

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0037002</u></p> <p>Facility Name: <u>Lexington of Streamwood</u></p> <p>Address: <u>815 East Irving Park Road</u> <u>Streamwood</u> <u>60107</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(630) 837-5300</u> Fax # <u>(630) 213-9076</u></p> <p>HFS ID Number: <u>363748803001</u></p> <p>Date of Initial License for Current Owners: <u>7/8/91</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u> Email Address: <u>mike.martin@rsmi.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td> </tr> </table> <p align="center">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>		(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	214	Skilled (SNF)	214	78,110	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	214	TOTALS	214	78,110	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			14,335	14,335	8
9	SNF/PED					9
10	ICF	43,681	4,550		48,231	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,681	4,550	14,335	62,566	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.10%

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 removed on 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 9,803

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number

Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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
	A. General Services										
1	Dietary	394,389	33,685	21,354	449,428		449,428	449,428			1
2	Food Purchase		296,677		296,677		296,677	(16,347)	280,330		2
3	Housekeeping	359,201	37,222		396,423		396,423	532	396,955		3
4	Laundry	83,989	20,447		104,436		104,436		104,436		4
5	Heat and Other Utilities			253,451	253,451		253,451	8,800	262,251		5
6	Maintenance	33,679		127,008	160,687		160,687	54,409	215,096		6
7	Other (specify):* Alloc. From Mgmt Cd							5,974	5,974		7
8	TOTAL General Services	871,258	388,031	401,813	1,661,102		1,661,102	53,368	1,714,470		8
	B. Health Care and Programs										
9	Medical Director			50,400	50,400		50,400		50,400		9
10	Nursing and Medical Records	4,290,889	384,758	225,116	4,900,763		4,900,763	48,637	4,949,400		10
10a	Therapy			989,825	989,825		989,825		989,825		10a
11	Activities	276,325	27,186	11,269	314,780		314,780		314,780		11
12	Social Services	216,926		7,513	224,439		224,439		224,439		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Alloc. From Mgmt Cd							5,872	5,872		15
16	TOTAL Health Care and Programs	4,784,140	411,944	1,284,123	6,480,207		6,480,207	54,509	6,534,716		16
	C. General Administration										
17	Administrative	129,642		1,197,860	1,327,502		1,327,502	(1,150,807)	176,695		17
18	Directors Fees										18
19	Professional Services			207,848	207,848		207,848	26,581	234,429		19
20	Dues, Fees, Subscriptions & Promotions			185,297	185,297		185,297	(478)	184,819		20
21	Clerical & General Office Expenses	360,055	39,209	26,743	426,007		426,007	413,664	839,671		21
22	Employee Benefits & Payroll Taxes			843,952	843,952		843,952	16,347	860,299		22
23	Inservice Training & Education			5,805	5,805		5,805	21	5,826		23
24	Travel and Seminar			4,140	4,140		4,140	1,169	5,309		24
25	Other Admin. Staff Transportation			543	543		543	19,173	19,716		25
26	Insurance-Prop.Liab.Malpractice			198,813	198,813		198,813	6,761	205,574		26
27	Other (specify):* Alloc. From Mgmt Cd							67,335	67,335		27
28	TOTAL General Administration	489,697	39,209	2,671,001	3,199,907		3,199,907	(600,234)	2,599,673		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,145,095	839,184	4,356,937	11,341,216		11,341,216	(492,357)	10,848,859		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lexington of Streamwood

#0037002

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			149,111	149,111		149,111	382,441	531,552			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,538	76,538		76,538	340,350	416,888			32
33	Real Estate Taxes							543,143	543,143			33
34	Rent-Facility & Grounds			1,929,543	1,929,543		1,929,543	(1,925,343)	4,200			34
35	Rent-Equipment & Vehicles			85,674	85,674		85,674	4,122	89,796			35
36	Other (specify):*											36
37	TOTAL Ownership			2,240,866	2,240,866		2,240,866	(655,287)	1,585,579			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		504,938	1,335	506,273		506,273		506,273			39
40	Barber and Beauty Shops			20,638	20,638		20,638		20,638			40
41	Coffee and Gift Shops			3,309	3,309		3,309		3,309			41
42	Provider Participation Fee			117,165	117,165		117,165		117,165			42
43	Other (specify):* Non-allowable cost			128,007	128,007		128,007	(128,007)				43
44	TOTAL Special Cost Centers		504,938	270,454	775,392		775,392	(128,007)	647,385			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,145,095	1,344,122	6,868,257	14,357,474		14,357,474	(1,275,651)	13,081,823			45

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

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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				4
5	Telephone, TV & Radio in Resident Rooms	(7,781)	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				9
10	Interest and Other Investment Income	(92,916)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(575)	43		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	(3,389)	43		19
20	Contributions	(5,750)	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	(42,210)	43		24
25	Fund Raising, Advertising and Promotional	(27,862)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(149,730)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (330,213)		\$	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)	(945,438)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (945,438)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,275,651)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
				52	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of StreamwoodID# 0037002Report Period Beginning: 01/01/2009Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Diagnostics Managed Care	\$ (633)	43	1
2	Labs-Part A	(14,116)	43	2
3	X-Rays-Part A	(25,491)	43	3
4	Cash Over/Short	(200)	43	4
5	Misc. Income	(732)	21	5
6	Trust Fees	(103)	43	6
7	Collections	(5,858)	19	7
8	Out of period legal	(260)	19	8
9	Marketing Salary	(101,097)	21	9
10	Chamber of Commerce dues	(1,240)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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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		(149,730)	49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Streamwood# 0037002

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	532	0	0	0	0	0	0	0	0	532	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	8,800	0	0	0	0	0	0	0	0	8,800	5
6	Maintenance	0	0	54,409	0	0	0	0	0	0	0	0	54,409	6
7	Other (specify):*	0	0	5,974	0	0	0	0	0	0	0	0	5,974	7
8	TOTAL General Services	0	0	69,715	0	0	0	0	0	0	0	0	69,715	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	48,637	0	0	0	0	0	0	0	0	48,637	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	5,872	0	0	0	0	0	0	0	0	5,872	15
16	TOTAL Health Care and Programs	0	0	54,509	0	0	0	0	0	0	0	0	54,509	16
	C. General Administration													
17	Administrative	0	0	47,053	(1,197,860)	0	0	0	0	0	0	0	(1,150,807)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,118)	200	32,499	0	0	0	0	0	0	0	0	26,581	19
20	Fees, Subscriptions & Promotions	(1,240)	0	762	0	0	0	0	0	0	0	0	(478)	20
21	Clerical & General Office Expenses	(101,829)	0	502,321	13,172	0	0	0	0	0	0	0	413,664	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	21	0	0	0	0	0	0	0	0	21	23
24	Travel and Seminar	0	0	0	1,169	0	0	0	0	0	0	0	1,169	24
25	Other Admin. Staff Transportation	0	0	0	19,173	0	0	0	0	0	0	0	19,173	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	6,761	0	0	0	0	0	0	0	6,761	26
27	Other (specify):*	0	0	0	67,335	0	0	0	0	0	0	0	67,335	27
28	TOTAL General Administration	(109,187)	200	582,656	(1,090,250)	0	(616,581)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,187)	200	706,880	(1,090,250)	0	(492,357)	29						

STATE OF ILLINOIS

Facility Name & ID Number Lexington of Streamwood# 0037002

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	322,929	0	59,512	0	0	0	0	0	0	0	382,441	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(92,916)	416,642	0	16,624	0	0	0	0	0	0	0	340,350	32
33	Real Estate Taxes	0	537,543	0	5,600	0	0	0	0	0	0	0	543,143	33
34	Rent-Facility & Grounds	0	(1,929,543)	0	4,200	0	0	0	0	0	0	0	(1,925,343)	34
35	Rent-Equipment & Vehicles	0	0	0	4,122	0	0	0	0	0	0	0	4,122	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(92,916)	(652,429)	0	90,058	0	(655,287)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(128,110)	103	0	0	0	0	0	0	0	0	0	(128,007)	43
44	TOTAL Special Cost Centers	(128,110)	103	0	0	0	0	0	0	0	0	0	(128,007)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(330,213)	(652,126)	706,880	(1,000,192)	0	(1,275,651)	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		See Schedule 6B		

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	**	322,929	322,929	2
3	V	32 Interest expense		Sambell of Streamwood Limited Partnership	**	414,349	414,349	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	**	537,543	537,543	5
6	V	34 Rental expense	1,929,543	Sambell of Streamwood Limited Partnership	**		(1,929,543)	6
7	V	43 Trust fees		Sambell of Streamwood Limited Partnership	**	103	103	7
8	V							8
9	V							9
10	V							10
11	V			Lexington Health Care Center of Streamwood, Inc.				11
12	V			own 100% of Sambell of Streamwood Limited Partnership.				12
13	V							13
14	Total		\$ 1,929,543			\$ 1,277,417	\$ * (652,126)	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.	**	\$ 532	\$	532	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	7,576		7,576	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	205		205	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	1,019		1,019	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	46,309		46,309	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	7,701		7,701	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	399		399	21
22	V	6 Security service		Royal Management Corp.	**				22
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,974		5,974	23
24	V	10 Medical consultant		Royal Management Corp.	**	3,117		3,117	24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	45,520		45,520	25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	5,872		5,872	26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	47,053		47,053	27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	21,532		21,532	28
29	V	19 Professional fees		Royal Management Corp.	**	10,967		10,967	29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	425		425	30
31	V	23 Inservice Training		Royal Management Corp.	**	21		21	31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	337		337	32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	474,908		474,908	33
34	V	21 Bank charges		Royal Management Corp.	**	9,543		9,543	34
35	V	21 Office supplies & printing		Royal Management Corp.	**	13,467		13,467	35
36	V	21 Postage		Royal Management Corp.	**	4,403		4,403	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% or Royal Management Corp.							38
39	Total		\$			\$ 706,880	\$ *	706,880	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	21 Telephone	\$	Royal Management Corp.	**	\$ 13,172	\$ 13,172
16	V	24 Travel & seminar		Royal Management Corp.	**	1,169	1,169
17	V	25 Auto expense		Royal Management Corp.	**	19,173	19,173
18	V	26 Insurance general		Royal Management Corp.	**	6,761	6,761
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	67,335	67,335
20	V	30 Depreciation		Royal Management Corp.	**	59,512	59,512
21	V	32 Interest		Royal Management Corp.	**	16,589	16,589
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	35	35
23	V	33 Property taxes		Royal Management Corp.	**	5,600	5,600
24	V	34 Rent expense		Royal Management Corp.	**	4,200	4,200
25	V	35 Equipment rental		Royal Management Corp.	**	968	968
26	V	17 Management fees	1,197,860	Royal Management Corp.	**		(1,197,860)
27	V	35 Auto Lease Expense		Royal Management Corp.	**	3,154	3,154
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 1,197,860			\$ 197,668	\$ * (1,000,192)

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

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/09 - 12/31/09

Schedule B

VII. Related Parties

Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

Related Nursing Homes

	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

Other Related Business Entities

Sambell of Streamwood Limited Partnership	Streamwood	Real Estate Partnership
Eastgate Manor	Algonquin	Supportive Living Facility
Vesta Management Group, LLC	Lombard	Management Company
Royal Management Corp.	Lombard	Management Company
Lexington Financial Services, L.L.C	Lombard	Finance Company

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	23.33	See Schedule 7A	3.47	8.67	Salary	\$ 11,445	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33	See Schedule 7A	3.79	7.59	Salary	18,501	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34	See Schedule 7A	3.47	8.67	Salary	8,702	L17, C7	3
4	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	5.42	10.84	Salary	8,405	L17, C7	4
5											5
6											6
7											7
8					Certain individuals work in excess of 40 hours per week						8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 47,053		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood# 0037002

Report Period Beginning:

01/01/2009Ending: 2/31/2009

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

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

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

1	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	720,658	10	\$ 4,909	\$ 78,110	\$ 532	1
2	5	Utilities - gas & electric	Bed Days	720,658	10	69,894	78,110	7,576	2
3	5	Utilities - water & sewer	Bed Days	720,658	10	1,894	78,110	205	3
4	5	Utilities - maintenance office	Bed Days	720,658	10	9,406	78,110	1,019	4
5	6	Management allocation - salaries	Bed Days	720,658	10	427,259	427,259	46,309	5
6	6	Repairs & maintenance	Bed Days	720,658	10	71,047	78,110	7,701	6
7	6	Scavenger & exterminating	Bed Days	720,658	10	3,681	78,110	399	7
8	6	Security service	Bed Days	720,658	10		78,110	0	8
9	7	Management allocation - employe	Bed Days	720,658	10	55,118	78,110	5,974	9
10	10	Medical consultant	Bed Days	720,658	10	28,762	78,110	3,117	10
11	10	Management allocation - salaries	Bed Days	720,658	10	419,975	419,975	45,520	11
12	15	Management allocation - employe	Bed Days	720,658	10	54,178	78,110	5,872	12
13	17	Management allocation - salaries	Bed Days	720,658	10	434,122	434,122	47,053	13
14	19	Computer consultant & supplies	Bed Days	720,658	10	198,663	78,110	21,532	14
15	19	Professional fees	Bed Days	720,658	10	101,182	78,110	10,967	15
16	20	Dues & subscriptions	Bed Days	720,658	10	3,923	78,110	425	16
17	23	Inservice Training	Bed Days	720,658	10	193	78,110	21	17
18	20	Advertising - help wanted	Bed Days	720,658	10	3,108	78,110	337	18
19	21	Management allocation - salaries	Bed Days	720,658	10	4,381,596	4,381,596	474,908	19
20	21	Bank charges	Bed Days	720,658	10	88,048	78,110	9,543	20
21	21	Office supplies & printing	Bed Days	720,658	10	124,253	78,110	13,467	21
22	21	Postage	Bed Days	720,658	10	40,624	78,110	4,403	22
23	21	Telephone	Bed Days	720,658	10	121,527	78,110	13,172	23
24	24	Travel and Seminar	Bed Days	720,658	10	10,782	78,110	1,169	24
25	TOTALS					\$ 6,654,144	\$ 5,662,952	\$ 721,221	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood

0037002 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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

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

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

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	25	Auto expense	Bed Days	720,658	10	\$ 176,898	\$ 78,110	\$ 19,173	1
2	26	Insurance general	Bed Days	720,658	10	62,379	78,110	6,761	2
3	27	Management allocation - employe	Bed Days	720,658	10	621,243	78,110	67,335	3
4	30	Depreciation - leasehold improv.	Bed Days	720,658	10	549,069	78,110	59,512	4
5	32	Interest	Bed Days	720,658	10	153,050	78,110	16,589	5
6	32	Amortization of mortgage costs	Bed Days	720,658	10	321	78,110	35	6
7	33	Property taxes	Bed Days	720,658	10	51,670	78,110	5,600	7
8	34	Rent expense	Bed Days	720,658	10	38,747	78,110	4,200	8
9	35	Equipment rental	Bed Days	720,658	10	8,933	78,110	968	9
10	35	Auto lease	Bed Days	720,658	10	29,106	78,110	3,155	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,691,416	\$	\$ 183,328	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3	Lexington Financial																
4	Services, L.L.C	X		Mortgage	Varies	5/22/08	6,734,000	6,616,244	1/1/33	Variable	414,349						
5							Interest on financing insurance permium				607						
	Working Capital																
6	Shareholders	X		Working Capital	None	Various	1,154,048	6,786,828	Demand	Prime +1	75,931						
7	Bank of America		X	Working Capital	None	4/4/04	1,300,000		6/30/10	Prime/Libor							
8																	
9	TOTAL Facility Related						\$ 9,188,048	\$ 13,403,072			\$ 490,887						
	B. Non-Facility Related*																
10											2,328						
11											(16,985)						
12											16,589						
13											(75,931)						
14	TOTAL Non-Facility Related						\$	\$			\$ (73,999)						
15	TOTALS (line 9+line14)						\$ 9,188,048	\$ 13,403,072			\$ 416,888						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

1. Real Estate Tax accrual used on 2008 report.		\$	507,600	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.)	2008	\$	500,084	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,516)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	532,800	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.)		\$	12,259	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	5,600	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	543,143	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	441,442	8	
	2005	449,212	9	
	2006	443,467	10	
	2007	492,792	11	
	2008	500,084	12	

Accrual Computation				
See Attached Schedule				
Use: \$500,084				

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Streamwood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>06-25-300-006-0000</u>	<u>Land & Building</u>	\$ <u>500,083.57</u>	\$ <u>500,083.57</u>
2.	<u>Royal Management Corp(Samvest of Lombard II)</u>		\$ _____	\$ _____
3.	<u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>164,952.68</u>	\$ <u>5,600.00</u>

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>665,036.25</u>	\$ <u>505,683.57</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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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.**

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 B. General Construction Type: Exterior Concrete Blcok 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

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: _____ 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>30,000</u>	<u>1991</u>	<u>\$ 211,400</u>	1
2	<u>Allocated from Management Compnay</u>		<u>2002</u>	<u>20,006</u>	2
3	TOTALS	30,000		\$ 231,406	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	200	1991	1991	\$ 5,248,322	\$	35	\$ 149,952	\$ 149,952	\$ 2,774,113	4
5		1993	1993	105,236		35	3,007	3,007	49,611	5
6	14	1995	1995	82,650	2,361	35	2,361		34,240	6
7										7
8										8
	Improvement Type**									
9	Building Improvement	1993		7,336		35	210	210	3,459	9
10	Land Improvements	1995		7,000	467	15	467		6,767	10
11	Kitchen & Nurses Station	1996		12,316	352	35	352		4,751	11
12	Piping	1996		3,139	90	35	90		1,211	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			2,051	17
18	Tile	1998		11,697		10			11,697	18
19	Patio	1999		12,012	801	15	801		8,075	19
20	Parking lot	2000		1,773	177	10	177		1,684	20
21	110-ton A/C unit	2000		6,923	692	10	692		6,576	21
22	Rods for bedside curtains	2000		5,872	587	10	587		5,578	22
23	Automatic doors	2000		1,300	130	10	130		1,235	23
24	Rehab project: carpeting, wallcovering, handrails, painting	2000		85,195	8,519	10	8,519		80,934	24
25	Compressor/tube bundles-cooling system	2001		12,921	1,292	10	1,292		10,983	25
26	Rehab project: resident rooms, corridors, dining room	2001		212,217	10,611	20	10,611		90,193	26
27	Parking lot	2002		29,288	2,929	10	2,929		21,966	27
28	Office area rehab	2002		26,991	1,350	20	1,350		10,123	28
29	Elevator interior upgrade	2002		1,120	112	10	112		850	29
30	Gazebo	2002		3,393	339	10	339		2,544	30
31	Elevator electronic curtains	2002		4,500	450	10	450		3,563	31
32	Door frame protector	2003		5,276	528	10	528		3,650	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring	2003		9,392	939	10	939		6,026	33
34	Roof	2003		29,950	1,498	20	1,498		9,111	34
35	Kitchen Sewer/Dishroom	2004		6,224	622	10	622		3,319	35
36	Compressor/tube bundles-cooling system	2004		14,737	737	20	737		3,930	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood# 0037002

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	\$ 143	10	\$ 143	\$	\$ 821	37
38	Landscaping	2005	8,495	425	20	425		1,806	38
39	Kitchen renovation	2005	12,034	602	20	602		2,407	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		7,488	40
41	Therapy room renovation	2005	11,628	581	20	581		2,519	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		11,195	42
43	Dialysis units	2005	66,426	3,783	20	3,783		15,908	43
44	Create transitional unit	2005	14,490	725	20	725		2,899	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		1,479	45
46	Basement renovation	2005	46,561	2,328	20	2,328		9,700	46
47	Landscaping enhancement	2006	3,414	228	15	228		797	47
48	HVAC	2006	17,125	856	20	856		2,640	48
49	Door closer	2006	4,446	222	20	222		833	49
50	Blinds	2006	1,566	313	5	313		965	50
51	Employee lunch room rehab	2006	2,883	144	20	144		528	51
52	Storeroom door lock	2006	2,843	142	20	142		497	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		11,258	53
54	Fine dining	2006	7,650	382	20	382		1,370	54
55	Automatic door	2006	2,259	113	20	113		367	55
56	Landscaping	2007	10,606	530	20	530		1,104	56
57	Parking lot	2007	2,777	139	20	139		313	57
58	HVAC	2007	1,501	75	20	75		206	58
59	Painting Building	2007	16,150	808	20	808		1,952	59
60	Landscaping	2008	33,747	2,250	15	2,250		2,437	60
61	Common areas-metal doors	2008	7,055	353	20	353		618	61
62	Wanderguard	2008	3,882	194	20	194		388	62
63	Lawn Irrigation	2009	18,125	302	15	302		302	63
64	Landscaping	2009	3,138	139	15	139		139	64
65	Quick connectors	2009	9,375	313	20	313		313	65
66	1st floor admin office-heating,plumbing	2009	13,598	43	20	43		43	66
67	Fire alarm system	2009	5,271		20				67
68	Metal Doors-painting	2009	4,650	155	20	155		155	68
69	2nd Floor Remodel-carpentry	2009	33,503	628	40	628		628	69
70	TOTAL (lines 4 thru 69)		\$ 6,491,738	\$ 60,048		\$ 213,217	\$ 153,169	\$ 3,267,635	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12A, Carried Forward		\$ 6,491,738	\$ 60,048		\$ 213,217	\$ 153,169	\$ 3,267,635	1
2	Patio Pergola	2009	7,930	264	10	264		264	2
3									3
4									4
5									5
6	Real Estate Entity								6
7	1st floor remodel-Carpentry,flooring,electrical,painting	2008	531,230		27	19,317	19,317	38,635	7
8	2nd Floor Remodel-Carpentry,Flooring,Electrical,painting	2008	487,332		27	17,721	17,721	17,721	8
9	Remodel special care units-carpentry,electrical,painting	2008	32,914		27	1,197	1,197	1,197	9
10	3rd floor remodel-carpentry,flooring,electrical,painting	2009	667,142		27	16,173	16,173	16,173	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	Mgmt Co.								21
22									22
23	Building-management company	2002	276,840		40	8,053	8,053	65,192	23
24	HVAC, electrical, security system-management company	2003	2,432		30	165	165	1,077	24
25	Key card system-management company	2004	382		20	19	19	104	25
26	VAC TX controls-management company	2005	116		20	6	6	28	26
27	Build Imp-management company	2006	85		5	6	6	18	27
28	Building Improvement Management Co.	2008	9,194		5	688	688	867	28
29	Building Improvement Management Co.	2009	691		15	12	12	12	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,508,026	\$ 60,312		\$ 276,838	\$ 216,526	\$ 3,408,923	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 924,166	\$ 76,261	\$ 160,782	\$ 84,521	5	\$ 439,664	71
72	Current Year Purchases	453,048	12,538	43,368	30,830	5	43,368	72
73	Fully Depreciated Assets	16,720					16,720	73
74	Allocated from Mgmt Co.	304,420		44,430	44,430		221,422	74
75	TOTALS	\$ 1,698,354	\$ 88,799	\$ 248,580	\$ 159,781		\$ 721,174	75

D. Vehicle Depreciation (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.			44,945		6,134	6,134		28,354	79
80	TOTALS			\$ 44,945	\$	\$ 6,134	\$ 6,134		\$ 28,354	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)	\$ 10,482,731	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 149,111	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 531,552	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 382,441	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,158,451	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co.				4,200			6
7	TOTAL				\$ 4,200			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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 86,642 Description: Copier-\$8,913;Mailing System-\$72;Med Equip-\$38,799;Oxygen-\$37,890;Mgmt Co.-968

(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	Alloc. Mgmt Co.			3,154	19
20					20
21	TOTAL		\$	\$ 3,154	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,557	\$ 349,850	\$	5,557	\$ 349,850	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,748	113,289		1,748	113,289	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,571	526,686		11,571	526,686	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				504,938		504,938	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Dentist</u>	39(3)				1,335			1,335	12
13	Other (specify):									13
14	TOTAL			\$	18,876	\$ 991,160	\$ 504,938	18,876	\$ 1,496,098	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood# 0037002Report Period Beginning: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 193,593	\$ 204,360	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>516,137</u>)	1,957,160	1,957,160	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,135	11,135	6
7	Other Prepaid Expenses	56,932	56,932	7
8	Accounts Receivable (owners or related parties)	3,076	247,943	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,221,896	\$ 2,477,530	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,884	67,884	12
13	Land		231,406	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,138,771	3,154,468	15
16	Equipment, at Historical Cost	661,425	1,743,299	16
17	Accumulated Depreciation (book methods)	(752,188)	(4,158,451)	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</u>		53,633	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,115,892	\$ 6,445,797	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,337,788	\$ 8,923,327	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 536,069	\$ 536,069	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,117	4,117	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	355,800	355,800	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,676	7,676	31
32	Accrued Real Estate Taxes(Sch.IX-B)		532,800	32
33	Accrued Interest Payable		44,663	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	7,421,891	1,818,637	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,325,553	\$ 3,299,762	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,786,828	6,786,828	39
40	Mortgage Payable		6,616,244	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,786,828	\$ 13,403,072	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,112,381	\$ 16,702,834	46
47	TOTAL EQUITY(page 18, line 24)	\$ (11,774,593)	\$ (7,779,507)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,337,788	\$ 8,923,327	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/09-12/31/09

Schedule 17A

XV. Balance Sheet
C. Current Liabilities

36. Other current liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due from Royal	21,259	21,259
Due from LHCC Bloc	10,050	10,050
Escrow-Insurance	619,279	619,279
Accrued 401K	20,536	20,536
Accrued Expenses	76,880	76,880
Accrued Royl Genl IV	43,917	43,917
Accrued Rent	6,291,506	
Accrued Wage Assig	41	41
Deferred Income	338,423	338,423
Interest Rate Swap		688,252
	<u>7,421,891</u>	<u>1,818,637</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (9,117,922)	1
2	Restatements (describe):		2
3			3
4	Post closing adjustment	(359,980)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,477,902)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,296,691)	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)	\$ (2,296,691)	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)	\$ (11,774,593)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood# 0037002Report Period Beginning: 01/01/2009Ending: 12/31/2009

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		
Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 16,631,116	1	
2	Discounts and Allowances for all Levels	(7,797,558)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,833,558	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	2,344,939	6	
7	Oxygen	4,132	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,349,071	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	3,494	12	
13	Barber and Beauty Care	21,759	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	497,676	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	78,687	19	
20	Radiology and X-Ray	22,398	20	
21	Other Medical Services	240,819	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 864,833	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	12,589	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,589	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Miscellaneous Income	732	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 732	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,060,783	30	

		2		
Expenses		Amount		
A. Operating Expenses				
31	General Services	1,661,102	31	
32	Health Care	6,480,207	32	
33	General Administration	3,199,907	33	
B. Capital Expense				
34	Ownership	2,240,866	34	
C. Ancillary Expense				
35	Special Cost Centers	658,227	35	
36	Provider Participation Fee	117,165	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,357,474	40	
41	Income before Income Taxes (line 30 minus line 40)**	(2,296,691)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,296,691)	43	

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

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

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

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

Facility Name & ID Number Lexington of Streamwood

0037002

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	1,937	2,124	\$ 123,774	\$ 58.27	1
2	Assistant Director of Nursing	11,115	12,028	436,179	36.26	2
3	Registered Nurses	42,985	46,582	1,468,759	31.53	3
4	Licensed Practical Nurses	32,190	33,878	824,226	24.33	4
5	CNAs & Orderlies	102,422	107,836	1,284,827	11.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,243	10,015	122,721	12.25	8
9	Activity Director					9
10	Activity Assistants	18,923	20,265	276,325	13.64	10
11	Social Service Workers	13,551	14,429	216,926	15.03	11
12	Dietician	7,027	7,411	71,908	9.70	12
13	Food Service Supervisor	2,073	2,193	45,780	20.88	13
14	Head Cook	2,106	2,212	33,158	14.99	14
15	Cook Helpers/Assistants	7,827	8,406	88,231	10.50	15
16	Dishwashers	18,282	19,023	155,312	8.16	16
17	Maintenance Workers	2,016	2,160	33,679	15.59	17
18	Housekeepers	37,013	39,815	359,201	9.02	18
19	Laundry	9,203	9,801	83,989	8.57	19
20	Administrator	1,735	1,968	129,642	65.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,872	23,274	360,055	15.47	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	1,758	1,928	30,403	15.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	343,278	365,348	\$ 6,145,095 *	\$ 16.82	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	372	\$ 21,354	1(3)	35
36	Medical Director	Monthly	50,400	9(3)	36
37	Medical Records Consultant	15	825	10(3)	37
38	Nurse Consultant	Monthly	9,196	10(3)	38
39	Pharmacist Consultant	Monthly	12,090	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	107	5,290	11(3)	44
45	Social Service Consultant	109	5,473	12(3)	45
46	Other(specify) <u>Psychosocial</u>	43	2,040	12(3)	46
47	<u>Pulmonary Consultant</u>	Monthly	11,193	10(3)	47
48	<u>See Sch 20A</u>		3,949		48
49	TOTAL (lines 35 - 48)	646	\$ 121,810		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,804	\$ 97,436	10(3)	50
51	Licensed Practical Nurses	898	35,550	10(3)	51
52	Certified Nurse Assistants/Aides	2,231	57,994	10(3)	52
53	TOTAL (lines 50 - 52)	4,933	\$ 190,980		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/09-12/31/09

Schedule 20 A

B. Consultant Services

<u>Type</u>	<u>Hours</u>	<u>Amount</u>	<u>Line</u>
Project Development	Monthly	832	10(3)
Medical Consultant	Monthly	3,117	10(7)
		<u>3,949</u>	

See Accountants' Compilation Report

Schedule 21C

XIX. Support Schedules

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Life Insurance Annuity	Pension Administrator	4,245
RSM McGladrey	Accounting	9,825
Action Computer Service	Computer Consulting	597
B2B Computer Products	Computer Consulting	46
C.D.W. Direct	Computer Consulting	735
E-Health Data Solutions	Computer Consulting	2,400
Healthware Consulting	Computer Consulting	1,415
Information Control	Computer Consulting	1,445
Krakau Business	Computer Consulting	353
Lanac/GP	Computer Consulting	3,055
Lintech LLC	Computer Consulting	4,306
Microsoft License	Computer Consulting	4,823
Micro Center A/R	Computer Consulting	43
MNJ Technologies	Computer Consulting	112
National Datacare	Computer Consulting	2,205
Silverchair Learning Systems	Computer Consulting	4,200
Vision Share	Computer Consulting	863
Visual Click	Computer Consulting	125
		40,793

Schedule V, line 19, column 3 207,848

Collection fees -5858
 Out of period legal -260

Sambell of Streamwood
James Samatas 200

Samvest of Lombard
Legal 231
Accounting 98
329

Allocated from Mgmt Co.
James Samatas Legal 63
Reed Smith Legal 2573
Much Shelist Legal 1620
Serpico, Petrosino, Dipiero Legal 12
McGladrey & Pullen Accounting 787
RSM McGladrey Accounting 606
Aronberg, Goldgehn Davis 401K Administration 2
LaSalle Network Accounting 1026
Gilson Labus & Silverman Accounting 512
KMZ Rosenmann Legal 1875
ING Life & Annuity 401K Administration 124
Pension Administrators, Inc. 401K Administration 547
Personnel Planners, Inc. Unemployment Consu 33
Gene Whitehorn Medicaid Reimb Spec 858
Computer Services Computer Consulting 21532
32170

Schedule V, line 19, column 8 234,429

See Accountants' Compilation Report

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood# 0037002Report Period Beginning: 01/01/2009 Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,126 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES No 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. \$ 117,165
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. \$ 16,347 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT