		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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2015 to 12/31/2015 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)	RSM US 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

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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			12,902	12,902	8
9	SNF/PED					9
10	ICF	46,751	1,380		48,131	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,751	1,380	12,902	61,033	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.14%

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 10,561

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Lexington of Streamwood # 0037002 **Report Period Beginning:** 1/01/2015 **Ending:** 12/31/2015

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	419,278	33,690	4,021	456,989		456,989		456,989			1
2	Food Purchase		414,700		414,700		414,700	(21,131)	393,569			2
3	Housekeeping	344,024	43,949		387,973		387,973	279	388,252			3
4	Laundry	77,487	23,776		101,263		101,263		101,263			4
5	Heat and Other Utilities			276,932	276,932		276,932	8,156	285,088			5
6	Maintenance	35,604		171,178	206,782		206,782	63,384	270,166			6
7	Other (specify):* Alloc. From Mgmt Co							10,743	10,743			7
8	**TOTAL General Services**	876,393	516,115	452,131	1,844,639		1,844,639	61,431	1,906,070			8
	B. Health Care and Programs											
9	Medical Director			43,213	43,213		43,213		43,213			9
10	Nursing and Medical Records	5,014,629	389,782	102,218	5,506,629		5,506,629	46,964	5,553,593			10
10a	Therapy											10a
11	Activities	197,788	24,054	8,211	230,053		230,053		230,053			11
12	Social Services	118,415		3,116	121,531		121,531		121,531			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. From Mgmt Co							5,926	5,926			15
16	**TOTAL Health Care and Programs**	5,330,832	413,836	156,758	5,901,426		5,901,426	52,890	5,954,316			16
	C. General Administration											
17	Administrative	140,884		1,722,236	1,863,120		1,863,120	(1,653,815)	209,305			17
18	Directors Fees											18
19	Professional Services			285,234	285,234		285,234	20,574	305,808			19
20	Dues, Fees, Subscriptions & Promotions			147,324	147,324		147,324	4,760	152,084			20
21	Clerical & General Office Expenses	200,574	28,507	43,295	272,376		272,376	695,672	968,048			21
22	Employee Benefits & Payroll Taxes			1,215,152	1,215,152		1,215,152	20,055	1,235,207			22
23	Inservice Training & Education			10,771	10,771		10,771	654	11,425			23
24	Travel and Seminar							1,423	1,423			24
25	Other Admin. Staff Transportation			5,862	5,862		5,862	13,668	19,530			25
26	Insurance-Prop.Liab.Malpractice			396,989	396,989		396,989	3,492	400,481			26
27	Other (specify):* Alloc. From Mgmt Co							106,542	106,542			27
28	**TOTAL General Administration**	341,458	28,507	3,826,863	4,196,828		4,196,828	(786,975)	3,409,853			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,548,683	958,458	4,435,752	11,942,893		11,942,893	(672,654)	11,270,239			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: 1/01/2015 Ending: 12/31/2015

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			179,570	179,570		179,570	372,936	552,506			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,497	127,497		127,497	324,524	452,021			32
33	Real Estate Taxes							574,009	574,009			33
34	Rent-Facility & Grounds			1,958,685	1,958,685		1,958,685	(1,953,970)	4,715			34
35	Rent-Equipment & Vehicles			97,999	97,999		97,999	2,759	100,758			35
36	Other (specify):*											36
37	TOTAL Ownership			2,363,751	2,363,751		2,363,751	(679,742)	1,684,009			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		610,806	1,539,943	2,150,749		2,150,749		2,150,749			39
40	Barber and Beauty Shops			16,075	16,075		16,075		16,075			40
41	Coffee and Gift Shops			3,738	3,738		3,738		3,738			41
42	Provider Participation Fee			417,418	417,418		417,418		417,418			42
43	Other (specify):* Non-Allowable Cos	94,196		199,434	293,630		293,630	(293,630)				43
44	TOTAL Special Cost Centers	94,196	610,806	2,176,608	2,881,610		2,881,610	(293,630)	2,587,980			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,642,879	1,569,264	8,976,111	17,188,254		17,188,254	(1,646,026)	15,542,228			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: 1/01/2015 Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,076)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,699)	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	1,412	30		9
10	Interest and Other Investment Income	(47,235)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10,329)	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	(23,498)	43		18
19	Entertainment				19
20	Contributions	(3,000)	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	(76,777)	43		24
25	Fund Raising, Advertising and Promotional	(32,518)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(472)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	44,216	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (157,976)		$	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)	(1,488,050)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,488,050)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,646,026)		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: 1/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (6,014)	43	1
2	Labs-Part A	(13,532)	43	2
3	X-Rays-Part A	(24,570)	43	3
4	Dues and Subscriptions Marketing	(25)	20	4
5	Collections	(3,352)	19	5
6	Out of period legal	(3,263)	19	6
7	Marketing Salary	(94,196)	43	7
8	Trust fees	(50)	43	8
9	Unrealized loss on FMV swap	215,289	43	9
10	Salesforce.com	(7,043)	19	10
11	Reclass Repairs & Maintenance	(18,951)	6	11
12	Disallow Lobbying	(77)	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**	44,216		49

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Sambell of Streamwood Limited Partnership	**	$ 2,800	$ 2,800	1
2	V	30	Depreciation		Sambell of Streamwood Limited Partnership	**	261,865	261,865	2
3	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	350,062	350,062	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	**	566,685	566,685	5
6	V	34	Rental expense	1,958,685	Sambell of Streamwood Limited Partnership	**		(1,958,685)	6
7	V	43	Trust fees		Sambell of Streamwood Limited Partnership	**	50	50	7
8	V	43	Unrealized loss on interest rate swap	215,289	Sambell of Streamwood Limited Partnership	**		(215,289)	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			$ 2,173,974			$ 1,183,755	$ * (990,219)	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: 1/01/2015 Ending: 12/31/2015

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.	**	$ 279	$ 279	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	7,252	7,252	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	300	300	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	604	604	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	74,281	74,281	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	7,742	7,742	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	312	312	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	10,743	10,743	22
23	V	10	Medical consultant		Royal Management Corp.	**	5,990	5,990	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	40,974	40,974	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	5,926	5,926	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	68,421	68,421	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	18,778	18,778	27
28	V	19	Professional fees		Royal Management Corp.	**	12,654	12,654	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	2,373	2,373	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	2,464	2,464	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	668,250	668,250	31
32	V	21	Bank charges		Royal Management Corp.	**	2,389	2,389	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	9,583	9,583	33
34	V	21	Postage		Royal Management Corp.	**	4,289	4,289	34
35	V	21	Telephone		Royal Management Corp.	**	11,161	11,161	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			$			$ 954,765	$ * 954,765	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: 1/01/2015 Ending: 12/31/2015

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.	**	$ 654	$ 654	15
16	V	24	Travel & seminar		Royal Management Corp.	**	1,423	1,423	16
17	V	25	Auto expense		Royal Management Corp.	**	13,668	13,668	17
18	V	26	Insurance general		Royal Management Corp.	**	3,492	3,492	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	106,542	106,542	19
20	V	30	Depreciation		Royal Management Corp.	**	109,659	109,659	20
21	V	32	Interest		Royal Management Corp.	**	17,201	17,201	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,203	2,203	22
23	V	33	Property taxes		Royal Management Corp.	**	7,324	7,324	23
24	V	34	Rent expense		Royal Management Corp.	**	4,715	4,715	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,562	1,562	25
26	V	17	Management fees	1,722,236	Royal Management Corp.	**		(1,722,236)	26
27	V	35	Auto Lease		Royal Management Corp.	**	1,197	1,197	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			$ 1,722,236			$ 269,640	$ * (1,452,596)	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: 1/01/2015 Ending: 12/31/2015

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	Streamwood	Real Estate	10
11					Streamwood Ltd. Ptsp		Property	11
12					Royal Management	Lombard	Mgmt. Company	12
13					Corporation			13
14					Lexington Financial	Lombard	Finance Company	14
15					Services, LLC			15
16					Heron Point Mgmt.	Lombard	Mgmt. Company	16
17					Corportation			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: 1/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					North Heron	Lombard	Finance Company	1
2					Investments, LLC			2
3								3
4					Lexington Home	Lombard	Home Health	4
5					Health Care, Inc.			5
6								6
7					Lexington Hospice	Lombard	Hospice	7
8					Services, LLC			8
9								9
10					Lexington Private	Lombard	Healthcare	10
11					Home Care			11
12								12
13					Merit Sleep	Lombard	Management	13
14					Management, LLC		Company	14
15								15
16					Merit Sleep	Lombard	Management	16
17					Management, LLC		Company	17
18								18
19					Samvest of	Algonquin	Real Estate	19
20					Algonquin Ltd. Ptsp		Property	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: 1/01/2015 Ending: 12/31/2015

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. Pts		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: 1/01/2015 Ending: 12/31/2015

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	$ 9,890	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,930	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,241	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	17,278	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	24,682	L17, C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 68,021		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: 1/01/2015 Ending: 2/31/2015

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	$ 2,585	$ 0	78,110	$ 279	1
2	5	Utilities - gas & electric	Bed Days Available	723,430	10	67,169	0	78,110	7,252	2
3	5	Utilities - water & sewer	Bed Days Available	723,430	10	2,778	0	78,110	300	3
4	5	Utilities - maintenance office	Bed Days Available	723,430	10	5,597	0	78,110	604	4
5	6	Management allocation - salaries	Bed Days Available	723,430	10	687,966	687,966	78,110	74,281	5
6	6	Repairs & maintenance	Bed Days Available	723,430	10	71,704	0	78,110	7,742	6
7	6	Scavenger & exterminating	Bed Days Available	723,430	10	2,893	0	78,110	312	7
8	7	Management allocation - employe	Bed Days Available	723,430	10	99,498	0	78,110	10,743	8
9	10	Medical consultant	Bed Days Available	723,430	10	55,482	0	78,110	5,990	9
10	10	Management allocation - salaries	Bed Days Available	723,430	10	379,485	379,485	78,110	40,974	10
11	15	Management allocation - employe	Bed Days Available	723,430	10	54,884	0	78,110	5,926	11
12	17	Management allocation - salaries	Bed Days Available	723,430	10	633,695	633,695	78,110	68,421	12
13	19	Computer consultant & supplies	Bed Days Available	723,430	10	173,912	0	78,110	18,778	13
14	19	Professional fees	Bed Days Available	723,430	10	117,198	0	78,110	12,654	14
15	20	Dues & subscriptions	Bed Days Available	723,430	10	21,979	0	78,110	2,373	15
16	20	Advertising - help wanted	Bed Days Available	723,430	10	22,821	0	78,110	2,464	16
17	21	Management allocation - salaries	Bed Days Available	723,430	10	6,189,117	6,189,117	78,110	668,250	17
18	21	Bank charges	Bed Days Available	723,430	10	22,129	0	78,110	2,389	18
19	21	Office supplies & printing	Bed Days Available	723,430	10	88,755	0	78,110	9,583	19
20	21	Postage	Bed Days Available	723,430	10	39,720	0	78,110	4,289	20
21	21	Telephone	Bed Days Available	723,430	10	103,369	0	78,110	11,161	21
22										22
23										23
24										24
25	TOTALS					$ 8,842,736	$ 7,890,263		$ 954,765	25

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 2/31/2015

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	23	Inservice Training	Bed Days Available	723,430	10	$ 6,055	$	78,110	$ 654	1
2	24	Travel and Seminar	Bed Days Available	723,430	10	13,182		78,110	1,423	2
3	25	Auto expense	Bed Days Available	723,430	10	126,592		78,110	13,668	3
4	26	Insurance general	Bed Days Available	723,430	10	32,340		78,110	3,492	4
5	27	Management allocation - employe	Bed Days Available	723,430	10	986,762		78,110	106,542	5
6	30	Depreciation	Bed Days Available	723,430	10	1,015,630		78,110	109,659	6
7	32	Interest	Bed Days Available	723,430	10	159,306		78,110	17,201	7
8	32	Amortization of mortgage costs	Bed Days Available	723,430	10	20,406		78,110	2,203	8
9	33	Property taxes	Bed Days Available	723,430	10	67,835		78,110	7,324	9
10	34	Rent expense	Bed Days Available	723,430	10	43,669		78,110	4,715	10
11	35	Equipment rental	Bed Days Available	723,430	10	14,465		78,110	1,562	11
12	35	Auto Lease	Bed Days Available	723,430	10	11,086		78,110	1,197	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					$ 2,497,328	$		$ 269,640	25

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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	5,547,023	1/1/33	Variable	350,062	2
3												3
4								Finance Charge - Insurance Policy			2,104	4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	1,154,048	9,159,205	Demand	Prime +1	76,835	6
7	Bank of America		X	Working Capital	None	9/30/14	13,700,000	1,806,000	9/30/16	Prime/Libor	48,558	7
8												8
9	TOTAL Facility Related						$ 21,588,048	$ 16,512,228			$ 477,559	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			4,496	10
11								Interest income offset			(2,896)	11
12								Allocated from management company			17,201	12
13								See Sch 9A			(44,339)	13
14	TOTAL Non-Facility Related						$	$			$ (25,538)	14
15	TOTALS (line 9+line14)						$ 21,588,048	$ 16,512,228			$ 452,021	15

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

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

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

Facility Name: Lexington of Streamwood
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/2015

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$0.00		$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10								Non Allowable Shareholder Interest			(42,235)	10
11								Non Allowable Finance Charge			(2,104)	11
12												12
13												13
14	TOTAL Non-Facility Related				$0.00		$ 0	$ 0			$ (44,339)	14

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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.

Line	Description		Amount	Line
1	1. Real Estate Tax accrual used on 2014 report.		$ 650,400	1
2	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.)	2014	$ 603,107	2
3	3. Under or (over) accrual (line 2 minus line 1).		$ (47,293)	3
4	4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 621,600	4
5	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.)**		$ 33,757	5
		Allocated from Managment Co.	7,324	
6	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** $ 41,379 **For** 12 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (41,379)	6
7	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 574,009	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2010	492,260	8
2011	478,154	9
2012	541,750	10
2013	584,433	11
2014	603,107	12

See attached real estate accrual sheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.**

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-25-300-006-0000	Land & Building	$ 603,107.00	$ 603,107.00
2.	Royal Management Corp(Samvest of		$	$
3.	05-01-202-019	Land & Building	$ 290,524.00	$ 7,324.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 893,631.00	$ 610,431.00

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1991	$ 211,400	1
2	Management Company Allocation		2002	22,156	2
3	TOTALS	30,000		$ 233,556	3

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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	$ 3,673,825	4
5			1993	1993	105,236		35	3,007	3,007	67,653	5
6			1995	1995	82,650	2,361	35	2,361		48,406	6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	7,336		35	210	210	4,719	9
10	Land Improvements			1995	7,000		15			7,000	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		6,863	11
12	Piping			1996	3,139	90	35	90		1,751	12
13	Basement remodeling			1997	20,204		10			20,204	13
14	Floor repairs			1997	555		10			555	14
15	Corner Guards			1997	998		10			998	15
16	Corner Guards			1998	3,563		10			3,563	16
17	Wiring			1998	2,050		10			2,050	17
18	Tile			1998	11,697		10			11,697	18
19	Patio			1999	12,012		15			12,012	19
20	Parking lot			2000	1,773		10			1,773	20
21	110-ton A/C unit			2000	6,923		10			6,922	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		153,859	26
27	Parking lot			2002	29,288		10			29,288	27
28	Office area rehab			2002	26,991	1,350	20	1,350		18,223	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		18,099	34
35	Kitchen Sewer/Dishroom			2004	6,224		10			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: 1/01/2015 Ending: 12/31/2015

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	$	10	$	$	$ 1,427	37
38	Landscaping	2005	8,495	425	20	425		4,356	38
39	Kitchen renovation	2005	12,034	602	20	602		6,019	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		18,720	40
41	Therapy room renovation	2005	11,628	581	20	581		6,005	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		24,629	42
43	Dialysis units	2005	66,426	3,535	20	3,535		37,118	43
44	Create transitional unit	2005	14,490	725	20	725		7,249	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		3,255	45
46	Basement renovation	2005	46,561	2,328	20	2,328		23,668	46
47	Landscaping enhancement	2006	3,414	228	15	228		2,165	47
48	HVAC	2006	17,125	856	20	856		7,776	48
49	Door closer	2006	4,446	222	20	222		2,165	49
50	Blinds	2006	1,566		5			1,566	50
51	Employee lunch room rehab	2006	2,883	144	20	144		1,392	51
52	Storeroom door lock	2006	2,843	142	20	142		1,349	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		30,110	53
54	Fine dining	2006	7,650	382	20	382		3,662	54
55	Automatic door	2006	2,259	113	20	113		1,045	55
56	Landscaping	2007	10,606	530	20	530		4,284	56
57	Parking lot	2007	2,777	139	20	139		1,147	57
58	HVAC	2007	1,501	75	20	75		656	58
59	Painting Building	2007	16,150	808	20	808		6,800	59
60	Landscaping	2008	33,747	2,250	15	2,250		15,937	60
61	Common areas-metal doors	2008	7,055	353	20	353		2,736	61
62	Wanderguard	2008	3,882	194	20	194		1,552	62
63	Lawn Irrigation	2009	18,125	1,208	15	1,208		7,550	63
64	Landscaping	2009	3,138	209	15	209		1,393	64
65	Quick connectors	2009	9,375	469	20	469		3,127	65
66	1st floor admin office-heating,plumbing	2009	13,598	767	20	767		4,645	66
67	Fire alarm system	2009	5,271	264	20	264		1,584	67
68	Metal Doors-painting	2009	4,650	232	20	232		1,547	68
69	2nd Floor Remodel-carpentry	2009	33,503	838	40	838		5,656	69
70	TOTAL (lines 4 thru 69)		$ 6,491,737	$ 43,167		$ 196,336	$ 153,169	$ 4,474,557	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: 1/01/2015 Ending: 12/31/2015

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	$ 43,167		$ 196,336	$ 153,169	$ 4,474,557	1
2	Patio Pergola	2009	7,930	793	10	793		5,022	2
3	Landscaping	2010	5,785	386	15	386		2,123	3
4	HVAC Quick connectors, admin office	2010	15,373	561	27	561		2,870	4
5	Lockers and Pantry-plumbing, tile	2010	14,809	540	27	540		2,807	5
6	Director of Nursing office painting	2010	7,887	288	27	288		1,440	6
7	Ramp repair	2010	3,240	216	15	216		1,116	7
8	Library/Lounge update-art,flooring	2010	8,356	305	27	305		1,576	8
9	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	48,949	3,009	27	3,009		15,045	9
10	Office carpentry,flooring,electrical,painting,signs,HVAC	2011	4,714	171	27	171		784	10
11	Office-Doors, ADON, Locks	2011	26,169	952	27	952		3,967	11
12	HVAC Chiller	2011	95,360	3,468	27	3,468		15,317	12
13	Laundry Room-Painting, Tile	2011	7,686	279	27	279		1,232	13
14	2nd floor doors	2011	26,317	957	27	957		4,147	14
15									15
16	Install cast iron pipe sprinkler	2012	4,550	165	27	165		633	16
17	Shower room-tile-painting,plumbing	2012	87,763	3,191	27	3,191		9,839	17
18									18
19	Update Sprinkler Heads- Entire Facility	2013	28,070	1,021	27	1,021		2,552	19
20	EMR Building Wire- Entire Facility	2013	16,538	601	27	601		1,303	20
21									21
22	R/M Reclass: Intstallation of Kitchen Countertop	2014	2,800		15	187	187	280	22
23	R/M Reclass: Install Elevator Door Restrictor	2014	5,250		10	525	525	788	23
24	R/M Reclass: Cracked Pavement Sealing (Parking Lot)	2014	3,500		15	233	233	350	24
25									25
26	R/M Reclass: Decorating and Tiling- Service entrance ramp doors	2015	3,328		15	111	111	111	26
27	R/M Reclass: Cast iron piping and concrete bottom loading ramp	2015	4,825		20	121	121	121	27
28	R/M Reclass: Paving on outside parking lot	2015	4,600		20	115	115	115	28
29	R/M Reclass: Replace four sprinkler heads in outside canopy	2015	2,663		20	67	67	67	29
30	R/M Reclass: Cut out bad turf along curb of back driveway	2015	3,535		15	118	118	118	30
31	Update Shower Room in Facility	2015	6,100	55	27	55		55	31
32	EMR Building Wire- Entire Facility	2015	3,472	74	27	74		74	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,941,306	$ 60,199		$ 214,845	$ 154,646	$ 4,548,409	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: 1/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,941,306	$ 60,199		$ 214,845	$ 154,646	$ 4,548,409	1
2	Real Estate Entity								2
3	1st floor remodel-Carpentry,flooring,electrical,painting	2008	531,230		27	19,317	19,317	154,537	3
4	2nd Floor Remodel-Carpentry,Flooring,Electrical,painting	2008	487,333		27	17,721	17,721	124,048	4
5	Remodel special care units-carpentry,electrical,painting	2008	32,914		27	1,197	1,197	8,379	5
6	3rd floor remodel-carpentry,flooring,electrical,painting	2009	667,142		27	24,260	24,260	161,733	6
7	Parking lot seal and stripe	2011	3,600		27	131	131	557	7
8	Remodel LL Flooring-Carpentry,flooring, electrical	2011	27,575		27	1,003	1,003	4,096	8
9	Kitchen holding tank	2011	11,666		27	424	424	2,049	9
10	Drain tile and pits	2011	8,000		27	291	291	1,261	10
11									11
12									12
13	Mgmt Co.								13
14									14
15	Building-management company	2002	306,589		40	8,777	8,777	126,916	15
16	HVAC, electrical, security system-management company	2003	2,693		30	624	624	2,057	16
17	Key card system-management company	2004	423		20	20	20	242	17
18	VAC TX controls-management company	2005	129		20	6	6	70	18
19	Build Imp-management company	2006	94		20	6	6	57	19
20	Building Improvement Management Co.	2008	14,857		20	396	396	6,157	20
21	Building Improvement Management Co.	2009	2,773		20	49	49	975	21
22	Building Improvement Management Co.	2010	2,703		20	48	48	923	22
23	Building Improvement Management Co.	2011	1,908		20	86	86	399	23
24	Building Improvement Management Co.	2012	6,591		20	12	12	882	24
25	Building Improvement Management Co.	2013	4,981		20	349	349	822	25
26	Building Improvement Management Co.	2014	2,695		20	259	259	407	26
27	Building Improvement Management Co.	2015	474		20	28	28	29	27
28									28
29									29
30	Reconcile to book depreciation			68			(68)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,057,675	$ 60,267		$ 289,851	$ 229,584	$ 5,145,007	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: 1/01/2015 Ending: 12/31/2015

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	$ 1,082,907	$ 113,832	$ 158,187	$ 44,355	5	$ 929,098	71
72	Current Year Purchases	56,935	5,471	5,471		5	5,471	72
73	Fully Depreciated Assets	441,643				5	441,643	73
74	Allocated from Mgmt. Co.	625,907		96,092	96,092	5-7	441,110	74
75	TOTALS	$ 2,207,393	$ 119,303	$ 259,750	$ 140,447		$ 1,817,323	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		2,905	2,905	5	50,378	79
80	TOTALS			$ 56,071	$	$ 2,905	$ 2,905		$ 50,378	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)	$ 11,554,694	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,570	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 552,506	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 372,936	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,012,708	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: 1/01/2015 Ending: 12/31/2015

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				4,715			6
7	TOTAL				$ 4,715 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 99,561 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			1,197	20
21	TOTAL		$	$ 1,197	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: **12/31/2015**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	6,985
Printer System	693
Postage	6,242
Equipment Rental	26,280
Oxygen	55,703
Dietary Equipment	2,096
Management Company Allocation	1,562
Total - Line 16	**99,561**

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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	$	10,002	$ 511,742	$	10,002	$ 511,742	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		6,190	238,081		6,190	238,081	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		16,661	781,103		16,661	781,103	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				581,965		581,965	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				9,017			9,017	12
13	Other (specify): See Sch 16A	39(2)					28,841		28,841	13
14	TOTAL			$	32,853	$ 1,539,943	$ 610,806	32,853	$ 2,150,749	14

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

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

Schedule 16A

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/01/2015 Ending:

		1	2	3	4	5	6	7	
	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)	To (Col.
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)					10,345		
13	Other (specify): DME	39(2)					18,496		
14	TOTAL			$		$	$ 28,841		$

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
10,345	12
18,496	13
28,841	14

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (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	$ 863,562	$ 918,626	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (410,113))	3,119,938	3,119,938	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,742	6,742	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Insurance Receivable	269,919	269,919	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,260,161	$ 4,315,225	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,884	67,884	12
13	Land		233,556	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,539,118	3,704,117	15
16	Equipment, at Historical Cost	787,849	2,263,464	16
17	Accumulated Depreciation (book methods)	(1,420,303)	(7,012,708)	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 (spe			22
23	Other(specify): Mortgage cost, net		39,873	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 974,548	$ 4,649,744	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,234,709	$ 8,964,969	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 570,516	$ 570,516	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,965,205	10,965,205	29
30	Accrued Salaries Payable	498,772	498,772	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,933	24,933	31
32	Accrued Real Estate Taxes(Sch.IX-B)		621,600	32
33	Accrued Interest Payable		27,766	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	15,829,239	4,747,686	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 27,888,665	$ 17,456,478	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,547,023	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)**	$	$ 5,547,023	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 27,888,665	$ 23,003,501	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (22,653,956)	$ (14,038,532)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,234,709	$ 8,964,969	48

*(See instructions.)

Facility Name: **Lexington of Streamwood**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/2015**

Schedule 17A

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

Description	Operating	After Consolidation
Rent Receivable	-	(11,614,821)
Due to/from Republic Construction	-	-
Due to/from Eastgate Manor	-	-
Due from LLC 1	-	1,445
Prepaid Insurance	20,491	20,491
Escrow - Insurance	712,531	712,531
401K Withholding	(190)	(190)
Accrued Expenses	43,899	43,899
Accrued Resident Tax	49,155	49,155
Accrued Royl/Vesta Mgmt Fees	2,917,155	2,917,155
Accrued Rent	11,614,821	11,614,821
Accrued Insurance	16,426	16,426
Due to Patient Trust Fund	6,589	6,589
Advance - Biweekly Part A Payment	(135,635)	(135,635)
Uncollectible Part A Co Pvts	(17,867)	(17,867)
Due to - Royal Operations	8,597	8,597
Due to/from Republic	43	43
Due to/from Vesta Mgmt	6,924	6,924
Interest Rate Swap Liability	-	531,823
Professional Liabilities Claims	586,300	586,300
Total - Line 36	**15,829,239**	**4,747,686**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (20,962,633)	1
2	Restatements (describe):		2
3	Post closing adjustment	(598,417)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (21,561,050)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,092,906)	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)**	$ (1,092,906)	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)**	$ (22,653,956)	24 *

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

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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	$ 24,153,124	1
2	Discounts and Allowances for all Levels	(14,778,026)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,375,098	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,118,837	6
7	Oxygen	54,890	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,173,727	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	4,233	12
13	Barber and Beauty Care	19,774	13
14	Non-Patient Meals	1,076	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	825,660	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	239,500	19
20	Radiology and X-Ray	34,954	20
21	Other Medical Services	418,430	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 1,543,627	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,896	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,896	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)**	$ 16,095,348	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,844,639	31
32	Health Care	5,901,426	32
33	General Administration	4,196,828	33
	B. Capital Expense		
34	Ownership	2,363,751	34
	C. Ancillary Expense		
35	Special Cost Centers	2,464,192	35
36	Provider Participation Fee	417,418	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,188,254	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,092,906)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,092,906)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,826,726	44
45	Private Pay - Net Inpatient Revenue	363,929	45
46	Medicare - Net Inpatient Revenue	969,777	46
47	Other-(specify) **Managed Care**	214,666	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,375,098	49

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

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

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

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

^ - Entity is a cash basis taxpayer

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,778	2,285	$ 119,241	$ 52.18	1
2	Assistant Director of Nursing	29,945	36,845	989,270	26.85	2
3	Registered Nurses	20,225	26,805	817,523	30.50	3
4	Licensed Practical Nurses	35,867	46,343	1,239,387	26.74	4
5	CNAs & Orderlies	111,955	138,979	1,810,385	13.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,997	13,095	149,708	11.43	10
11	Social Service Workers	5,608	6,487	118,415	18.25	11
12	Dietician	1,997	2,205	52,727	23.91	12
13	Food Service Supervisor	1,921	2,193	48,370	22.06	13
14	Head Cook	1,783	2,113	35,268	16.69	14
15	Cook Helpers/Assistants	24,823	28,418	282,913	9.96	15
16	Dishwashers					16
17	Maintenance Workers	1,937	2,186	35,604	16.29	17
18	Housekeepers	27,352	32,953	344,024	10.44	18
19	Laundry	6,234	7,791	77,487	9.95	19
20	Administrator	1,722	2,270	140,884	62.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,245	11,844	200,574	16.93	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	1,825	2,255	38,823	17.22	31
32	Other Health Ca Memory Care	2,536	2,743	48,080	17.53	32
33	Other(specify) Marketing	2,418	2,591	94,196	36.36	33
34	TOTAL (lines 1 - 33)	300,168	370,401	$ 6,642,879 *	$ 17.93	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	24	43,213	9(3)	36
37	Medical Records Consultant	10	650	10(3)	37
38	Nurse Consultant	Monthly	4,892	10(3)	38
39	Pharmacist Consultant	12	14,391	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	4,738	11(3)	44
45	Social Service Consultant	68	3,116	12(3)	45
46	Other(specify) Pulmonary	12	73,222	10(3)	46
47	Medical Consultant	Monthly	5,990	10(7)	47
48	See Sch 20B	Monthly	9,063	10(3)	48
49	TOTAL (lines 35 - 48)	222	$ 159,275		49

C. CONTRACT NURSES

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

Facility Name: Lexington of Streamwood
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/2015

Schedule 20B

XVIII. Staffing and Salary Costs
Consulting Services

Description	# of Hrs. Actually Worked	Total Consulting cost of reporting period	Sch V Line and Column Reference	
Post Acute Consultant	Monthly	563	10(3)	
Telemedicine Consultant	Monthly	8,500	10(3)	
Total - Consulting Services	**-**	**9,063**	**-**	

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kalsang Youtso	Administrator	0	$ 140,884
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 140,884

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 1,240,662
Management Fees-Vesta Mgmt.	481,574
Management Fees (Eliminated in Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,722,236

C. Professional Services

Vendor/Payee	Type	Amount
Cassiday Schade LLP	Legal	$ 74,953
Grabowski Law Center, LLC	Legal	1,106
Duane Morris	Collections	126
Lexington Financial	Legal	7,161
RSM LLP	Accounting	43,955
Much Shelist	Legal	62,078
Pension Administrators	401(k) Administration	1,510
Personnel Planners Inc	U/C Consulting	1,703
Serpico, Petrosino, Dipier	Legal	5,280
Cash Receipts	Collections	2,246
See Schedule 21C	Various	85,116
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 285,234

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 222,255
Unemployment Compensation Insurance	66,339
FICA Taxes	493,409
Employee Health Insurance	371,031
Employee Meals	20,055
Illinois Municipal Retirement Fund (IMRF)*	
401K	22,525
Other Employee Benefits	33,857
Tuition Reimbursement	5,373
Uniform Allowance	363
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,235,207

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	16,254
Health Care Worker Background Check	
(Indicate # of checks performed 303)	3,639
Patient Background Checks 591	7,097
Miscellaneous Licenses & Fees	9,075
Miscellaneous Dues & Subscriptions	7,772
Employment Fees	103,870
Less Non Allowable Dues	(77)
Management Company Allocation	2,464
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 152,084

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Management Company Allocation	1,423
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,423

**See instructions.

Facility Name: **Lexington of Streamwood**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Ability Network	Computer Services	3,364
Allscripts	Computer Services	223
Amazon Marketplace	Computer Services	77
Availity	Computer Services	198
Avatier	Computer Services	393
Bank of America (P KNIGHT)	Computer Services	130
Business Software Inc.	Computer Services	1,152
Centino	Computer Services	110
Citrix	Computer Services	534
Corepoint	Computer Services	1,511
Docusign Inc.	Computer Services	829
E-Health Data Solutions	Computer Services	3,450
Genesis Technology	Computer Services	859
Greenshades Software	Computer Services	71
HealthMedx	Computer Services	13,657
Home Depot	Computer Services	1
Infor(US) Inc.	Computer Services	7,003
Information Controls	Computer Services	2,481
Inpriva Inc.	Computer Services	99
MHC Software	Computer Services	747
Microsoft Licensing	Computer Services	7,389
National Datacare	Computer Services	2,606
OnShift	Computer Services	5,434
Provinet	Computer Services	452
Relias	Computer Services	7,657
RSM US LLP (McGladrey)	Computer Services	4,906
Salesforce.com	Computer Services	7,043
Softchoice Corporation	Computer Services	5,229

Symbria	Computer Services	2,400
Tableau	Computer Services	407
Trisys	Computer Services	96
Tympani	Computer Services	1,350
Duane Morris	Legal	3,260
		85,116
To disallow collection fees		(3,352)
Salesforce.com		(7,043)
Out of period legal		(3,263)
		(13,658)
Legal allocated from Real Estate		
Secretary of State		2,800
Samvest of Lombard		
Accounting		122
Filing Fees		10
		132
Allocated from Mgmt Co.		
Much Shelist	Legal	42
RSM LLP	Accounting	1,418
Frost, Ruttenberg & Rothblatt, P.C	Accounting	532
Gilson Labus & Silverman	Accounting	2,918
Illinois Secretary of State	Filing Fees	50
LaSalle Network	Recruiting/Finance	3,360
Pension Administrators, Inc.	401K Administration	465
Gene Whitehorn	Medicaid Reimb Specialist	1,707
M. Werner Consulting	Financial Consultant	2,018
Healthcents	Managed Care Consultants	12
Computer Services	Computer Consulting	18,778
		31,300
Schedule V, line 19, column 8		305,808

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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		$		$	$	$	$	$	$	$	$	$

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 - $205**

(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. $ **50,377** 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. $ **417,418**
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. $ **20,055** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,096**

(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.