		FOR BHF USE			

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 (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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	McGladrey LLP 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
	(Telephone)	(847) 517-7070 Fax # (847) 517-7067

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

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

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			13,243	13,243	8
9	SNF/PED					9
10	ICF	47,603	2,404		50,007	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,603	2,404	13,243	63,250	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.98%

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 10,359

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: 12/31/14 Fiscal Year: 12/31/14

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

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	445,523	37,712	3,286	486,521		486,521		486,521			1
2	Food Purchase		408,663		408,663		408,663	(21,294)	387,369			2
3	Housekeeping	359,185	40,907		400,092		400,092	280	400,372			3
4	Laundry	74,357	22,770		97,127		97,127		97,127			4
5	Heat and Other Utilities			283,246	283,246		283,246	8,377	291,623			5
6	Maintenance	34,983		200,900	235,883		235,883	70,382	306,265			6
7	Other (specify):* Alloc. From Mgmt Co							11,445	11,445			7
8	**TOTAL General Services**	914,048	510,052	487,432	1,911,532		1,911,532	69,190	1,980,722			8
	B. Health Care and Programs											
9	Medical Director			50,722	50,722		50,722		50,722			9
10	Nursing and Medical Records	4,849,014	397,023	152,688	5,398,725		5,398,725	50,193	5,448,918			10
10a	Therapy											10a
11	Activities	227,225	27,322	6,309	260,856		260,856		260,856			11
12	Social Services	122,612		4,297	126,909		126,909		126,909			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt Co							6,858	6,858			15
16	**TOTAL Health Care and Programs**	5,198,851	424,345	214,016	5,837,212		5,837,212	57,051	5,894,263			16
	C. General Administration											
17	Administrative	134,663		1,624,243	1,758,906		1,758,906	(1,565,749)	193,157			17
18	Directors Fees											18
19	Professional Services			366,426	366,426		366,426	12,711	379,137			19
20	Dues, Fees, Subscriptions & Promotions			155,277	155,277		155,277	4,329	159,606			20
21	Clerical & General Office Expenses	150,176	27,755	48,724	226,655		226,655	679,323	905,978			21
22	Employee Benefits & Payroll Taxes			1,189,848	1,189,848		1,189,848	19,902	1,209,750			22
23	Inservice Training & Education			8,152	8,152		8,152	843	8,995			23
24	Travel and Seminar							1,731	1,731			24
25	Other Admin. Staff Transportation			8,747	8,747		8,747	15,510	24,257			25
26	Insurance-Prop.Liab.Malpractice			460,817	460,817		460,817	11,373	472,190			26
27	Other (specify):* Alloc. From Mgmt Co							107,178	107,178			27
28	**TOTAL General Administration**	284,839	27,755	3,862,234	4,174,828		4,174,828	(712,849)	3,461,979			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,397,738	962,152	4,563,682	11,923,572		11,923,572	(586,608)	11,336,964			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 of Streamwood #0037002 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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			193,298	193,298		193,298	339,333	532,631			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			118,340	118,340		118,340	296,009	414,349			32
33	Real Estate Taxes							642,068	642,068			33
34	Rent-Facility & Grounds			2,026,303	2,026,303		2,026,303	(2,021,605)	4,698			34
35	Rent-Equipment & Vehicles			110,462	110,462		110,462	2,664	113,126			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,448,403	2,448,403		2,448,403	(741,531)	1,706,872			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		561,824	1,425,196	1,987,020		1,987,020		1,987,020			39
40	Barber and Beauty Shops	8,458		4,017	12,475		12,475		12,475			40
41	Coffee and Gift Shops			5,127	5,127		5,127		5,127			41
42	Provider Participation Fee			439,872	439,872		439,872		439,872			42
43	Other (specify):* Non-Allowable Cos	136,691		170,638	307,329		307,329	(307,329)				43
44	**TOTAL Special Cost Centers**	145,149	561,824	2,044,850	2,751,823		2,751,823	(307,329)	2,444,494			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,542,887	1,523,976	9,056,935	17,123,798		17,123,798	(1,635,468)	15,488,330			45

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

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(1,392)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,204)	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	85	30		9
10	Interest and Other Investment Income	(76,213)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,219)	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	(1,430)	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	(78,791)	43		24
25	Fund Raising, Advertising and Promotional	(27,282)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(464)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(52,455)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (256,365)		$	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)	(1,379,103)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,379,103)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,635,468)		37

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

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

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

Lexington of Streamwood

ID# 0037002

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (9,190)	43	1
2	Labs-Part A	(12,969)	43	2
3	X-Rays-Part A	(20,853)	43	3
4	Misc. Income	(571)	21	4
5	Collections	(3,691)	19	5
6	Out of period legal	(9,429)	19	6
7	Marketing Salary	(136,691)	43	7
8	Trust fees	(120)	43	8
9	Unrealized loss on FMV swap	157,896	43	9
10	Salesforce.com	(5,004)	19	10
11	Reclass Repairs & Maintenance	(11,550)	6	11
12	Disallow Lobbying	(283)	20	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**	(52,455)		49

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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	**	264,754	264,754	2
3	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	352,243	352,243	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	**	634,302	634,302	5
6	V	34	Rental expense	2,026,303	Sambell of Streamwood Limited Partnership	**		(2,026,303)	6
7	V	43	Trust fees		Sambell of Streamwood Limited Partnership	**	120	120	7
8	V	43	Unrealized loss on interest rate swap	159,132	Sambell of Streamwood Limited Partnership	**		(159,132)	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			$ 2,185,435			$ 1,253,912	$ * (931,523)	14

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

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	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.	**	$ 280	$ 280	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	7,304	7,304	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	327	327	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	746	746	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	75,297	75,297	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	6,600	6,600	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	35	35	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	11,445	11,445	22
23	V	10	Medical consultant		Royal Management Corp.	**	5,076	5,076	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	45,117	45,117	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	6,858	6,858	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	58,494	58,494	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	16,750	16,750	27
28	V	19	Professional fees		Royal Management Corp.	**	13,885	13,885	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	2,261	2,261	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	2,351	2,351	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	646,622	646,622	31
32	V	21	Bank charges		Royal Management Corp.	**	2,619	2,619	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	13,234	13,234	33
34	V	21	Postage		Royal Management Corp.	**	4,687	4,687	34
35	V	21	Telephone		Royal Management Corp.	**	12,732	12,732	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			$			$ 932,720	$ * 932,720	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: 01/01/14 Ending: 12/31/14

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	23	Inservice Training	$	Royal Management Corp.	**	$ 843	$ 843	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,731	1,731	16
17	V	25	Auto expense		Royal Management Corp.	**	15,510	15,510	17
18	V	26	Insurance general		Royal Management Corp.	**	11,373	11,373	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	107,178	107,178	19
20	V	30	Depreciation		Royal Management Corp.	**	74,494	74,494	20
21	V	32	Interest		Royal Management Corp.	**	15,094	15,094	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,592	2,592	22
23	V	33	Property taxes		Royal Management Corp.	**	7,766	7,766	23
24	V	34	Rent expense		Royal Management Corp.	**	4,698	4,698	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,514	1,514	25
26	V	17	Management fees	1,624,243	Royal Management Corp.	**		(1,624,243)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,150	1,150	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			$ 1,624,243			$ 243,943	$ * (1,380,300)	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: 01/01/14 Ending: 12/31/14

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		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	Bloomingdale	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					Corpotation			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: 01/01/14 Ending: 12/31/14

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	Bloomingdale	Real Estate	1
2					Bloomingdale 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: 01/01/14 Ending: 12/31/14

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	James Samatas	Owner/officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 10,273	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	7,486	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,379	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	12,189	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	19,167	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,494		13

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

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

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days Available	723,430	10	$ 2,591	$	78,110	$ 280	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,650		78,110	7,304	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	3,027		78,110	327	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	6,910		78,110	746	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	697,374	697,374	78,110	75,297	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	61,125		78,110	6,600	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	320		78,110	35	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	106,001		78,110	11,445	8
9	10	Medical consultant	Bed Days Available	723,430	10	47,016		78,110	5,076	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	417,860	417,860	78,110	45,117	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	63,515		78,110	6,858	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	541,757	541,757	78,110	58,494	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	155,132		78,110	16,750	13
14	19	Professional fees	Bed Days Available	723,430	10	128,599		78,110	13,885	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	20,945		78,110	2,261	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	21,776		78,110	2,351	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	5,988,811	5,988,811	78,110	646,622	17
18	21	Bank charges	Bed Days Available	723,430	10	24,252		78,110	2,619	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	122,570		78,110	13,234	19
20	21	Postage	Bed Days Available	723,430	10	43,413		78,110	4,687	20
21	21	Telephone	Bed Days Available	723,430	10	117,921		78,110	12,732	21
22										22
23										23
24										24
25	TOTALS					$ 8,638,565	$ 7,645,802		$ 932,720	25

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	23	Inservice Training	Bed Days Available	723,430	10	$ 7,807	$	78,110	$ 843	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	16,032		78,110	1,731	2
3	25	Auto expense	Bed Days Available	723,430	10	143,653		78,110	15,510	3
4	26	Insurance general	Bed Days Available	723,430	10	105,333		78,110	11,373	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	992,646		78,110	107,178	5
6	30	Depreciation	Bed Days Available	723,430	10	689,938		78,110	74,494	6
7	32	Interest	Bed Days Available	723,430	10	139,794		78,110	15,094	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	24,007		78,110	2,592	8
9	33	Property taxes	Bed Days Available	723,430	10	71,926		78,110	7,766	9
10	34	Rent expense	Bed Days Available	723,430	10	43,516		78,110	4,698	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,023		78,110	1,514	11
12	35	Auto Lease	Bed Days Available	723,430	10	10,648		78,110	1,150	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					$ 2,259,323	$		$ 243,943	25

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	5,734,525	1/1/33	Variable	352,243	2
3												3
4								Finance Charge - Insurance Policy			1,330	4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	1,154,048	9,116,970	Demand	Prime +1	75,198	6
7	Bank of America		X	Working Capital	None	9/30/14	13,700,000	1,756,000	9/30/15	Prime/Libor	41,812	7
8												8
9	TOTAL Facility Related						$ 21,588,048	$ 16,607,495			$ 470,583	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			4,885	10
11								Interest income offset			(1,015)	11
12								Less: Shareholder interest			(75,198)	12
13								Allocated from management company			15,094	13
14	TOTAL Non-Facility Related						$	$			$ (56,234)	14
15	TOTALS (line 9+line14)						$ 21,588,048	$ 16,607,495			$ 414,349	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 of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2013 report.		$ 596,400	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.)	2013	$ 584,433	2
3. Under or (over) accrual (line 2 minus line 1).		$ (11,967)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 650,400	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.)		$ 32,407	5
	Allocated from Managment Co.	7,766	
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 $ 36,538 For 03/11 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (36,538)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 642,068	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2009	368,079	8
2010	492,260	9
2011	478,154	10
2012	541,750	11
2013	584,433	12

See attached real estate accrual sheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Streamwood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-25-300-006-0000	Land & Building	$ 584,433.21	$ 584,433.21
2.	Royal Management Corp(Samvest of Lombard II)		$	$
3.	05-01-202-019	Land & Building	$ 282,411.22	$ 7,766.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 866,844.43	$ 592,199.21

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [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: 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	22,398	2
3	TOTALS	30,000		$ 233,798	3

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 3,523,873	4
5			1993	1993	105,236		35	3,007	3,007	64,646	5
6			1995	1995	82,650	2,361	35	2,361		46,045	6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	7,336		35	210	210	4,509	9
10	Land Improvements			1995	7,000		15			7,000	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		6,511	11
12	Piping			1996	3,139	90	35	90		1,661	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	733	15	733		12,012	19
20	Parking lot			2000	1,773		10			1,773	20
21	110-ton A/C unit			2000	6,923		10			6,922	21
22	Rods for bedside curtains			2000	5,872		10			5,872	22
23	Automatic doors			2000	1,300		10			1,300	23
24	Rehab project: carpeting, wallcovering, handrails, painting			2000	85,195		10			85,194	24
25	Compressor/tube bundles-cooling system			2001	12,921		10			12,921	25
26	Rehab project: resident rooms, corridors, dining room			2001	212,217	10,611	20	10,611		143,248	26
27	Parking lot			2002	29,288		10			29,288	27
28	Office area rehab			2002	26,991	1,350	20	1,350		16,873	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, wirirng			2003	9,392		10			9,392	33
34	Roof			2003	29,950	1,498	20	1,498		16,601	34
35	Kitchen Sewer/Dishroom			2004	6,224	417	10	417		6,224	35
36	Compressor/tube bundles-cooling system			2004	14,737	737	20	737		7,615	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: 01/01/14 Ending: 12/31/14

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	$ 34	10	$ 34	$	$ 1,427	37
38	Landscaping	2005	8,495	425	20	425		3,931	38
39	Kitchen renovation	2005	12,034	602	20	602		5,417	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		16,848	40
41	Therapy room renovation	2005	11,628	581	20	581		5,424	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		22,390	42
43	Dialysis units	2005	66,426	3,535	20	3,535		33,583	43
44	Create transitional unit	2005	14,490	725	20	725		6,524	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		2,959	45
46	Basement renovation	2005	46,561	2,328	20	2,328		21,340	46
47	Landscaping enhancement	2006	3,414	228	15	228		1,937	47
48	HVAC	2006	17,125	856	20	856		6,920	48
49	Door closer	2006	4,446	222	20	222		1,943	49
50	Blinds	2006	1,566		5			1,566	50
51	Employee lunch room rehab	2006	2,883	144	20	144		1,248	51
52	Storeroom door lock	2006	2,843	142	20	142		1,207	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		26,968	53
54	Fine dining	2006	7,650	382	20	382		3,280	54
55	Automatic door	2006	2,259	113	20	113		932	55
56	Landscaping	2007	10,606	530	20	530		3,754	56
57	Parking lot	2007	2,777	139	20	139		1,008	57
58	HVAC	2007	1,501	75	20	75		581	58
59	Painting Building	2007	16,150	808	20	808		5,992	59
60	Landscaping	2008	33,747	2,250	15	2,250		13,687	60
61	Common areas-metal doors	2008	7,055	353	20	353		2,383	61
62	Wanderguard	2008	3,882	194	20	194		1,358	62
63	Lawn Irrigation	2009	18,125	1,208	15	1,208		6,342	63
64	Landscaping	2009	3,138	209	15	209		1,184	64
65	Quick connectors	2009	9,375	469	20	469		2,658	65
66	1st floor admin office-heating,plumbing	2009	13,598	767	20	767		3,878	66
67	Fire alarm system	2009	5,271	264	20	264		1,320	67
68	Metal Doors-painting	2009	4,650	232	20	232		1,315	68
69	2nd Floor Remodel-carpentry	2009	33,503	838	40	838		4,818	69
70	TOTAL (lines 4 thru 69)		$ 6,491,737	$ 44,351		$ 197,520	$ 153,169	$ 4,278,958	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: 01/01/14 Ending: 12/31/14

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	$ 44,351		$ 197,520	$ 153,169	$ 4,278,958	1
2	Patio Pergola	2009	7,930	793	10	793		4,229	2
3	Landscaping	2010	5,785	386	15	386		1,737	3
4	HVAC Quick connectors, admin office	2010	15,373	561	27	561		2,309	4
5	Lockers and Pantry-plumbing, tile	2010	14,809	540	27	540		2,267	5
6	Director of Nursing office painting	2010	7,887	288	27	288		1,152	6
7	Ramp repair	2010	3,240	216	15	216		900	7
8	Library/Lounge update-art,flooring	2010	8,356	305	27	305		1,271	8
9	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	48,949	3,009	27	3,009		12,036	9
10	Office carpentry,flooring,electrical,painting,signs,HVAC	2011	4,714	171	27	171		613	10
11	Office-Doors, ADON, Locks	2011	26,169	952	27	952		3,015	11
12	HVAC Chiller	2011	95,360	3,468	27	3,468		11,849	12
13	Laundry Room-Painting, Tile	2011	7,686	279	27	279		953	13
14	2nd floor doors	2011	26,317	957	27	957		3,190	14
15									15
16	Install cast iron pipe sprinkler	2012	4,550	165	27	165		468	16
17	Shower room-tile-painting,plumbing	2012	87,763	3,191	27	3,191		6,648	17
18									18
19	Update Sprinkler Heads- Entire Facility	2013	28,070	1,021	27	1,021		1,531	19
20	EMR Building Wire- Entire Facility	2013	16,538	601	27	601		702	20
21									21
22	R/M Reclass: Intstallation of Kitchen Countertop	2014	2,800		15	93	93	93	22
23	R/M Reclass: Install Elevator Door Restrictor	2014	5,250		10	263	263	263	23
24	R/M Reclass: Cracked Pavement Sealing (Parking Lot)	2014	3,500		15	117	117	117	24
25									25
26									26
27									27
28									28
29									29
30	Reconcile to book depreciation			388			(388)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,912,783	$ 61,642		$ 214,895	$ 153,253	$ 4,334,300	34

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,912,783	$ 61,642		$ 214,895	$ 153,253	$ 4,334,300	1
2	Real Estate Entity								2
3	1st floor remodel-Carpentry,flooring,electrical,painting	2008	531,230		27	19,317	19,317	135,220	3
4	2nd Floor Remodel-Carpentry,Flooring,Electrical,painting	2008	487,333		27	17,721	17,721	106,327	4
5	Remodel special care units-carpentry,electrical,painting	2008	32,914		27	1,197	1,197	7,182	5
6	3rd floor remodel-carpentry,flooring,electrical,painting	2009	667,142		27	24,260	24,260	137,473	6
7	Parking lot seal and stripe	2011	3,600		27	131	131	426	7
8	Remodel LL Flooring-Carpentry,flooring, electrical	2011	27,575		27	1,003	1,003	3,093	8
9	Kitchen holding tank	2011	11,666		27	424	424	1,625	9
10	Drain tile and pits	2011	8,000		27	291	291	970	10
11									11
12									12
13	Mgmt Co.								13
14									14
15	Building-management company	2002	309,939		40	8,929	8,929	119,083	15
16	HVAC, electrical, security system-management company	2003	2,722		30	645	645	1,996	16
17	Key card system-management company	2004	428		20	21	21	223	17
18	VAC TX controls-management company	2005	130		20	6	6	64	18
19	Build Imp-management company	2006	95		5	6	6	52	19
20	Building Improvement Management Co.	2008	14,968		5	483	483	5,624	20
21	Building Improvement Management Co.	2009	2,781		15	50	50	825	21
22	Building Improvement Management Co.	2010	2,712		15	109	109	814	22
23	Building Improvement Management Co.	2011	1,929		15	87	87	313	23
24	Building Improvement Management Co.	2012	6,593		15	12	12	640	24
25	Building Improvement Management Co.	2013	5,035		15	355	355	464	25
26	Building Improvement Management Co.	2014	2,725		15	134	134	139	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,032,299	$ 61,642		$ 290,079	$ 228,437	$ 4,856,853	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: 01/01/14 Ending: 12/31/14

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	$ 1,171,389	$ 129,475	$ 176,717	$ 47,242	5	$ 694,282	71
72	Current Year Purchases	32,375	2,181	2,181		5	2,181	72
73	Fully Depreciated Assets	516,093				5	516,093	73
74	Allocated from Mgmt. Co.	528,597		59,627	59,627	5-7	340,238	74
75	TOTALS	$ 2,248,455	$ 131,656	$ 238,525	$ 106,869		$ 1,552,794	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.			56,071		4,027	4,027	5	49,053	79
80	TOTALS			$ 56,071	$	$ 4,027	$ 4,027		$ 49,053	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)	$ 11,570,623	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,298	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 532,631	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 339,333	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,458,700	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Company				4,698			6
7	TOTAL				$ 4,698 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 111,976 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			1,150	20
21	TOTAL		$	$ 1,150	21

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

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

Facility Name: **Lexington of Streamwood**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/14**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	7,449
Printer System	4,810
Postage	180
Equipment Rental	37,520
Oxygen	58,209
Dietary Equipment	2,294
Management Company Allocation	1,514
Total - Line 16	**111,976**

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	8,855	$ 436,267	$	8,855	$ 436,267	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		5,174	246,167		5,174	246,167	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		11,247	733,213		11,247	733,213	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				551,031		551,031	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				9,549			9,549	12
13	Other (specify): See Sch 16A	39(2)					10,793		10,793	13
14	TOTAL			$	25,276	$ 1,425,196	$ 561,824	25,276	$ 1,987,020	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 of Streamwood
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/14

Schedule 16A

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending:

	Service	1	2	3	4	5	6	7	
		Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	To (Col.
			Units of Service	Cost	Units	Cost			
1	Licensed Occupational Therapist		hrs	$		$	$		$
2	Licensed Speech and Language Development Therapist		hrs						
3	Licensed Recreational Therapist		hrs						
4	Licensed Physical Therapist		hrs						
5	Physician Care		visits						
6	Dental Care		visits						
7	Work Related Program		hrs						
8	Habilitation		hrs						
9	Pharmacy		# of prescrpts						
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						
11	Academic Education		hrs						
12	Other (specify): Oxygen	39(2)					9,482		
13	Other (specify): DME	39(2)					1,311		
14	TOTAL			$		$	$ 10,793		$

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.

8	
tal Cost 3 + 5 + 6)	
	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
9,482	12
1,311	13
10,793	14

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 589,199	$ 598,904	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 510,639)	3,453,343	3,453,343	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,485	41,465	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Insurance Receivable	206,289	206,289	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,254,316	$ 4,300,001	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,884	67,884	12
13	Land		233,798	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,534,822	3,678,741	15
16	Equipment, at Historical Cost	752,217	2,304,526	16
17	Accumulated Depreciation (book methods)	(1,269,990)	(6,458,700)	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		42,166	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,084,933	$ 5,221,973	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,339,249	$ 9,521,974	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 673,357	$ 673,357	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,872,970	10,872,970	29
30	Accrued Salaries Payable	483,366	483,366	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,635	22,635	31
32	Accrued Real Estate Taxes(Sch.IX-B)		650,400	32
33	Accrued Interest Payable		26,940	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	14,727,211	4,675,179	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 26,779,539	$ 17,404,847	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,734,525	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)**	$	$ 5,734,525	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 26,779,539	$ 23,139,372	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (21,440,290)	$ (13,617,398)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,339,249	$ 9,521,974	48

*(See instructions.)

Facility Name: Lexington of Streamwood
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/14

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Sambel Due From LLC 1	-	1,490
Due To/ From Republic Construction	(4,004)	(4,004)
Due To/ From Eastgate Manor	(2,360)	(2,360)
Prepaid Insurance	18,693	18,693
Escrow - Insurance	925,337	925,337
Accrued Expenses	126,826	126,826
Accrued Resident Tax	49,501	49,501
Accrued Royal / Vesta Mgmt Fees	2,226,934	2,226,934
Accrued Rent	10,800,634	
Accrued Insurance	37,267	37,267
Due To Patient Trust Fund	37,829	37,829
Advance - Biweekly Part A Paym	(15,093)	(15,093)
Uncollectible Part A Co Pvts	10,377	10,377
Due To - Royal Operations	2,077	2,077
Due To/ From Republic	(9,235)	(9,235)
Sambel Interest Rate Swap Liability	-	747,112
Professional Liabilities Claims	522,428	522,428
Total - Line 36	**14,727,211**	**4,675,179**
	-	-

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (19,580,468)	1
2	Restatements (describe):		2
3	Post closing adjustment	(291,721)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (19,872,189)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,568,101)	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)**	$ (1,568,101)	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)**	$ (21,440,290)	24 *

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

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 20,796,591	1
2	Discounts and Allowances for all Levels	(11,556,280)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,240,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,698,215	6
7	Oxygen	56,303	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,754,518	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	7,648	12
13	Barber and Beauty Care	15,799	13
14	Non-Patient Meals	1,392	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	789,355	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	215,778	19
20	Radiology and X-Ray	42,324	20
21	Other Medical Services	486,986	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,559,282	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,015	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,015	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	571	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 571	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,555,697	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,911,532	31
32	Health Care	5,837,212	32
33	General Administration	4,174,828	33
	B. Capital Expense		
34	Ownership	2,448,403	34
	C. Ancillary Expense		
35	Special Cost Centers	2,311,951	35
36	Provider Participation Fee	439,872	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,123,798	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,568,101)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,568,101)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,568,472	44
45	Private Pay - Net Inpatient Revenue	619,661	45
46	Medicare - Net Inpatient Revenue	814,194	46
47	Other-(specify) Managed Care	237,984	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,240,311	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 has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

^ - Entity is a cash basis tax payer.

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,745	2,136	$ 112,626	$ 52.73	1
2	Assistant Director of Nursing	31,078	37,078	1,012,697	27.31	2
3	Registered Nurses	20,089	25,352	764,174	30.14	3
4	Licensed Practical Nurses	40,252	50,558	1,330,019	26.31	4
5	CNAs & Orderlies	112,354	135,033	1,592,304	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,765	14,700	164,210	11.17	10
11	Social Service Workers	5,394	6,188	122,612	19.81	11
12	Dietician	1,917	2,206	49,370	22.38	12
13	Food Service Supervisor	1,880	2,092	51,969	24.84	13
14	Head Cook	1,933	2,132	36,785	17.25	14
15	Cook Helpers/Assistants	22,910	26,179	259,406	9.91	15
16	Dishwashers	4,941	5,521	47,993	8.69	16
17	Maintenance Workers	1,910	2,169	34,983	16.13	17
18	Housekeepers	30,149	36,052	359,185	9.96	18
19	Laundry	6,351	7,550	74,357	9.85	19
20	Administrator	1,594	2,326	134,663	57.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,028	10,065	150,176	14.92	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	1,828	2,188	37,194	17.00	31
32	Other Health Ca Memory Care	3,031	3,348	63,015	18.82	32
33	Other(specify) See Sch 20A	4,300	4,778	145,149	30.38	33
34	TOTAL (lines 1 - 33)	314,449	377,651	$ 6,542,887 *	$ 17.33	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		$		35
36	Medical Director	Monthly	50,722	9(3)	36
37	Medical Records Consultant	10	573	10(3)	37
38	Nurse Consultant	Monthly	45,872	10(3)	38
39	Pharmacist Consultant	Monthly	14,085	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	96	4,651	11(3)	44
45	Social Service Consultant	80	4,297	12(3)	45
46	Other(specify) Pulmonary	Monthly	92,158	10(3)	46
47	Medical Consultant	Monthly	5,076	10(7)	47
48					48
49	TOTAL (lines 35 - 48)	186	$ 217,434		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: Lexington of Streamwood
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/14

Schedule 20A

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Barber Beauty	692	769	8,458	$ 11.00
Marketing	3,608	4,009	136,691	$ 34.10
Total - Line 33 Other (specify):	**4,300**	**4,778**	**145,149**	**$ 30.38**

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kalsang Youtso	Administrator	0	$ 134,663
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 134,663

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 1,160,271
Management Fees-Vesta Mgmt.	463,972
Management Fees (Eliminated in Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,624,243

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Cassiday Schade LLP	Legal	$ 75,449
Generation Law	Legal	1,662
Grabowski Law Center, LLC	Collections	3,691
Duane Morris	Legal	490
Lexington Financial	Financial	8,480
McGladrey LLP	Accounting	36,458
Monahan Law Group	Legal	1,725
Personnel Planners	U/C Consulting	1,840
Much Shelist	Legal	22,349
Pension Administrators	401(k) Administration	795
Gilson Silverman and Labus	Accounting	1,135
See Schedule 21C	Various	212,352
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 366,426

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 211,591
Unemployment Compensation Insurance	77,865
FICA Taxes	494,652
Employee Health Insurance	327,281
Employee Meals	19,902
Illinois Municipal Retirement Fund (IMRF)*	
401K	26,208
Other Employee Benefits	38,029
Tuition Reimbursement	11,906
Uniform Allowance	2,316
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,209,750

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 1,990
Advertising: Employee Recruitment		20,472
Health Care Worker Background Check		
(Indicate # of checks performed	186)	2,226
Patient Background Checks	362	4,342
Miscellaneous Licenses & Fees		5,843
Miscellaneous Dues & Subscriptions		2,628
Employment Fees		117,039
IHCA		454
Management Company Allocation		4,612
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 159,606

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Management Company Allocation	
Entertainment Expense	1,731
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,731

**See instructions.

Facility Name: **Lexington of Streamwood**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/14**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Information Controls	Computer	5,398.25
Americorp Financial	Computer	129,304
Ability Network	Computer	1,513
Avalere Health	Computer	2,000
Citrix	Computer	348
Corepoint	Computer	945
E-Health Data Solutions	Computer	3,450
ILHIE	Computer	200
Information Controls	Computer	371
National Research	Computer	513
On Shift	Computer	7,912
Relias	Computer	8,041
Salesforce.com	Computer	5,004
Symbria	Computer	1,200
Tableau	Computer	1,716
Availity	Computer	139
Centino	Computer	750
Information Control	Computer	1,560
Lintech LLC	Computer	73
National Datacare	Computer	2,600
Tympani	Computer	385
Softchoice	Computer	2,106
Hpcommericial Repair	Computer	5
Information Control	Computer	341
Soft choice Corporation	Computer	449
Touch Point/Satisfaction Survey	Computer	235

WoundrRounds Care Management	Computer	1,800
MS Licensing	Computer	18,951
Soft choice Corporation	Computer	736
Health Medx	Computer	14,308
		212,352
	Total (agree to Schedule V, line 19, column 3)	366,426
Less: Non-Allowable Legal Fees		(13,120)
Less: Marketing Software		(5,004)
Allocated from Sambell		
Secretary of State	Filing Fees	200
Allocated from Management Company		
Much Shelist	Legal	173
Serpico, Petrosino, Dipiero & O'Shea, LTD	Legal	56
Duane Morris	Legal	298
McGladrey LLP	Accounting	1,560
Frost, Ruttenberg & Rothblatt, P.C	Accounting	108
Gilson Labus & Silverman	Accounting	1,148
Illinois Secretary of State	Filing Fees	42
LaSalle Network	Recruiting/Finance	5,747
Pension Administrators, Inc.	401K Administration	358
Gene Whitehorn	Medicaid Reimb Specialist	1,548
M. Werner Consulting	Financial Consultant	2,031
McNamara & Associates	SNF Consultants	297
Healthcents	Managed Care Consultants	394
Computer Services	Computer Consulting	16,750
Allocated from SV of Lombard II		
Gilson Labus & Silverman	Accounting	109
Illinois Secretary of State	Filing Fees	17
	Total (agree to Schedule V, line 19, column 8)	379,137

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/14 Ending: 12/31/14

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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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 of Streamwood** **# 0037002** **Report Period Beginning: 01/01/14** **Ending: 12/31/14**

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 - $454**

(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. $ **50,155** 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. $ **439,872**
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. $ **19,902** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,392**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) 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.