



Facility Name & ID Number Lexington of Streamwood

# 0037002 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	78,324	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	78,324	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			10,986	10,986	8
9	SNF/PED					9
10	ICF	41,792	4,020	3,518	49,330	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,792	4,020	14,504	60,316	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.01%

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  NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 7/8/91

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

YES  Date New Construction NO

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

YES  NO  If YES, enter number of beds certified 214 and days of care provided 8,789

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	408,013	35,331	8,471	451,815		451,815		451,815		1
2	Food Purchase		389,166		389,166		389,166	(657)	388,509		2
3	Housekeeping	424,118	44,038		468,156		468,156	353	468,509		3
4	Laundry		20,675		20,675		20,675		20,675		4
5	Heat and Other Utilities			273,126	273,126		273,126	8,637	281,763		5
6	Maintenance	31,301		182,576	213,877		213,877	87,899	301,776		6
7	Other (specify):* <b>Alloc. From Mgmt Co</b>							11,301	11,301		7
8	<b>TOTAL General Services</b>	863,432	489,210	464,173	1,816,815		1,816,815	107,533	1,924,348		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			47,850	47,850		47,850		47,850		9
10	Nursing and Medical Records	5,247,521	421,783	86,531	5,755,835		5,755,835	39,223	5,795,058		10
10a	Therapy										10a
11	Activities	161,243	25,088	22,074	208,405		208,405		208,405		11
12	Social Services	160,196		3,052	163,248		163,248		163,248		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Alloc. From Mgmt Co</b>							5,117	5,117		15
16	<b>TOTAL Health Care and Programs</b>	5,568,960	446,871	159,507	6,175,338		6,175,338	44,340	6,219,678		16
	<b>C. General Administration</b>										
17	Administrative	109,927		1,746,640	1,856,567		1,856,567	(1,686,188)	170,379		17
18	Directors Fees										18
19	Professional Services			254,074	254,074		254,074	19,194	273,268		19
20	Dues, Fees, Subscriptions & Promotions			146,910	146,910		146,910	13,520	160,430		20
21	Clerical & General Office Expenses	169,789	27,196	37,986	234,971		234,971	771,819	1,006,790		21
22	Employee Benefits & Payroll Taxes			1,292,312	1,292,312		1,292,312		1,292,312		22
23	Inservice Training & Education			10,737	10,737		10,737	392	11,129		23
24	Travel and Seminar							1,184	1,184		24
25	Other Admin. Staff Transportation			1,811	1,811		1,811	12,905	14,716		25
26	Insurance-Prop.Liab.Malpractice			385,726	385,726		385,726	3,196	388,922		26
27	Other (specify):* <b>Alloc. From Mgmt Co</b>							113,348	113,348		27
28	<b>TOTAL General Administration</b>	279,716	27,196	3,876,196	4,183,108		4,183,108	(750,630)	3,432,478		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,712,108	963,277	4,499,876	12,175,261		12,175,261	(598,757)	11,576,504		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			138,708	138,708		138,708	338,820	477,528		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			162,364	162,364		162,364	314,838	477,202		32
33	Real Estate Taxes							673,004	673,004		33
34	Rent-Facility & Grounds			2,057,946	2,057,946		2,057,946	(2,052,759)	5,187		34
35	Rent-Equipment & Vehicles			110,016	110,016		110,016	2,460	112,476		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			2,469,034	2,469,034		2,469,034	(723,637)	1,745,397		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		527,316	1,392,007	1,919,323		1,919,323		1,919,323		39
40	Barber and Beauty Shops			16,371	16,371		16,371		16,371		40
41	Coffee and Gift Shops			2,295	2,295		2,295		2,295		41
42	Provider Participation Fee			432,178	432,178		432,178		432,178		42
43	Other (specify):* <b>Non-Allowable Cos</b>	67,285		385,319	452,604		452,604	(452,604)			43
44	<b>TOTAL Special Cost Centers</b>	67,285	527,316	2,228,170	2,822,771		2,822,771	(452,604)	2,370,167		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,779,393	1,490,593	9,197,080	17,467,066		17,467,066	(1,774,998)	15,692,068		45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(657)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,233)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,211	30		9
10	Interest and Other Investment Income	(42,809)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,597)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,030)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(296,432)	43		24
25	Fund Raising, Advertising and Promotional	(17,989)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,571)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	90,383	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (298,724)		\$	30

**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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,476,274)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,476,274)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,774,998)		37

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

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

		1	2	3	4
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Lexington of Streamwood

ID# 0037002

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	\$ (3,885)	43	1
2	Labs-Part A	(16,217)	43	2
3	X-Rays-Part A	(17,365)	43	3
4	Collections	(3,037)	19	4
5	Marketing Salary	(67,285)	43	5
6	Trust fees	(85)	43	6
7	Unrealized loss on FMV swap	218,993	43	7
8	Salesforce.com	(6,648)	19	8
9	Disallow Lobbying	(2,861)	20	9
10	Non-Allowable Professional Fees	(1,395)	19	10
11	Non-Allowable Legal	(9,832)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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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	<b>Total</b>	90,383		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional fees	\$	Sambell of Streamwood Limited Partnership	**	\$ 200	\$ 200	1
2	V	30 Depreciation		Sambell of Streamwood Limited Partnership	**	228,697	228,697	2
3	V	32 Interest expense		Sambell of Streamwood Limited Partnership	**	335,732	335,732	3
4	V	32 Amortization of mortgage costs		Sambell of Streamwood Limited Partnership	**	2,293	2,293	4
5	V	33 Property taxes		Sambell of Streamwood Limited Partnership	**	665,946	665,946	5
6	V	34 Rental expense	2,057,946	Sambell of Streamwood Limited Partnership	**		(2,057,946)	6
7	V	43 Trust fees		Sambell of Streamwood Limited Partnership	**	85	85	7
8	V	43 Unrealized loss on interest rate swap	218,993	Sambell of Streamwood Limited Partnership	**		(218,993)	8
9	V							9
10	V							10
11	V			The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Sambell of Streamwood Limited Partnership.				11
12	V							12
13	V							13
14	Total		\$ 2,276,939			\$ 1,232,953	\$ * (1,043,986)	14

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

VII. RELATED PARTIES (continued)

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

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

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

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



VII. RELATED PARTIES (continued)

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

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

1	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 <u>Inservice Training</u>	\$	<u>Royal Management Corp.</u>	**	\$ 392	\$	392	15	
16	V	24 <u>Travel &amp; seminar</u>		<u>Royal Management Corp.</u>	**	1,184		1,184	16	
17	V	25 <u>Auto expense</u>		<u>Royal Management Corp.</u>	**	12,905		12,905	17	
18	V	26 <u>Insurance general</u>		<u>Royal Management Corp.</u>	**	3,196		3,196	18	
19	V	27 <u>Management allocation - employee benefits</u>		<u>Royal Management Corp.</u>	**	113,348		113,348	19	
20	V	30 <u>Depreciation</u>		<u>Royal Management Corp.</u>	**	107,912		107,912	20	
21	V	32 <u>Interest</u>		<u>Royal Management Corp.</u>	**	17,193		17,193	21	
22	V	32 <u>Amortization of mortgage costs</u>		<u>Royal Management Corp.</u>	**	2,429		2,429	22	
23	V	33 <u>Property taxes</u>		<u>Royal Management Corp.</u>	**	7,058		7,058	23	
24	V	34 <u>Rent expense</u>		<u>Royal Management Corp.</u>	**	5,187		5,187	24	
25	V	35 <u>Equipment rental</u>		<u>Royal Management Corp.</u>	**	1,509		1,509	25	
26	V	17 <u>Management fees</u>	1,746,640	<u>Royal Management Corp.</u>	**			(1,746,640)	26	
27	V	35 <u>Auto Lease</u>		<u>Royal Management Corp.</u>	**	951		951	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V	** The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.								38
39	Total		\$ 1,746,640			\$ 273,264	\$ *	(1,473,376)	39	

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

Facility Name & ID Number

Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Samatas Discretionary Trust	33.33%	Lexington HC Ctr. of Bloomingdale, Inc.	Bloomingdale	Eastgate Manor	Algonquin	Supportive	1
2	John Samatas Discretionary Trust	33.33%	Lexington HC Ctr. of Chicago Ridge, Inc.	Chicago Ridge	of Algonquin, LLC		Living Facility	2
3	Cynthia Thiem Discretionary Trust	33.34%	Lexington HC Ctr. of Elmhurst, Inc.	Elmhurst	Lexington Square	Lombard	Independent and	3
4			Lexington HC Ctr. of LaGrange, Inc.	LaGrange	Life Care of		Assisted Living	4
5			Lexington HC Ctr. of Lake Zurich, Inc.	Lake Zurich	Lombard, LLC		Facility	5
6			Lexington HC Ctr. of Lombard, Inc.	Lombard	Lexington Square	Elmhurst	Independent	6
7			Lexington HC Ctr. of Orland Park, Inc.	Orland Park	Life Care of Elmhurst,		Living Facility	7
8			Lexington HC Ctr. of Schaumburg, Inc.	Schaumburg	Vesta Mgmt	Lombard	Mgmt. Company	8
9			Lexington HC Ctr. of Wheeling, Inc.	Wheeling	Group, LLC			9
10					Sambell of	Streamwood	Real Estate	10
11					Streamwood Ltd. Ptsp		Property	11
12					Royal Management	Lombard	Mgmt. Company	12
13					Corporation			13
14					Lexington Financial	Lombard	Finance Company	14
15					Services, LLC			15
16					Heron Point Mgmt.	Lombard	Mgmt. Company	16
17					Corporation			17
18					Samvest of	Lombard	Lessor	18
19					Lombard II, LLC			19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## VII. RELATED PARTIES

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

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

Facility Name & ID Number

Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					North Heron	Lombard	Finance Company	1
2					Investments, LLC			2
3								3
4					Lexington Home	Lombard	Home Health	4
5					Health Care, Inc.			5
6								6
7					Lexington Hospice	Lombard	Hospice	7
8					Services, LLC			8
9								9
10					Lexington Private	Lombard	Healthcare	10
11					Home Care			11
12								12
13					Merit Sleep	Lombard	Management	13
14					Management, LLC		Company	14
15								15
16					Samvest of	Algonquin	Real Estate	16
17					Algonquin Ltd. Ptsp		Property	17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	3	Housekeeping supplies	Bed Days Available	724,314	10	\$ 3,263	\$ 78,324	\$ 353	1	
2	5	Utilities - gas & electric	Bed Days Available	724,314	10	72,000	78,324	7,786	2	
3	5	Utilities - water & sewer	Bed Days Available	724,314	10	3,036	78,324	328	3	
4	5	Utilities - maintenance office	Bed Days Available	724,314	10	4,835	78,324	523	4	
5	6	Management allocation - salaries	Bed Days Available	724,314	10	741,281	741,281	78,324	80,159	5
6	6	Repairs & maintenance	Bed Days Available	724,314	10	68,481	78,324	7,405	6	
7	6	Scavenger & exterminating	Bed Days Available	724,314	10	3,101	78,324	335	7	
8	7	Management allocation - employees	Bed Days Available	724,314	10	104,504	78,324	11,301	8	
9	10	Medical consultant	Bed Days Available	724,314	10	27,047	78,324	2,925	9	
10	10	Management allocation - salaries	Bed Days Available	724,314	10	335,674	335,674	78,324	36,298	10
11	15	Management allocation - employees	Bed Days Available	724,314	10	47,322	78,324	5,117	11	
12	17	Management allocation - salaries	Bed Days Available	724,314	10	559,036	559,036	78,324	60,452	12
13	19	Computer consultant & supplies	Bed Days Available	724,314	10	149,651	78,324	16,183	13	
14	19	Professional fees	Bed Days Available	724,314	10	219,386	78,324	23,723	14	
15	20	Dues & subscriptions	Bed Days Available	724,314	10	22,289	78,324	2,410	15	
16	20	Advertising - help wanted	Bed Days Available	724,314	10	129,203	78,324	13,971	16	
17	21	Management allocation - salaries	Bed Days Available	724,314	10	6,876,284	6,876,284	78,324	743,570	17
18	21	Bank charges	Bed Days Available	724,314	10	27,523	78,324	2,976	18	
19	21	Office supplies & printing	Bed Days Available	724,314	10	92,982	78,324	10,055	19	
20	21	Postage	Bed Days Available	724,314	10	34,606	78,324	3,742	20	
21	21	Telephone	Bed Days Available	724,314	10	106,126	78,324	11,476	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 9,627,630	\$ 8,512,275	\$ 1,041,088	25	

Facility Name & ID Number Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	724,314	10	\$ 3,621	\$ 78,324	\$ 392	1
2	24	Travel and Seminar	Bed Days Available	724,314	10	10,947	78,324	1,184	2
3	25	Auto expense	Bed Days Available	724,314	10	119,337	78,324	12,905	3
4	26	Insurance general	Bed Days Available	724,314	10	29,556	78,324	3,196	4
5	27	Management allocation - employees	Bed Days Available	724,314	10	1,048,208	78,324	113,348	5
6	30	Depreciation	Bed Days Available	724,314	10	997,930	78,324	107,912	6
7	32	Interest	Bed Days Available	724,314	10	158,994	78,324	17,193	7
8	32	Amortization of mortgage costs	Bed Days Available	724,314	10	22,462	78,324	2,429	8
9	33	Property taxes	Bed Days Available	724,314	10	65,273	78,324	7,058	9
10	34	Rent expense	Bed Days Available	724,314	10	47,968	78,324	5,187	10
11	35	Equipment rental	Bed Days Available	724,314	10	13,953	78,324	1,509	11
12	35	Auto Lease	Bed Days Available	724,314	10	8,793	78,324	951	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,527,042	\$	\$ 273,264	25

Facility Name &amp; ID Number

Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Lexington Financial									1										
2	Services, L.L.C	X		Mortgage	Varies	5/22/08	\$ 6,734,000	\$ 5,348,254	1/1/33	Variable	335,732	2								
3											3									
4											4									
5									Finance Charge - Insurance Policy		1,754	5								
<b>Working Capital</b>																				
6	Shareholders	X		Working Capital	None	Various	1,154,048	9,244,097	Demand	Prime +1	120,580	6								
7	Bank of America		X	Working Capital	None	9/30/14	13,700,000	1,356,000	4/30/2017	Prime/Libor	40,030	7								
8											8									
9	<b>TOTAL Facility Related</b>						\$ 21,588,048	\$ 15,948,351			\$ 498,096	9								
<b>B. Non-Facility Related*</b>																				
10								Amortization of loan cost			2,293	10								
11								Allocated from Mgmt Co.			19,622	11								
12								Interest Income offset			(5,367)	12								
13								See Sch 9A			(37,442)	13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (20,894)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 21,588,048	\$ 15,948,351			\$ 477,202	15								

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

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

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



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

**Schedule 9A**

**IX. Interest Expense and Real Estate Tax Expense**

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

**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.**

1. Real Estate Tax accrual used on 2015 report.			\$	<b>621,600</b>	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.)		2015	\$	<b>612,375</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(9,225)</b>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>700,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>(48,066)</b>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ 23,237 For 13-14 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>23,237</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>673,004</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	<b>478,154</b>	8	<b>FOR BHF USE ONLY</b>	
	2012	<b>541,750</b>	9	13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
	2013	<b>584,433</b>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2014	<b>603,107</b>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2015	<b>612,375</b>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<a href="#">See attached real estate accrual sheet</a>					

**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.**

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Karen Gillis

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>30,000</u>	<u>1991</u>	<u>\$ 211,400</u>	<u>1</u>
2	<u>Management Company Allocation</u>		<u>2002</u>	<u>22,198</u>	<u>2</u>
3	<b>TOTALS</b>	<b>30,000</b>		<b>\$ 233,598</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	214	1991	1991	\$ 5,248,322	\$	35	\$ 149,952	\$ 149,952	\$ 3,823,777	4
5		1993	1993	105,236		35	3,007	3,007	70,660	5
6		1995	1995	82,650	2,361	35	2,361		50,767	6
7										7
8										8
<b>Improvement Type**</b>										
9	Building Improvement		1993	7,336		35	210	210	4,929	9
10	Land Improvements		1995	7,000		15			7,000	10
11	Kitchen & Nurses Station		1996	12,316	352	35	352		7,215	11
12	Piping		1996	3,139	90	35	90		1,841	12
13	Basement remodeling		1997	20,204		10			20,204	13
14	Floor repairs		1997	555		10			555	14
15	Corner Guards		1997	998		10			998	15
16	Corner Guards		1998	3,563		10			3,563	16
17	Wiring		1998	2,050		10			2,050	17
18	Tile		1998	11,697		10			11,697	18
19	Patio		1999	12,012		15			12,012	19
20	Parking lot		2000	1,773		10			1,773	20
21	110-ton A/C unit		2000	6,923		10			6,923	21
22	Rods for bedside curtains		2000	5,872		10			5,872	22
23	Automatic doors		2000	1,300		10			1,300	23
24	Rehab project: carpeting, wallcovering, handrails, painting		2000	85,195		10			85,195	24
25	Compressor/tube bundles-cooling system		2001	12,921		10			12,921	25
26	Rehab project: resident rooms, corridors, dining room		2001	212,217	10,611	20	10,611		164,470	26
27	Parking lot		2002	29,288		10			29,288	27
28	Office area rehab		2002	26,991	1,350	20	1,350		19,573	28
29	Elevator interior upgrade		2002	1,120		10			1,120	29
30	Gazebo		2002	3,393		10			3,393	30
31	Elevator electronic curtains		2002	4,500		10			4,500	31
32	Door frame protector		2003	5,276		10			5,276	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring		2003	9,392		10			9,392	33
34	Roof		2003	29,950	1,498	20	1,498		19,597	34
35	Kitchen Sewer/Dishroom		2004	6,224		10			6,224	35
36	Compressor/tube bundles-cooling system		2004	14,737	737	20	737		9,088	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Lexington of Streamwood

# 0037002

Report Period Beginning:

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

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

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

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

Facility Name &amp; ID Number Lexington of Streamwood

# 0037002

Report Period Beginning:

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

## XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name &amp; ID Number Lexington of Streamwood

# 0037002

Report Period Beginning:

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

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

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

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



XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,831,135	\$ 62,284		\$ 281,804	\$ 219,520	\$ 5,282,890	1
2									2
3	Mgmt Co.								3
4									4
5	Building-management company	2002	307,173		40	8,914	8,914	136,294	5
6	HVAC, electrical, security system-management company	2003	2,698		30	633	633	2,143	6
7	Key card system-management company	2004	424		20	21	21	263	7
8	VAC TX controls-management company	2005	129		20	6	6	76	8
9	Build Imp-management company	2006	94		20	6	6	64	9
10	Building Improvement Management Co.	2008	14,885		20	162	162	6,505	10
11	Building Improvement Management Co.	2009	2,779		20	50	50	1,128	11
12	Building Improvement Management Co.	2010	2,708		20	49	49	1,041	12
13	Building Improvement Management Co.	2011	1,911		20	87	87	489	13
14	Building Improvement Management Co.	2012	6,604		20	12	12	1,129	14
15	Building Improvement Management Co.	2013	4,990		20	355	355	1,187	15
16	Building Improvement Management Co.	2014	2,701		20	263	263	678	16
17	Building Improvement Management Co.	2015	475		20	57	57	87	17
18	Building Improvement Management Co.	2016	7,836		20	225	225	225	18
19									19
20	Reconcile to book depreciation			(204)			204		20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,186,542	\$ 62,080		\$ 292,644	\$ 230,564	\$ 5,434,199	34

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

Facility Name & ID Number Lexington of Streamwood

# 0037002

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,118,542	\$ 74,583	\$ 85,767	\$ 11,184	5-10	\$ 996,353	71
72	Current Year Purchases	36,098	2,045	2,045	-	7	2,045	72
73	Fully Depreciated Assets	622,464			-	5-10	622,464	73
74	Allocated from Mgmt. Co.	637,099		94,265	94,265	5-7	525,687	74
75	TOTALS	\$ 2,414,203	\$ 76,628	\$ 182,077	\$ 105,449		\$ 2,146,549	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$ -	\$ -	\$ -	\$ -		\$ -	76
77					-	-	-			77
78					-	-	-			78
79	Allocated from Mgmt. Co.			57,433	-	2,807	2,807	5	50,999	79
80	TOTALS			\$ 57,433	\$ -	\$ 2,807	\$ 2,807		\$ 50,999	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)	\$ 11,891,776	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 138,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 477,528	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 338,820	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,631,747	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from Management Company</u>				<u>5,187</u>			6
7	TOTAL				\$ <u>5,187</u>			7

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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 111,525 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocated from Management Company</u>			<u>951</u>	20
21	TOTAL		\$	\$ <u>951</u>	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:** 12/31/2016

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

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

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39(3)	hrs	\$	7,951	\$ 462,693	\$	7,951	\$ 462,693							1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,703	146,937		4,703	146,937							2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs		17,415	766,250		17,415	766,250							4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39(2)	# of prescripts						515,627						515,627	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Ambulance</u>	39(3)							16,127						16,127	12
13	Other (specify): <u>See Sch 16A</u>	39(2)							11,689						11,689	13
14	TOTAL			\$	30,069	\$ 1,392,007	\$	30,069	\$ 527,316	\$	30,069	\$	1,919,323			14

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

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

Schedule 16A

STATE OF ILLINOIS

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 037002 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

1	2	3	4	5	6	7	8						
								Staff		Outside Practitioner (other than consultant)	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)
								Units of Service	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$		\$	1				
2	Licensed Speech and Language Development Therapist		hrs						2				
3	Licensed Recreational Therapist		hrs						3				
4	Licensed Physical Therapist		hrs						4				
5	Physician Care		visits						5				
6	Dental Care		visits						6				
7	Work Related Program		hrs						7				
8	Habilitation		hrs						8				
9	Pharmacy		# of prescripts						9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						10				
11	Academic Education		hrs						11				
12	Other (specify): <u>Oxygen</u>	<u>39(2)</u>					<u>8,696</u>		<u>10,345</u>				
13	Other (specify): <u>DME</u>	<u>39(2)</u>					<u>2,993</u>		<u>18,496</u>				
14	TOTAL			\$		\$	<u>11,689</u>	\$	<u>28,841</u>				

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 774,477	\$ 830,809	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,817,899</u> )	2,216,116	2,216,116	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	18,226	18,226	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,008,819	\$ 3,065,151	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,884	67,884	12
13	Land		233,598	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,654,234	3,832,984	15
16	Equipment, at Historical Cost	624,673	2,471,636	16
17	Accumulated Depreciation (book methods)	(1,354,483)	(7,631,747)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage cost, net</u>		37,580	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 992,308	\$ 4,365,493	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,001,127	\$ 7,430,644	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 505,253	\$ 505,253	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,600,097	10,600,097	29
30	Accrued Salaries Payable	518,288	518,288	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,836	25,836	31
32	Accrued Real Estate Taxes(Sch.IX-B)		700,000	32
33	Accrued Interest Payable		25,230	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	17,425,115	5,192,759	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 29,074,589	\$ 17,567,463	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,348,254	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,348,254	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 29,074,589	\$ 22,915,717	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (25,073,462)	\$ (15,485,073)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,001,127	\$ 7,430,644	48

\*(See instructions.)



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

**Schedule 17A**

**XV. Balance Sheet**

**Line 23 Long-Term Assets Other (specify):**

Description	Operating	After Consolidation
<b>Total - Line 23</b>	-	-

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

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

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(22,653,956)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post closing adjustment</b>	<b>(510,447)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(23,164,403)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,909,059)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,909,059)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(25,073,462)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

**classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 24,136,820	1
2	Discounts and Allowances for all Levels	(14,777,600)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,359,220	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,535,965	6
7	Oxygen	43,948	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,579,913	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,824	12
13	Barber and Beauty Care	18,190	13
14	Non-Patient Meals	657	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	777,826	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	235,255	19
20	Radiology and X-Ray	27,603	20
21	Other Medical Services	552,152	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,613,507	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,367	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,367	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,558,007	30

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

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

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

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

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

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

^ - Entity is a cash basis taxpayer

Facility Name & ID Number Lexington of Streamwood

# 0037002

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,863	2,185	\$ 120,733	\$ 55.26	1
2	Assistant Director of Nursing	1,695	2,164	97,486	45.05	2
3	Registered Nurses	22,368	29,693	972,637	26.76	3
4	Licensed Practical Nurses	36,215	48,155	1,292,144	26.83	4
5	CNAs & Orderlies	118,714	148,613	2,082,793	14.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,127	2,459	48,876	19.87	9
10	Activity Assistants	9,129	10,400	112,367	10.80	10
11	Social Service Workers	7,544	8,582	160,196	18.67	11
12	Dietician	1,881	2,246	57,029	25.40	12
13	Food Service Supervisor	864	1,062	22,039	20.76	13
14	Head Cook	1,437	1,620	31,217	19.27	14
15	Cook Helpers/Assistants	24,794	28,208	297,728	10.55	15
16	Dishwashers					16
17	Maintenance Workers	1,449	1,802	31,301	17.37	17
18	Housekeepers	33,272	40,374	424,118	10.50	18
19	Laundry					19
20	Administrator	1,439	1,772	109,927	62.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,769	9,778	169,789	17.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,817	2,282	41,851	18.34	31
32	Other Health C: <a href="#">See Sch 20A</a>	19,761	25,063	639,877	25.53	32
33	Other(specify) <a href="#">Marketing</a>	1,562	1,933	67,285	34.80	33
34	TOTAL (lines 1 - 33)	295,700	368,391	\$ 6,779,393 *	\$ 18.40	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

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

**C. CONTRACT NURSES**

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

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

**Schedule 20A**

**XVIII. Staffing and Salary Costs**  
**Line 32 Other Health Care (specify):**

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

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

**Schedule 20B**

**XVIII. Staffing and Salary Costs**

**B. Consultant Services**

**Line 48**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Kalsang Youtso</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 109,927</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 224,733</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>63,635</u>	<u>Advertising: Employee Recruitment</u>	<u>3,062</u>	
				<u>FICA Taxes</u>	<u>505,648</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>420,939</u>	<u>(Indicate # of checks performed <u>324</u>)</u>	<u>3,884</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>631</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Fees</u>	<u>3,211</u>	
				<u>401K</u>	<u>26,728</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>11,549</u>	
				<u>Other Employee Benefits</u>	<u>38,469</u>	<u>Employment Fees</u>	<u>109,007</u>	
				<u>Tuition Reimbursement</u>	<u>5,794</u>	<u>Management Company Allocation</u>	<u>13,971</u>	
				<u>Uniform Allowance</u>	<u>6,366</u>	<u>IHCA Dues</u>	<u>6,181</u>	
						<u>Less: Public Relations Expense</u>	<u>( )</u>	
						<u>Non-allowable advertising</u>	<u>( )</u>	
						<u>Yellow page advertising</u>	<u>( )</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 109,927</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 1,292,312</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 160,430</b>	
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-Royal Operating</u>			<u>\$ 1,281,408</u>	<u>N/A</u>		<u>\$</u>	<u>Out-of-State Travel</u>	<u>\$</u>
<u>Management Fees-Vesta Mgmt.</u>			<u>465,232</u>					
<u>Management Fees (Eliminated in Column 7)</u>							<u>In-State Travel</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 1,746,640</b>				<u>Seminar Expense</u>	
<b>(Attach a copy of any management service agreement)</b>							<u>Management Company Allocation</u>	<u>1,184</u>
C. Professional Services							<u>Entertainment Expense</u>	<u>( )</u>
Vendor/Payee	Type		Amount				<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	<b>\$ 1,184</b>
<u>Cassiday Schade LLP</u>	<u>Legal</u>		<u>\$ 96,950</u>					
<u>Cook County Med</u>	<u>Storage</u>		<u>500</u>					
<u>Duane Morris</u>	<u>Legal</u>		<u>871</u>					
<u>Generation Law</u>	<u>Legal</u>		<u>7,068</u>					
<u>Grabowski</u>	<u>Collections</u>		<u>104</u>					
<u>RSM US LLP</u>	<u>Accounting</u>		<u>46,446</u>					
<u>Much Shelist</u>	<u>Legal</u>		<u>2,825</u>					
<u>Attadale</u>	<u>Operations Consulting</u>		<u>9,990</u>					
<u>Amalgamated Bank</u>	<u>Administrative Fee</u>		<u>483</u>					
<u>Cash Receipts</u>	<u>Collections</u>		<u>1,703</u>					
<u>See Schedule 21C</u>	<u>Various</u>		<u>87,134</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 254,074</b>	<b>TOTAL</b>		<b>\$</b>		
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

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

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**  
**C. Professional Services**

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



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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$6,181
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,478 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 432,178  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ - Has any meal income been offset against related costs? Yes Indicate the amount. \$ 657
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Adequate records have been maintained  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees