FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0037002

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

Address: 815 E. Irving Park Road (Number) Streamwood (City) 60107 (Zip Code)

County: Cook

Telephone Number: (630) 837-5300 **Fax #** (630) 213-9076

HFS ID Number:

Date of Initial License for Current Owners: 7/8/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: 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 1/1/18 to 12/31/18 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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			8,040	8,040	8
9	SNF/PED					9
10	ICF	36,259	6,214	2,764	45,237	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,259	6,214	10,804	53,277	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.21%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 6,448

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Lexington Health Care Center of Streamwoo(# 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	466,933	36,468	872	504,273		504,273	-	504,273			1
2	Food Purchase		398,167		398,167		398,167	(1,067)	397,100			2
3	Housekeeping	399,179	33,581	-	432,760		432,760	292	433,052			3
4	Laundry	-	17,348	-	17,348		17,348	-	17,348			4
5	Heat and Other Utilities			275,152	275,152		275,152	7,773	282,925			5
6	Maintenance	32,521	-	196,073	228,594		228,594	136,169	364,763			6
7	Other (specify):* Alloc. From Mgmt Co	-	-	-				13,619	13,619			7
8	**TOTAL General Services**	898,633	485,564	472,097	1,856,294		1,856,294	156,786	2,013,080			8
	B. Health Care and Programs											
9	Medical Director	-	-	43,275	43,275		43,275	-	43,275			9
10	Nursing and Medical Records	4,890,219	337,219	87,688	5,315,126		5,315,126	24,882	5,340,008			10
10a	Therapy	-	-	-				-				10a
11	Activities	140,203	19,996	10,744	170,943		170,943	-	170,943			11
12	Social Services	155,701	-	4,002	159,703		159,703	-	159,703			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):* Alloc. From Mgmt Co	-	-	-				2,606	2,606			15
16	**TOTAL Health Care and Programs**	5,186,123	357,215	145,709	5,689,047		5,689,047	27,488	5,716,535			16
	C. General Administration											
17	Administrative	125,661	-	1,580,510	1,706,171		1,706,171	(1,559,784)	146,387			17
18	Directors Fees			-				-				18
19	Professional Services			220,057	220,057		220,057	87,971	308,028			19
20	Dues, Fees, Subscriptions & Promotions			112,373	112,373		112,373	15,097	127,470			20
21	Clerical & General Office Expenses	127,937	21,943	51,496	201,376		201,376	980,456	1,181,832			21
22	Employee Benefits & Payroll Taxes			947,842	947,842		947,842	-	947,842			22
23	Inservice Training & Education			7,813	7,813		7,813	569	8,382			23
24	Travel and Seminar			-				737	737			24
25	Other Admin. Staff Transportation		-	3,998	3,998		3,998	16,381	20,379			25
26	Insurance-Prop.Liab.Malpractice			611,900	611,900		611,900	2,966	614,866			26
27	Other (specify):* Alloc. From Mgmt Co	-	-	-				103,972	103,972			27
28	**TOTAL General Administration**	253,598	21,943	3,535,989	3,811,530		3,811,530	(351,635)	3,459,895			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,338,354	864,722	4,153,795	11,356,871		11,356,871	(167,361)	11,189,510			29

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. #0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			94,072	94,072		94,072	245,180	339,252			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			400,392	400,392		400,392	256,754	657,146			32
33	Real Estate Taxes			-				673,404	673,404			33
34	Rent-Facility & Grounds			1,579,920	1,579,920		1,579,920	(1,575,467)	4,453			34
35	Rent-Equipment & Vehicles			82,342	82,342		82,342	1,927	84,269			35
36	Other (specify):*			-				-				36
37	**TOTAL Ownership**			2,156,726	2,156,726		2,156,726	(398,202)	1,758,524			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	276,888	1,187,339	1,464,227		1,464,227	-	1,464,227			39
40	Barber and Beauty Shops	-	-	12,258	12,258		12,258	-	12,258			40
41	Coffee and Gift Shops	-	-	2,372	2,372		2,372	-	2,372			41
42	Provider Participation Fee			401,999	401,999		401,999	-	401,999			42
43	Other (specify):* Non-Allowable Cos	911	-	574,128	575,039		575,039	(575,039)				43
44	**TOTAL Special Cost Centers**	911	276,888	2,178,096	2,455,895		2,455,895	(575,039)	1,880,856			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,339,265	1,141,610	8,488,617	15,969,492		15,969,492	(1,140,602)	14,828,890			45

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	(1,067)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,649)	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	3,076	30		9
10	Interest and Other Investment Income	(254,124)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,530)	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	(28,405)	43		18
19	Entertainment				19
20	Contributions	(200)	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	(454,237)	43		24
25	Fund Raising, Advertising and Promotional	(32,566)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(520)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(13,342)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (806,564)		$	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)	(334,038)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (334,038)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,140,602)		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 Health Care Center of Streamwood, Inc.

ID# 0037002

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Diagnostics Managed Care	$ (1,275)	43	1
2	Labs-Part A	(18,251)	43	2
3	X-Rays-Part A	(13,476)	43	3
4	Collections	(18,280)	19	4
5	Out of Period legal	(97)	19	5
6	Marketing Salary	(911)	43	6
7	Trust fees	(135)	43	7
8	Unrealized Loss on FMV swap	74,926	43	8
9	Disallow Lobbying	(1,493)	20	9
10	Pharmacy	(19)	43	10
11	Loss on disposal	(34,331)	43	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,342)		49

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Sambell of Streamwood Limited Partnership	**	$ 250	$ 250	1
2	V	30	Depreciation Expense		Sambell of Streamwood Limited Partnership	**	217,512	217,512	2
3	V	32	Amortization of Mortgage Cost		Sambell of Streamwood Limited Partnership	**	47,596	47,596	3
4	V	32	Interest		Sambell of Streamwood Limited Partnership	**	445,775	445,775	4
5	V	33	Property Tax		Sambell of Streamwood Limited Partnership	**	666,862	666,862	5
6	V	34	Rent	1,579,920	Sambell of Streamwood Limited Partnership	**		(1,579,920)	6
7	V	43	Unrealized loss on FMV of Swap	74,926	Sambell of Streamwood Limited Partnership	**		(74,926)	7
8	V	43	(Gain)/Loss - disposal - mortgage costs		Sambell of Streamwood Limited Partnership	**	34,331	34,331	8
9	V	21	Miscellaneous Expense		Sambell of Streamwood Limited Partnership	**	3	3	9
10	V	43	Trust fees		Sambell of Streamwood Limited Partnership	**	135	135	10
11	V								11
12	V				The owners of Lexington Health Care Center of Streamwood, Inc				12
13	V				own 100% of Sambell of Streamwood Limited Partnership.				13
14	Total			$ 1,654,846			$ 1,412,464	$ * (242,382)	14

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.	**	$ 292	$ 292	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	7,572	7,572	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	201	201	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	543	543	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	127,415	127,415	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	7,881	7,881	20
21	V	6	Scavenger & exterminating		Royal Management Corp.	**	330	330	21
22	V	7	Management allocation - employee benefits		Royal Management Corp.	**	13,619	13,619	22
23	V	10	Medical consultant		Royal Management Corp.	**	503	503	23
24	V	10	Management allocation - salaries		Royal Management Corp.	**	24,379	24,379	24
25	V	15	Management allocation - employee benefits		Royal Management Corp.	**	2,606	2,606	25
26	V	17	Management allocation - salaries		Royal Management Corp.	**	20,726	20,726	26
27	V	19	Computer consultant & supplies		Royal Management Corp.	**	20,970	20,970	27
28	V	19	Professional fees		Royal Management Corp.	**	85,128	85,128	28
29	V	20	Dues & subscriptions		Royal Management Corp.	**	1,581	1,581	29
30	V	20	Advertising - help wanted		Royal Management Corp.	**	15,009	15,009	30
31	V	21	Management allocation - salaries		Royal Management Corp.	**	951,993	951,993	31
32	V	21	Bank charges		Royal Management Corp.	**	2,585	2,585	32
33	V	21	Office supplies & printing		Royal Management Corp.	**	8,792	8,792	33
34	V	21	Postage		Royal Management Corp.	**	4,354	4,354	34
35	V	21	Telephone		Royal Management Corp.	**	12,729	12,729	35
36	V								36
37	V								37
38	V		** The owners of Lexington Health Care Center of Streamwood, Inc.						38
39	Total			$			$ 1,309,208	$ * 1,309,208	39

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	23	Inservice Training	$	Royal Management Corp.	**	$ 569	$ 569	15
16	V	24	Travel & seminar		Royal Management Corp.	**	737	737	16
17	V	25	Auto expense		Royal Management Corp.	**	16,381	16,381	17
18	V	26	Insurance general		Royal Management Corp.	**	2,966	2,966	18
19	V	27	Management allocation - employee benefits		Royal Management Corp.	**	103,972	103,972	19
20	V	30	Depreciation		Royal Management Corp.	**	24,592	24,592	20
21	V	32	Interest		Royal Management Corp.	**	15,226	15,226	21
22	V	32	Amortization of mortgage costs		Royal Management Corp.	**	2,281	2,281	22
23	V	33	Property taxes		Royal Management Corp.	**	6,542	6,542	23
24	V	34	Rent expense		Royal Management Corp.	**	4,453	4,453	24
25	V	35	Equipment rental		Royal Management Corp.	**	1,711	1,711	25
26	V	17	Management fees	1,580,510	Royal Management Corp.	**		(1,580,510)	26
27	V	35	Auto Lease		Royal Management Corp.	**	216	216	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.						38
39	Total			$ 1,580,510			$ 179,646	$ * (1,400,864)	39

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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					Corportation			17
18					Samvest of	Lombard	Lessor	18
19					Lombard II, LLC			19
20					Curatess, LLC	Lombard	Telemedicine	20
21					Republic Construction	Lombard	Construction Comp	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Health Care Center of Streamwoc # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	$ 5,324	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,993	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	5,324	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative		See Schedule 7A	See Sch 7B	See Sch 7B	Salary	3,993	L17, C7	4
5	Phil Thiem	Executive Committee	Administrative		See Schedule 7A	See Sch 7B	See Sch 7B	Salary	842	L17, C7	5
6	Jeremy Samatas	Executive Committee	Administrative		See Schedule 7A	See Sch 7B	See Sch 7B	Salary	1,252	L17, C7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,726		13

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days Available	722,335	10	$ 2,704	$	78,110	$ 292	1
2	5	Utilities - gas & electric	Bed Days Available	722,335	10	70,024		78,110	7,572	2
3	5	Utilities - water & sewer	Bed Days Available	722,335	10	1,855		78,110	201	3
4	5	Utilities - maintenance office	Bed Days Available	722,335	10	5,025		78,110	543	4
5	6	Management allocation - salaries	Bed Days Available	722,335	10	1,178,292	1,178,292	78,110	127,415	5
6	6	Repairs & maintenance	Bed Days Available	722,335	10	72,883		78,110	7,881	6
7	6	Scavenger & exterminating	Bed Days Available	722,335	10	3,054		78,110	330	7
8	7	Management allocation - employee	Bed Days Available	722,335	10	125,945		78,110	13,619	8
9	10	Medical consultant	Bed Days Available	722,335	10	4,651		78,110	503	9
10	10	Management allocation - salaries	Bed Days Available	722,335	10	225,449	225,449	78,110	24,379	10
11	15	Management allocation - employee	Bed Days Available	722,335	10	24,098		78,110	2,606	11
12	17	Management allocation - salaries	Bed Days Available	722,335	10	191,670	191,670	78,110	20,726	12
13	19	Computer consultant & supplies	Bed Days Available	722,335	10	193,924		78,110	20,970	13
14	19	Professional fees	Bed Days Available	722,335	10	787,232		78,110	85,128	14
15	20	Dues & subscriptions	Bed Days Available	722,335	10	14,624		78,110	1,581	15
16	20	Advertising - help wanted	Bed Days Available	722,335	10	138,799		78,110	15,009	16
17	21	Management allocation - salaries	Bed Days Available	722,335	10	8,803,710	8,803,710	78,110	951,993	17
18	21	Bank charges	Bed Days Available	722,335	10	23,902		78,110	2,585	18
19	21	Office supplies & printing	Bed Days Available	722,335	10	81,306		78,110	8,792	19
20	21	Postage	Bed Days Available	722,335	10	40,262		78,110	4,354	20
21	21	Telephone	Bed Days Available	722,335	10	117,714		78,110	12,729	21
22										22
23										23
24										24
25	TOTALS					$ 12,107,123	$ 10,399,121		$ 1,309,208	25

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	722,335	10	$ 5,261	$	78,110	$ 569	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	6,817		78,110	737	2
3	25	Auto expense	Bed Days Available	722,335	10	151,483		78,110	16,381	3
4	26	Insurance general	Bed Days Available	722,335	10	27,426		78,110	2,966	4
5	27	Management allocation - employee	Bed Days Available	722,335	10	961,496		78,110	103,972	5
6	30	Depreciation	Bed Days Available	722,335	10	227,415		78,110	24,592	6
7	32	Interest	Bed Days Available	722,335	10	140,807		78,110	15,226	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	21,094		78,110	2,281	8
9	33	Property taxes	Bed Days Available	722,335	10	60,494		78,110	6,542	9
10	34	Rent expense	Bed Days Available	722,335	10	41,178		78,110	4,453	10
11	35	Equipment rental	Bed Days Available	722,335	10	15,819		78,110	1,711	11
12	35	Auto Lease	Bed Days Available	722,335	10	1,993		78,110	216	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,661,283	$		$ 179,646	25

Facility Name & ID Number Lexington Health Care Center of Streamwoo(# 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	05/22/08	6,375,000		01/01/33	Variable	162,304	2
3	Midcap Financial Trust		X	Mortgage	Varies	05/29/18	5,058,006	6,342,934	05/29/21	Libor + 5.25%	283,471	3
4												4
5								Finance Charge - Insurance Policy			2,838	5
	Working Capital											
6	Bank of America		X	Working Capital	None	09/30/13	300,000		01/31/19	Prime/Libor	23,423	6
7	LHCS of Lombard LP	X		Working Capital	None	02/20/18	300,000	2,252,239	02/19/20	Libor + 5.25%	132,113	7
8	See Sch 9A	X		Working Capital	None	Various	1,154,048	8,598,145	Demand	Various	242,017	8
9	TOTAL Facility Related						$ 13,187,054	$ 17,193,318			$ 846,167	9
	B. Non-Facility Related*											
10								Amortization of Loan Cost			47,596	10
11								Interest Income offset			(9,269)	11
12								Allocated from management company			17,507	12
13								See Sch 9A			(244,855)	13
14	TOTAL Non-Facility Related						$	$			$ (189,021)	14
15	TOTALS (line 9+line14)						$ 13,187,054	$ 17,193,318			$ 657,146	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 Health Care Center of Streamwood, Inc.
IDPH License I 0037002
Fiscal Year Enc 12/31/18

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various		398,823	Demand	Prime	18,161	6
7	Shareholders	X		Working Capital	None	Various		295,827	Demand	8.0%	23,069	7
8	Shareholders	X		Working Capital	None	Various	1,154,048	7,903,495	Demand	2.5%	200,787	8
9	TOTAL Facility Related				$0.00		$ 1,154,048	$ 8,598,145			$ 242,017	9
	B. Non-Facility Related*											
10								Finance charges			(2,838)	10
11								Non Allowable Shareholder Interest			(242,017)	11
12												12
13												13
14	TOTAL Non-Facility Related				$0.00		$ 0	$ 0			$ (244,855)	14

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 638,000	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.)	2017	$ 664,167	2
3. Under or (over) accrual (line 2 minus line 1).		$ 26,167	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 692,705	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 18,588	5
	Alloc Fr. Mgmt Co.	6,542	
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** $ 70,598 **For** ### **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (70,598)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 673,404	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	584,433	8
	2014	603,107	9
	2015	612,375	10
	2016	619,352	11
	2017	664,167	12

See attached real estate accrual sheet

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-25-300-018-0000	Land & Building	$ 664,167.30	$ 664,167.30
2.	Royal Management Corp(Samvest of	Lombard II)	$	$
3.	05-01-202-021	Land & Building	$ 253,394.82	$ 6,542.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 917,562.12	$ 670,709.30

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83942 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	20,613	2
3	TOTALS	30,000		$ 232,013	3

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 4,123,681	4
5			1993	1993	105236	-	35	2,361	2,361	75,382	5
6			1995	1995	82650	2,361	35	2,361		55,489	6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Building Improvement			1993	7,336	-	35	210	210	5,349	9
10	Land Improvements			1995	7,000	-	15	-		7,000	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		7,919	11
12	Piping			1996	3,139	90	35	90		2,021	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		185,692	26
27	Parking lot			2002	29,288	-	10	-		29,288	27
28	Office area rehab			2002	26,991	1,350	20	1,350		22,273	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		22,593	34
35	Kitchen Sewer/Dishroom			2004	6,224		10			6,224	35
36	Compressor/tube bundles-cooling system			2004	14,737	737	20	737		10,562	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		5,631	38
39	Kitchen renovation	2005	12,034	602	20	602		7,825	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		24,336	40
41	Therapy room renovation	2005	11,628	581	20	581		7,748	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		31,346	42
43	Dialysis units	2005	66,426	3,535	20	3,535		47,723	43
44	Create transitional unit	2005	14,490	725	20	725		9,424	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		4,143	45
46	Basement renovation	2005	46,561	2,328	20	2,328		30,652	46
47	Landscaping enhancement	2006	3,414	228	15	228		2,849	47
48	HVAC	2006	17,125	856	20	856		10,344	48
49	Door closer	2006	4,446	222	20	222		2,831	49
50	Blinds	2006	1,566	-	5	-		1,566	50
51	Employee lunch room rehab	2006	2,883	144	20	144		1,824	51
52	Storeroom door lock	2006	2,843	142	20	142		1,775	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		39,536	53
54	Fine dining	2006	7,650	382	20	382		4,808	54
55	Automatic door	2006	2,259	113	20	113		1,384	55
56	Landscaping	2007	10,606	530	20	530		5,874	56
57	Parking lot	2007	2,777	139	20	139		1,564	57
58	HVAC	2007	1,501	75	20	75		881	58
59	Painting Building	2007	16,150	808	20	808		9,224	59
60	Landscaping	2008	33,747	2,250	15	2,250		22,687	60
61	Common areas-metal doors	2008	7,055	353	20	353		3,795	61
62	Wanderguard	2008	3,882	194	20	194		2,134	62
63	Lawn Irrigation	2009	18,125	1,208	15	1,208		11,174	63
64	Landscaping	2009	3,138	209	15	209		2,020	64
65	Quick connectors	2009	9,375	469	20	469		4,534	65
66	1st floor admin office-heating,plumbing	2009	13,598	767	20	767		6,946	66
67	Fire alarm system	2009	5,271	264	20	264		2,376	67
68	Metal Doors-painting	2009	4,650	232	20	232		2,243	68
69	2nd Floor Remodel-carpentry	2009	33,503	838	40	838		8,170	69
70	TOTAL (lines 4 thru 69)		$ 6,491,737	$ 43,167		$ 195,690	$ 152,523	$ 5,063,011	70

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		$ 195,690	$ 152,523	$ 5,063,011	1
2	Patio Pergola	2009	7,930	793	10	793		7,401	2
3	Landscaping	2010	5,785	386	15	386		3,281	3
4	HVAC Quick connectors, admin office	2010	15,373	561	27	561		4,553	4
5	Lockers and Pantry-plumbing, tile	2010	14,809	540	27	540		4,427	5
6	Director of Nursing office painting	2010	7,887	288	27	288		2,304	6
7	Ramp repair	2010	3,240	216	15	216		1,764	7
8	Library/Lounge update-art,flooring	2010	8,356	305	27	305		2,491	8
9	Office carpentry,flooring,electrical,painting,signs,HVAC	2010	48,949	1,958	27	1,958		15,664	9
10	Office carpentry,flooring,electrical,painting,signs,HVAC	2011	4,714	171	27	171		1,297	10
11	Office-Doors, ADON, Locks	2011	26,169	952	27	952		6,823	11
12	HVAC Chiller	2011	95,360	3,468	27	3,468		25,721	12
13	Laundry Room-Painting, Tile	2011	7,686	279	27	279		2,069	13
14	2nd floor doors	2011	26,317	957	27	957		7,018	14
15				-		-			15
16	Install cast iron pipe sprinkler	2012	4,550	165	27	165		1,128	16
17	Shower room-tile-painting,plumbing	2012	87,763	3,191	27	3,191		19,412	17
18				-		-			18
19	Update Sprinkler Heads- Entire Facility	2013	28,070	1,021	27	1,021		5,615	19
20	EMR Building Wire- Entire Facility	2013	16,538	601	27	601		3,106	20
21				-		-			21
22	R/M Reclass: Intstallation of Kitchen Countertop	2014	2,800	-	15	187	187	841	22
23	R/M Reclass: Install Elevator Door Restrictor	2014	5,250	-	10	525	525	2,363	23
24	R/M Reclass: Cracked Pavement Sealing (Parking Lot)	2014	3,500	-	15	233	233	1,049	24
25				-		-			25
26	R/M Reclass: Decorating and Tiling- Service entrance ramp doors	2015	3,328	-	15	221	221	885	26
27	R/M Reclass: Cast iron piping and concrete bottom loading ramp	2015	4,825	-	20	241	241	965	27
28	R/M Reclass: Paving on outside parking lot	2015	4,600	-	20	230	230	920	28
29	R/M Reclass: Replace four sprinkler heads in outside canopy	2015	2,663	-	20	133	133	532	29
30	R/M Reclass: Cut out bad turf along curb of back driveway	2015	3,535	-	15	235	235	941	30
31	Update Shower Room in Facility	2015	6,100	222	27	222		721	31
32	EMR Building Wire- Entire Facility	2015	3,472	126	27	126		452	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 6,941,306	$ 59,367		$ 213,895	$ 154,528	$ 5,186,754	34

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,941,306	$ 59,367		$ 213,895	$ 154,528	$ 5,186,754	1
2				-		-			2
3				-		-			3
4	Update HVAC - Mechanical Room	2016	106,947	3,961	27	3,961		10,839	4
5	Room Renovations - 1st floor chair rails	2016	13,423	498	27	498		996	5
6	R/M reclass: Floor Pipe Repair Kitchen	2017	6,700	-	20	335	335	670	6
7	Update Tiles & Plumbing in 2nd & 3rd Floor Shower Rooms	2018	32,209	-	27	596.46	596	596	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	212,490	19
20	2nd Floor Remodel-Carpentry,Flooring,Electrical,painting	2008	487,333	-	27	17,721	17,721	177,213	20
21	Remodel special care units-carpentry,electrical,painting	2008	32,914	-	27	1,197	1,197	11,972	21
22	3rd floor remodel-carpentry,flooring,electrical,painting	2009	667,142	-	27	24,260	24,260	234,515	22
23	Parking lot seal and stripe	2011	3,600	-	27	131	131	952	23
24	Remodel LL Flooring-Carpentry,flooring, electrical	2011	27,575	-	27	1,003	1,003	7,107	24
25	Kitchen holding tank	2011	11,666	-	27	424	424	3,321	25
26	Drain tile and pits	2011	8,000	-	27	291	291	2,134	26
27				-					27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 8,870,044	$ 63,826		$ 283,632	$ 219,806	$ 5,849,557	34

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 12C, Carried Forward		$ 8,870,044	$ 63,826		$ 283,632	$ 219,806	$ 5,849,557	1
2				-		-			2
3	Mgmt Co.			-		-			3
4				-		-			4
5	Building-management company	2002	285,241	-	40	6,165	6,165	139,381	5
6	HVAC, electrical, security system-management company	2003	2,505	-	30	214	214	2,142	6
7	Key card system-management company	2004	394	-	20	19	19	284	7
8	VAC TX controls-management company	2005	120	-	20	6	6	83	8
9	Build Imp-management company	2006	87	-	20	6	6	71	9
10	Building Improvement Management Co.	2008	12,610	-	20	148	148	5,707	10
11	Building Improvement Management Co.	2009	2,405	-	20	129	129	1,246	11
12	Building Improvement Management Co.	2010	2,359	-	20	99	99	1,133	12
13	Building Improvement Management Co.	2011	1,774	-	20	81	81	620	13
14	Building Improvement Management Co.	2012	5,577	-	20	201	201	1,366	14
15	Building Improvement Management Co.	2013	4,634	-	20	262	262	1,709	15
16	Building Improvement Management Co.	2014	2,508	-	20	245	245	1,131	16
17	Building Improvement Management Co.	2015	441	-	20	53	53	189	17
18	Building Improvement Management Co.	2016	7,277	-	20	527	527	1,290	18
19	Building Improvement Management Co.	2017	4,654	-	20	196	196	288	19
20	Building Improvement Management Co.	2018	883	-	20	18	18	19	20
21				-					21
22				-					22
23				-					23
24				-					24
25				-					25
26				-					26
27				-					27
28				-					28
29				-					29
30				-					30
31	Reconcile to book depreciation			(782)			782		31
32				-					32
33				-					33
34	TOTAL (lines 1 thru 33)		$ 9,203,513	$ 63,044		$ 292,001	$ 228,957	$ 6,006,216	34

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 170,835	$ 30,546	$ 30,546	$ -	5-10	$ 92,855	71
72	Current Year Purchases	13,487	482	482	-	7	482	72
73	Fully Depreciated Assets	1,211,885	-	-	-	5-10	1,211,885	73
74	Allocated from Mgmt. Co.	547,684		14,356	14,356	5-7	501,760	74
75	TOTALS	$ 1,943,891	$ 31,028	$ 45,384	$ 14,356		$ 1,806,982	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.			51,837	-	1,867	1,867	5	46,876	79
80	TOTALS			$ 51,837	$	$ 1,867	$ 1,867		$ 46,876	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)	$	11,431,254	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	94,072	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	339,252	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	245,180	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	7,860,074	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 Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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				4,453			6
7	TOTAL				$ 4,453 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 84053 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			216	20
21	TOTAL		$	$ 216	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 Health Care Center of Streamwood, Inc.**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/18**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	5,730
Postage	323
Printer System	2,765
Equipment Rental	38,122
Oxygen	35,402
Mgmt Co.	1,711
Total - Line 16	**84,053**

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	7,581	$ 450,914	$	7,581	$ 450,914	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		6,081	170,136		6,081	170,136	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,058	560,889		9,058	560,889	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				264,266		264,266	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				5,400			5,400	12
13	Other (specify): See Sch 16A	39(2)					12,622		12,622	13
14	TOTAL			$	22,720	$ 1,187,339	$ 276,888	22,720	$ 1,464,227	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: **12/31/18**

Schedule 16A

Line 13 Other (specify)

Description	Units	Amount
Oxygen	39(2)	12,027
DME	39(2)	595
Total - Line 13	**-**	**12,622**

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 2,347	$ 72,577	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (3,480,661))	1,848,522	1,848,522	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	38,654	38,654	7
8	Accounts Receivable (owners or related parties)	882	882	8
9	Other(specify): Accrued Insurance	(2,508,894)	(1,583,188)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (618,489)	$ 377,447	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		232,013	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,686,443	3,849,955	15
16	Equipment, at Historical Cost	669,045	1,995,728	16
17	Accumulated Depreciation (book methods)	(1,545,520)	(7,860,074)	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 Rec from Ins Rec	81,917	81,917	22
23	Other(specify): Mortgage cost, net		193,225	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 891,885	$ 3,846,322	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 273,396	$ 4,223,769	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 497,519	$ 497,519	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,651,062	2,651,062	29
30	Accrued Salaries Payable	494,262	494,262	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,884	26,884	31
32	Accrued Real Estate Taxes(Sch.IX-B)		692,705	32
33	Accrued Interest Payable		41,507	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	18,718,400	4,863,512	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 22,388,127	$ 9,267,451	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,199,322	8,199,322	39
40	Mortgage Payable		6,342,934	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)**	$ 8,199,322	$ 14,542,256	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 30,587,449	$ 23,809,707	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (30,314,053)	$ (19,585,938)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 273,396	$ 4,223,769	48

*(See instructions.)

Facility Name: **Lexington Health Care Center of Streamwood, Inc.**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/18**

Schedule 17A

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

Description	Operating	After Consolidation
Cash Patient Trust	34,320	34,320
Rent Receivable	-	(13,854,888)
Due To Lex Fin Svcs I	-	-
Due To / From Rehab Care Therapy	24,336	24,336
Prepaid Insurance	48,468	48,468
Cobra	(591)	(591)
Withholding - Dental Insurance	(507)	(507)
Withholding - Ep/Ci/Wl	785	785
Vision Withholding	62	62
401K Withholding	(927)	(927)
Accrued Expenses	50,453	50,453
Accrued Resident Tax	-	-
Accrued Vesta 3% Management Fees	2,531,853	2,531,853
Accrued Royal Management Fees	1,626,750	1,626,750
Accrued Rent	13,854,888	13,854,888
Accrued Insurance	139,461	139,461
Due To Patient Trust Fund	(32,771)	(32,771)
Advance - Biweekly Part A Paym	66,826	66,826
Uncollectible Part A Co Pvts	(1)	(1)
Due To - Royal Operations	19,481	19,481
Due To Republic	2,340	2,340
Due To Lhcc Elmhurst	-	-
Due To Lagrange	-	-
Due To Lhcc Lombard	130,000	130,000
Due To Schaumburg	-	-
Due/To From	-	-
Due From Ins Carrier	(18,227)	(18,227)
Professional Liabilities Claims	241,401	241,401
Total - Line 36	**18,718,400**	**4,863,512**
	-	-

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (27,644,325)	1
2	Restatements (describe):		2
3	**Changes in Equity and Post Closing Adjustment**	(270,342)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (27,914,667)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,399,386)	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)**	$ (2,399,386)	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)**	$ (30,314,053)	24 *

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

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 18,533,239	1
2	Discounts and Allowances for all Levels	(9,813,359)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,719,880	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,864,157	6
7	Oxygen	(224)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,863,933	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	2,451	12
13	Barber and Beauty Care	13,620	13
14	Non-Patient Meals	1,067	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	357,654	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	135,966	19
20	Radiology and X-Ray	16,841	20
21	Other Medical Services	449,425	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 977,024	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,269	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,269	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,570,106	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,856,294	31
32	Health Care	5,689,047	32
33	General Administration	3,811,530	33
	B. Capital Expense		
34	Ownership	2,156,726	34
	C. Ancillary Expense		
35	Special Cost Centers	2,053,896	35
36	Provider Participation Fee	401,999	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,969,492	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,399,386)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,399,386)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,681,338	44
45	Private Pay - Net Inpatient Revenue	595,363	45
46	Medicare - Net Inpatient Revenue	514,638	46
47	Other-(specify) Managed Care	3,928,541	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,719,880	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 Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,884	2,249	$ 142,929	$ 63.56	1
2	Assistant Director of Nursing	1,773	2,238	103,399	46.20	2
3	Registered Nurses	26,508	33,473	1,137,737	33.99	3
4	Licensed Practical Nurses	32,275	40,496	1,113,919	27.51	4
5	CNAs & Orderlies	94,031	114,355	1,824,414	15.95	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	2,226	2,630	49,405	18.78	9
10	Activity Assistants	7,418	8,346	90,798	10.88	10
11	Social Service Workers	6,858	8,194	155,701	19.00	11
12	Dietician	2,058	2,295	61,988	27.01	12
13	Food Service Supervisor	1,246	1,505	43,086	28.62	13
14	Head Cook	-	-	-		14
15	Cook Helpers/Assistants	25,973	29,859	361,859	12.12	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	1,528	1,668	32,521	19.50	17
18	Housekeepers	29,199	34,660	399,179	11.52	18
19	Laundry	-	-	-		19
20	Administrator	1,454	2,079	125,661	60.44	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	-	-	-		23
24	Clerical	5,738	7,087	127,937	18.05	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	2,261	46,382	20.52	31
32	Other Health C: See Sch 20A	17,319	21,362	521,439	24.41	32
33	Other(specify) Marketing	-	-	911		33
34	TOTAL (lines 1 - 33)	259,305	314,759	$ 6,339,265 *	$ 20.14	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	Monthly	1,132	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,904	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	4,748	11(3)	44
45	Social Service Consultant	Monthly	4,002	12(3)	45
46	Other(specify) Pulmonary	Monthly	48,494	10(3)	46
47	Medical Consultant	Monthly	503	10(7)	47
48	See Sch 20B	Monthly	13,147	10(3)	48
49	TOTAL (lines 35 - 48)		$ 88,930		49

C. CONTRACT NURSES

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

Facility Name: **Lexington Health Care Center of Streamwood, Inc.**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/18**

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	2,331	2,819	41,854	14.85
Unit Secretary	4,850	6,036	130,438	21.61
Accounts Coordinator	1,917	2,374	40,158	16.91
Admissions	871	1,136	34,775	30.62
MDS	4,148	5,116	181,890	35.55
Clinical Coordinator	189	230	8,045	35.00
Dietetic Technician	1,442	1,675	28,742	17.16
Wound Care Coordinator	1,570	1,978	55,537	28.08
Total - Line 32 Other Health Care (specify):	**17,319**	**21,362**	**521,439**	

Facility Name: **Lexington Health Care Center of Streamwood, Inc.**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/18**

Schedule 20B

B. CONSULTANT SERVICES

Description	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
Post Acute Consultant	Monthly	4,072	10(3)
Telemedicine Consultant	Monthly	9,075	10(3)
Total - Line 48		**13,147**	

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kalsang Youtso	Administrator	0	$ 105,526
Jason Lee	Administrator	0	20,135
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,661

B. Administrative - Other

Description	Amount
Management Fees-Royal Operating	$ 883,009
Royal- Shared Services	697,501
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,580,510
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM US LLP	Accounting	$ 33,604
Royal Management/ Operation	Consulting	1,171
Midcap Financial	Rent	4,546
Lexington Financial Services	Financial	3,776
Personnel Planners Inc	Other Professional	1,665
The Joint commission	Joint Commission Consultant	6,525
See Schedule 21C	Various	168,770
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 220,057

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,081
Unemployment Compensation Insurance	50,981
FICA Taxes	468,195
Employee Health Insurance	264,942
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	14,445
Other Employee Benefits	22,512
Tuition Reimbursement	608
Uniform Allowance	3,078
TOTAL (agree to Schedule V, line 22, col.8)	$ 947,842

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	29,713
Health Care Worker Background Check	
(Indicate # of checks performed 163)	1,950
Patient Background Checks 317	3,805
Miscellaneous Licenses & Fees	4,906
Miscellaneous Dues & Subscriptions	2,542
Employment Fees	62,781
Allocated from Home Office	16,590
IHCA Dues	4,686
Less: Public Relations Expense	(1,493)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 127,470

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from Home Office	737
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 737

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Lexington Health Care Center of Streamwood, Inc.**
IDPH License ID Number: **0037002**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Various	Collections	18,280
Much Shelist	Legal	6,542
Mcguire Woods	Legal	3,168
Huges socol Piers	Legal	942
Serpico,Petrosino	Legal	9,168
Bert Spilker	Legal	76
Midacap Financial	Legal	2,765
Duane Morris	Legal	1,042
Hinshaw & Culbertson	Legal	234
Secretary of state	Legal	100
Favaro & Gorman limited	Legal	5,555
Connected For Care Ll	Computer Services	7,758
Curatess	Computer Services	2,587
Lawson	Computer Services	13,511
Relias	Computer Services	9,297
Mhc Sw	Computer Services	24
Onshift	Computer Services	8,846
Icims	Computer Services	4,690
Salesforce	Computer Services	8,705
Info Control	Computer Services	2,344
National Datacare Corp.	Computer Services	2,276
Computer Software	Computer Services	16,766
Comp Supply	Computer Services	1,436
Computer Services - Prof Services	Computer Services	5,271
Softchoice	Computer Services	2,186
Hardware Support	Computer Services	114
Touch Point	Computer Services	2,553
Alexa Internet	Computer Services	8
Microsoft	Computer Services	13,177
Netsmart	Computer Services	12,848
Health Medx Software	Computer Services	641
Gp Software	Computer Services	5,857
Total (agree to Schedule V, line 19, column 3)		220,057.00
Allocated from Management Company	Professional Services	250
Less: Non-Allowable Legal Fees		(18,377)
		201,930
Allocated from Mgmt Co.		
Much Shelist	Legal	1,596
Duane Morris	Legal	1,021
Partridge Partners	Legal	77
RSM	Accounting	1,752
Friedman & Huey	Accounting	528
IL Secretary of State	Filing Fees	5
West Suburban Bank	Banking	6
Personnel Planners	U/C Consultant	11
LaSalle Network	Recruiting / Finance	9,255
Pension Administrators, Inc.	401K Administration	241
Gene Whitehorn	Public Aid Pending Consultant	1,595
Steely Group LLC	Financial Consulting	2,602
M Werner Consulting	Public Aid Consultant	72
Early Stage Solutions	Financial Consulting	17,643
Objective Arts	Public Aid Pending Consultants	323
Adam Lefton	Financial Consulting	7,482
Brilliant Staffing LLC	Financial Consulting	2,487
Mark J Eenigenburg	Budgeting Consultant	2,328
Deloitte Consulting LLP	Compensation Consulting	1,091
John Mattone Partners	Workplace Consultant	6,016
Mark Rodeghier	Survey Preparation Consultant	322
JGC Advisors LLC	Contracting Consultant	151
Michel Desjardins	Contracting Consultant	81
Pathway Health Services	Operational & Financial Consulti	(172)
Brandlin & Associates	Banking Consultants	23,207
Steven Wood	Strategy/Operations Consulting	915
Susan Parker	Social Service Consultant	15
Focus Pointe Global	Strategic Planning	253
Andrzej Stankiewicz	General Business Consulting	212
DLC	Financial Planning & Analysis	3,400
Fieldwork	Recruitment Consultant	455
Computer Services	Computer Consulting	20,970
		105,939
Allocated from SV of Lombard II		
Friedman & Huey	Accounting	131
Duane Morris	Legal	25
Illinois Secretary of State	Filing Fees	3
		159
Total (agree to Schedule V, line 19, column 8)		**308,028**

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 - $4686**

(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. $ **46,153** 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. $ **401,999**
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. $ **1067**

(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? **Yes**
Firm Name: **RSM US LLP**

(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.