,424
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski Law Center, LLC	Collections	$ 1,837
Cassiday Schade LLP	Legal	74,926
Illinois Secretary of State	Filing Fees	100
Johnson and Bell LTD	Legal	1,171
McGladrey & Pullen, LLP	Accounting	34,856
Much Shelist	Legal	7,282
North Heron Insurance	Insurance Company	1,725
Personnel Planners	U/C Consulting	1,290
CT Corp	Legal	195
RealMed	Workers Compensation	76
RSM McGladrey	Accounting	5,938
See Schedule 21C		86,481
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 215,876

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 135,061
Unemployment Compensation Insurance	87,833
FICA Taxes	478,537
Employee Health Insurance	222,717
Employee Meals	17,730
Illinois Municipal Retirement Fund (IMRF)*	
401K	25,645
Other Employee Benefits	39,000
Tuition Reimbursement	4,253
Uniform Allowance	3,921
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,014,697

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,015
Advertising: Employee Recruitment	36,283
Health Care Worker Background Check	
(Indicate # of checks performed)	2,117
Patient Background Checks	4,127
Miscellaneous Licenses & Fees	2,308
Miscellaneous Dues & Subscriptions	1,648
Employment Fees	103,237
Less: Chamber of Commerce Dues & Mkt	(918)
Allocated from Mgmt Co.	7,766
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 160,583

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	0
Alloc. From Mgmt Co.	2,938
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,938

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Streamwood
FYE: 12/31/11
Professional Fees

Schedule 21C

XIX. Support Schedules

C. Professional Services

Vendor/Payee	Type	Amount
Pension Administrators	Pension Administration	828
Duane Morris	Legal	4,299
Ability Network	Computer Services	1052.32
Action Computer Service	Computer Services	1,211.31
ADI	Computer Services	1,021.46
Avtech Software	Computer Services	0.00
Brook Electric	Computer Services	27.15
BSKLIVE INC. (Staffknex)	Computer Services	1,054.80
Bridgepoint Technologies	Computer Services	0.00
Cimco Communications	Computer Services	0.00
Efax Corporate	Computer Services	2,105.26
E-Health Data Solutions	Computer Services	2,400.00
Elton Designs Inc	Computer Services	2,219.10
Facility Wizard	Computer Services	358.00
Information Control	Computer Services	1,335.81
Krakau Business	Computer Services	0.00
Kronos	Computer Services	1,400.00
Lanac Technology	Computer Services	0.00
Lintech L LC	Computer Services	5,049.86
Micro Center A/R	Computer Services	0.00
Microsoft Licensing	Computer Services	7,799.04
MNJ Technologies Direct	Computer Services	4,185.00
MY Innerview	Computer Services	1,848.00
National Datacare	Computer Services	2,467.80
Paragon Clinical	Computer Services	1,100.00
Question Pro	Computer Services	66.70
On Shift	Computer Services	3,967.60
Republic Construction	Computer Services	1,833.80
Right Now Technologies	Computer Services	8,927.40
Royal Mgmt Maintenance Labor	Computer Services	1,525.36
RSM McGladrey	Computer Services	0.00
SilverChair Learning Systems	Computer Services	8,610.00
Softchoice	Computer Services	2,377.75
SPM Marketing & Communications	Computer Services	0.00
Survey Analytics	Computer Services	300.00
Telemedicine Solutions	Computer Services	7,200.00
TouchPoint Care	Computer Services	0.00
Tympani	Computer Services	8,779.62
Vision Share, Inc.	Computer Services	84.51
Xclutel Communications	Computer Services	0.00
XO Communications	Computer Services	1,046.16
		86,481
Schedule V, line 19, column 3		215,876
Collection fees		(1,837)
Out of period legal		(128)
Sambell of Streamwood		
Secretary of State		200
Samvest of Lombard		
Legal		243
Accounting		263
Allocated from Mgmt Co.		
Katten, Muchin, Rosenman	Legal	453
Much Shelist	Legal	409
Laner Muchin	Legal	17
Seyfarth Shaw LLP	Legal	310
McGladrey & Pullen LLP	Accounting	1,542
Illinois Secretary of State	Filing Fees	42
LaSalle Network	Recruiting/Finance	1,895
Gilson Labus & Silverman	KEP	210
Pension Administrators, Inc.	401K Administration	292
Susan Parker	Social Service Consulting	32
M Werner Consulting	Financial Consultant	4
Christine Toolan	Social Service Consulting	7
Gene Whitehorn	Medicaid Reimb Specialist	1,127
Computer Services	Computer Consulting	18,163
Schedule V, line 19, column 8		239,120

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **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? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **51,392** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **292,922**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,730** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,033**

(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) 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.