

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc.

0037002 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	<u>214</u>	Skilled (SNF)	<u>214</u>	<u>78,110</u>	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	<u>214</u>	TOTALS	<u>214</u>	<u>78,110</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			<u>9,810</u>	<u>9,810</u>		8
9	SNF/PED						9
10	ICF	<u>35,789</u>	<u>8,075</u>	<u>2,962</u>	<u>46,826</u>		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	<u>35,789</u>	<u>8,075</u>	<u>12,772</u>	<u>56,636</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.51%

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 NO

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

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

YES NO

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

Date started 7/8/91

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

YES Date New Construction NO

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

YES NO If YES, enter number of beds certified 214 and days of care provided 7,772

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Lexington Health Care Center of Streamwood # 0037002 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	451,962	35,763	3,024	490,749		490,749	-	490,749		1
2	Food Purchase		382,026		382,026		382,026	(859)	381,167		2
3	Housekeeping	422,627	31,026	-	453,653		453,653	318	453,971		3
4	Laundry	-	19,747	-	19,747	-	19,747	-	19,747		4
5	Heat and Other Utilities			280,727	280,727		280,727	9,108	289,835		5
6	Maintenance	39,286	-	195,939	235,225		235,225	126,316	361,541		6
7	Other (specify):* Alloc. From Mgmt Co	-	-	-	-		-	16,566	16,566		7
8	TOTAL General Services	913,875	468,562	479,690	1,862,127	-	1,862,127	151,449	2,013,576		8
	B. Health Care and Programs										
9	Medical Director	-	-	46,750	46,750		46,750	-	46,750		9
10	Nursing and Medical Records	4,979,444	371,290	91,102	5,441,836		5,441,836	27,057	5,468,893		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	147,393	25,278	(1,075)	171,596		171,596	-	171,596		11
12	Social Services	188,995	-	3,775	192,770		192,770	-	192,770		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):* Alloc. From Mgmt Co	-	-	-	-		-	3,595	3,595		15
16	TOTAL Health Care and Programs	5,315,832	396,568	140,552	5,852,952	-	5,852,952	30,652	5,883,604		16
	C. General Administration										
17	Administrative	138,538	-	1,890,904	2,029,442		2,029,442	(1,826,769)	202,673		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			203,823	203,823		203,823	54,022	257,845		19
20	Dues, Fees, Subscriptions & Promotions			154,217	154,217		154,217	8,937	163,154		20
21	Clerical & General Office Expenses	167,875	23,149	40,009	231,033		231,033	869,960	1,100,993		21
22	Employee Benefits & Payroll Taxes			1,020,268	1,020,268		1,020,268	-	1,020,268		22
23	Inservice Training & Education			9,277	9,277		9,277	545	9,822		23
24	Travel and Seminar			82	82		82	957	1,039		24
25	Other Admin. Staff Transportation		-	5,476	5,476		5,476	15,240	20,716		25
26	Insurance-Prop.Liab.Malpractice			762,779	762,779		762,779	9,648	772,427		26
27	Other (specify):* Alloc. From Mgmt Co	-	-	-	-		-	119,628	119,628		27
28	TOTAL General Administration	306,413	23,149	4,086,835	4,416,397	-	4,416,397	(747,832)	3,668,565		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,536,120	888,279	4,707,077	12,131,476	-	12,131,476	(565,731)	11,565,745		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			96,965	96,965		96,965	287,150	384,115			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			262,903	262,903		262,903	210,679	473,582			32
33	Real Estate Taxes			-	-		-	560,388	560,388			33
34	Rent-Facility & Grounds			1,945,353	1,945,353		1,945,353	(1,940,225)	5,128			34
35	Rent-Equipment & Vehicles			102,826	102,826		102,826	2,217	105,043			35
36	Other (specify):*			-	-		-	-	-			36
37	TOTAL Ownership			2,408,047	2,408,047	-	2,408,047	(879,791)	1,528,256			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	409,605	1,360,755	1,770,360		1,770,360	-	1,770,360			39
40	Barber and Beauty Shops	-	-	13,483	13,483		13,483	-	13,483			40
41	Coffee and Gift Shops	-	-	2,239	2,239		2,239	-	2,239			41
42	Provider Participation Fee			411,901	411,901		411,901	-	411,901			42
43	Other (specify):* Non-Allowable Cos	103,072	-	517,267	620,339		620,339	(620,339)	-			43
44	TOTAL Special Cost Centers	103,072	409,605	2,305,645	2,818,322	-	2,818,322	(620,339)	2,197,983			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,639,192	1,297,884	9,420,769	17,357,845	-	17,357,845	(2,065,861)	15,291,984			45

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

Lexington Health Care Center of Streamwood, Inc.

ID# 0037002

Report Period Beginning: 01/01/17

Ending: 12/31/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Reclass R&M	\$ (6,700)	6	1
2	Diagnostics Managed Care	(2,125)	43	2
3	Labs-Part A	(16,737)	43	3
4	X-Rays-Part A	(15,089)	43	4
5	Collections	(12,875)	19	5
6	Out of Period legal	(69)	19	6
7	Marketing Salary	(103,072)	43	7
8	Trust fees	(50)	43	8
9	Unrealized Loss on FMV swap	223,983	43	9
10	Disallow Lobbying	(4,265)	20	10
11	Pharmacy	(4,458)	43	11
12	Chamber of Commerce Dues & Marketing	(420)	20	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	58,123		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional fees	\$	Sambell of Streamwood Limited Partnership	**	\$ 202	\$ 202	1
2	V	30 Depreciation		Sambell of Streamwood Limited Partnership	**	217,512	217,512	2
3	V	32 Interest expense		Sambell of Streamwood Limited Partnership	**	359,216	359,216	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	**	553,353	553,353	5
6	V	34 Rental expense	1,945,353	Sambell of Streamwood Limited Partnership	**		(1,945,353)	6
7	V	43 Trust fees		Sambell of Streamwood Limited Partnership	**	50	50	7
8	V	43 Unrealized loss on interest rate swap	223,983	Sambell of Streamwood Limited Partnership	**		(223,983)	8
9	V							9
10	V							10
11	V			The owners of Lexington Health Care Center of Streamwood, Inc own 100% of Sambell of Streamwood Limited Partnership.				11
12	V							12
13	V							13
14	Total		\$ 2,169,336			\$ 1,132,626	\$ * (1,036,710)	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.	**	\$ 318	\$	318	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	8,134		8,134	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	339		339	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	635		635	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	124,677		124,677	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	8,004		8,004	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	335		335	21
22	V	7 Management allocation - employee benefits		Royal Management Corp.	**	16,566		16,566	22
23	V	10 Medical consultant		Royal Management Corp.	**	0			23
24	V	10 Management allocation - salaries		Royal Management Corp.	**	27,057		27,057	24
25	V	15 Management allocation - employee benefits		Royal Management Corp.	**	3,595		3,595	25
26	V	17 Management allocation - salaries		Royal Management Corp.	**	64,135		64,135	26
27	V	19 Computer consultant & supplies		Royal Management Corp.	**	38,331		38,331	27
28	V	19 Professional fees		Royal Management Corp.	**	28,433		28,433	28
29	V	20 Dues & subscriptions		Royal Management Corp.	**	1,558		1,558	29
30	V	20 Advertising - help wanted		Royal Management Corp.	**	12,064		12,064	30
31	V	21 Management allocation - salaries		Royal Management Corp.	**	836,198		836,198	31
32	V	21 Bank charges		Royal Management Corp.	**	3,377		3,377	32
33	V	21 Office supplies & printing		Royal Management Corp.	**	13,648		13,648	33
34	V	21 Postage		Royal Management Corp.	**	4,040		4,040	34
35	V	21 Telephone		Royal Management Corp.	**	12,697		12,697	35
36	V								36
37	V								37
38	V	** The owners of Lexington Health Care Center of Streamwood, Inc.							38
39	Total		\$			\$ 1,204,141	\$ *	1,204,141	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	23 <u>Inservice Training</u>	\$	<u>Royal Management Corp.</u>	**	\$ 545	\$	545	15
16	V	24 <u>Travel & seminar</u>		<u>Royal Management Corp.</u>	**	957		957	16
17	V	25 <u>Auto expense</u>		<u>Royal Management Corp.</u>	**	15,240		15,240	17
18	V	26 <u>Insurance general</u>		<u>Royal Management Corp.</u>	**	9,648		9,648	18
19	V	27 <u>Management allocation - employee benefits</u>		<u>Royal Management Corp.</u>	**	119,628		119,628	19
20	V	30 <u>Depreciation</u>		<u>Royal Management Corp.</u>	**	67,654		67,654	20
21	V	32 <u>Interest</u>		<u>Royal Management Corp.</u>	**	18,842		18,842	21
22	V	32 <u>Amortization of mortgage costs</u>		<u>Royal Management Corp.</u>	**	2,473		2,473	22
23	V	33 <u>Property taxes</u>		<u>Royal Management Corp.</u>	**	7,035		7,035	23
24	V	34 <u>Rent expense</u>		<u>Royal Management Corp.</u>	**	5,128		5,128	24
25	V	35 <u>Equipment rental</u>		<u>Royal Management Corp.</u>	**	1,566		1,566	25
26	V	17 <u>Management fees</u>	1,890,904	<u>Royal Management Corp.</u>	**			(1,890,904)	26
27	V	35 <u>Auto Lease</u>		<u>Royal Management Corp.</u>	**	651		651	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		\$ 1,890,904			\$ 249,367	\$ *	(1,641,537)	39

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

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								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29		0						29
30		0						30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Lexington Health Care Center of Streamwoc # 0037002 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	\$ 10,077	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	6,999	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	9,333	L17, C7	3
4	Daniel Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	13,089	L17, C7	4
5	Jason Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	17,257	L17, C7	5
6	Phil Thiem	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	2,703	L17, C7	6
7	Jeremy Samatas	Executive Committee	Administrative	0.00	See Schedule 7A	See Sch 7B	See Sch 7B	Salary	4,677	L17, C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,135		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: 01/01/17 Ending: 12/31/17

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 Available	722,335	10	\$ 2,937	\$ 78,110	\$ 318	1
2	5	Utilities - gas & electric	Bed Days Available	722,335	10	75,222	78,110	8,134	2
3	5	Utilities - water & sewer	Bed Days Available	722,335	10	3,135	78,110	339	3
4	5	Utilities - maintenance office	Bed Days Available	722,335	10	5,869	78,110	635	4
5	6	Management allocation - salaries	Bed Days Available	722,335	10	1,152,969	1,152,969	124,677	5
6	6	Repairs & maintenance	Bed Days Available	722,335	10	74,022	78,110	8,004	6
7	6	Scavenger & exterminating	Bed Days Available	722,335	10	3,102	78,110	335	7
8	7	Management allocation - employees	Bed Days Available	722,335	10	153,196	78,110	16,566	8
9	10	Medical consultant	Bed Days Available	722,335	10	0	78,110	0	9
10	10	Management allocation - salaries	Bed Days Available	722,335	10	250,218	250,218	27,057	10
11	15	Management allocation - employees	Bed Days Available	722,335	10	33,247	78,110	3,595	11
12	17	Management allocation - salaries	Bed Days Available	722,335	10	593,100	593,100	64,135	12
13	19	Computer consultant & supplies	Bed Days Available	722,335	10	354,473	78,110	38,331	13
14	19	Professional fees	Bed Days Available	722,335	10	262,937	78,110	28,433	14
15	20	Dues & subscriptions	Bed Days Available	722,335	10	14,411	78,110	1,558	15
16	20	Advertising - help wanted	Bed Days Available	722,335	10	111,560	78,110	12,064	16
17	21	Management allocation - salaries	Bed Days Available	722,335	10	7,732,875	7,732,875	836,198	17
18	21	Bank charges	Bed Days Available	722,335	10	31,229	78,110	3,377	18
19	21	Office supplies & printing	Bed Days Available	722,335	10	126,211	78,110	13,648	19
20	21	Postage	Bed Days Available	722,335	10	37,365	78,110	4,040	20
21	21	Telephone	Bed Days Available	722,335	10	117,421	78,110	12,697	21
22									22
23									23
24									24
25	TOTALS					\$ 11,135,499	\$ 9,729,162	\$ 1,204,141	25

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	23	Inservice Training	Bed Days Available	722,335	10	\$ 5,038	\$ 78,110	\$ 545	1
2	24	Travel and Seminar	Bed Days Available	722,335	10	8,850	78,110	957	2
3	25	Auto expense	Bed Days Available	722,335	10	140,934	78,110	15,240	3
4	26	Insurance general	Bed Days Available	722,335	10	89,225	78,110	9,648	4
5	27	Management allocation - employees	Bed Days Available	722,335	10	1,106,283	78,110	119,628	5
6	30	Depreciation	Bed Days Available	722,335	10	625,643	78,110	67,654	6
7	32	Interest	Bed Days Available	722,335	10	174,244	78,110	18,842	7
8	32	Amortization of mortgage costs	Bed Days Available	722,335	10	22,869	78,110	2,473	8
9	33	Property taxes	Bed Days Available	722,335	10	65,056	78,110	7,035	9
10	34	Rent expense	Bed Days Available	722,335	10	47,418	78,110	5,128	10
11	35	Equipment rental	Bed Days Available	722,335	10	14,486	78,110	1,566	11
12	35	Auto Lease	Bed Days Available	722,335	10	6,017	78,110	651	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,306,063	\$	\$ 249,367	25

Facility Name & ID Number Lexington Health Care Center of Streamwood # 0037002 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		7	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	Lexington Financial						\$	\$			\$	1						
2	Services, LLC	X		Mortgage	Varies	5/22/08	6,734,000	5,137,437	1/1/33	Variable	359,216	2						
3												3						
4												4						
5												5						
	Working Capital																	
6	Shareholders	X		Working Capital	None	Various	1,154,048	8,702,708	Demand	1.5000	128,611	6						
7	Bank of America		X	Working Capital	None	9/30/14	13,700,000	2,206,000	1/31/2018	Prime/Libor	93,587	7						
8	See Sch 9A							670,000			37,997	8						
9	TOTAL Facility Related						\$ 21,588,048	\$ 16,716,145			\$ 619,411	9						
	B. Non-Facility Related*																	
10											2,292	10						
11											21,315	11						
12											(5,536)	12						
13											(163,900)	13						
14	TOTAL Non-Facility Related						\$	\$			\$ (145,829)	14						
15	TOTALS (line 9+line14)						\$ 21,588,048	\$ 16,716,145			\$ 473,582	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: Tabor Hills Health Care Facility, Inc.
 IDPH License II 0040543
 Fiscal Year End: 1/0/1900

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term	X										128611							
1							\$	\$				\$							
2																			
3																			
4																			
5																			
	Working Capital																		
6																			
7	Shareholders	X		Working Capital	None	Various		400,000	Demand	Prime		16,397							
8	Shareholders	X		Working Capital	None	Various		270,000	Demand	0.0800		21,600							
9	TOTAL Facility Related				\$0.00		\$	0	\$	670,000		\$	37,997						
	B. Non-Facility Related*																		
10								Non Allowable Shareholder Interest				(166,608)							
11								Microsoft				502							
12								Letter of Credit Fees				2,206							
13												(163,900)							
14	TOTAL Non-Facility Related				\$0.00		\$	0	\$	0		\$	(163,900)						

2016 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 2016 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 2016.

	(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>06-25-300-018-0000</u>	<u>Land & Building</u>	\$ <u>619,352.00</u>	\$ <u>619,352.00</u>
2.	<u>Royal Management Corp(Samvest of</u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u>05-01-202-021</u>	<u>Land & Building</u>	\$ <u>257,788.00</u>	\$ <u>7,035.00</u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>877,140.00</u></u>	\$ <u><u>626,387.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

01/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	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>	<u>1</u>
2	<u>Management Company Allocation</u>		<u>2002</u>	<u>22,899</u>	<u>2</u>
3	TOTALS	30,000		\$ 234,299	3

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc.

0037002

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	214	1991	1991	\$ 5,248,322	\$ -	35	\$ 149,952	\$ 149,952	\$ 3,973,729	4
5		1993	1993	105,236	-	35	2,361	2,361	73,021	5
6		1995	1995	82,650	2,361	35	2,361		53,128	6
7										7
8										8
	Improvement Type**									
9	Building Improvement	1993		7,336		35	210	210	5,139	9
10	Land Improvements	1995		7,000		15			7,000	10
11	Kitchen & Nurses Station	1996		12,316	352	35	352		7,567	11
12	Piping	1996		3,139	90	35	90		1,931	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		175,081	26
27	Parking lot	2002		29,288		10			29,288	27
28	Office area rehab	2002		26,991	1,350	20	1,350		20,923	28
29	Elevator interior upgrade	2002		1,120		10			1,120	29
30	Gazebo	2002		3,393		10			3,393	30
31	Elevator electronic curtains	2002		4,500		10			4,500	31
32	Door frame protector	2003		5,276		10			5,276	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring	2003		9,392		10			9,392	33
34	Roof	2003		29,950	1,498	20	1,498		21,095	34
35	Kitchen Sewer/Dishroom	2004		6,224		10			6,224	35
36	Compressor/tube bundles-cooling system	2004		14,737	737	20	737		9,825	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:

01/01/17

Ending:

12/31/17

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Kitchen fire protection upgrade	2004	\$ 1,427	\$	10	\$	\$	\$ 1,427	37
38	Landscaping	2005	8,495	425	20	425		5,206	38
39	Kitchen renovation	2005	12,034	602	20	602		7,223	39
40	Lobby, lounge and reception renovation	2005	37,439	1,872	20	1,872		22,464	40
41	Therapy room renovation	2005	11,628	581	20	581		7,167	41
42	Create first floor therapy room	2005	44,781	2,239	20	2,239		29,107	42
43	Dialysis units	2005	66,426	3,535	20	3,535		44,188	43
44	Create transitional unit	2005	14,490	725	20	725		8,699	44
45	Alzheimers unit renovation	2005	5,910	296	20	296		3,847	45
46	Basement renovation	2005	46,561	2,328	20	2,328		28,324	46
47	Landscaping enhancement	2006	3,414	228	15	228		2,621	47
48	HVAC	2006	17,125	856	20	856		9,488	48
49	Door closer	2006	4,446	222	20	222		2,609	49
50	Blinds	2006	1,566		5			1,566	50
51	Employee lunch room rehab	2006	2,883	144	20	144		1,680	51
52	Storeroom door lock	2006	2,843	142	20	142		1,633	52
53	Dialysis Stations	2006	62,832	3,142	20	3,142		36,394	53
54	Fine dining	2006	7,650	382	20	382		4,426	54
55	Automatic door	2006	2,259	113	20	113		1,271	55
56	Landscaping	2007	10,606	530	20	530		5,344	56
57	Parking lot	2007	2,777	139	20	139		1,425	57
58	HVAC	2007	1,501	75	20	75		806	58
59	Painting Building	2007	16,150	808	20	808		8,416	59
60	Landscaping	2008	33,747	2,250	15	2,250		20,437	60
61	Common areas-metal doors	2008	7,055	353	20	353		3,442	61
62	Wanderguard	2008	3,882	194	20	194		1,940	62
63	Lawn Irrigation	2009	18,125	1,208	15	1,208		9,966	63
64	Landscaping	2009	3,138	209	15	209		1,811	64
65	Quick connectors	2009	9,375	469	20	469		4,065	65
66	1st floor admin office-heating,plumbing	2009	13,598	767	20	767		6,179	66
67	Fire alarm system	2009	5,271	264	20	264		2,112	67
68	Metal Doors-painting	2009	4,650	232	20	232		2,011	68
69	2nd Floor Remodel-carpentry	2009	33,503	838	40	838		7,332	69
70	TOTAL (lines 4 thru 69)		\$ 6,491,737	\$ 43,167		\$ 195,690	\$ 152,523	\$ 4,867,321	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:

01/01/17

Ending:

12/31/17**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,491,737	\$ 43,167		\$ 195,690	\$ 152,523	\$ 4,867,321	1
2	Patio Pergola	2009	7930	793	10	793		6,608	2
3	Landscaping	2010	5785	386	15	386		2,895	3
4	HVAC Quick connectors, admin office	2010	15373	561	27	561		3,992	4
5	Lockers and Pantry-plumbing, tile	2010	14809	540	27	540		3,887	5
6	Director of Nursing office painting	2010	7887	288	27	288		2,016	6
7	Ramp repair	2010	3240	216	15	216		1,548	7
8	Library/Lounge update-art, flooring	2010	8356	305	27	305		2,186	8
9	Office carpentry, flooring, electrical, painting, signs, HVAC	2010	48949	1,958	27	1,958		13,706	9
10	Office carpentry, flooring, electrical, painting, signs, HVAC	2011	4714	171	27	171		1,126	10
11	Office-Doors, ADON, Locks	2011	26169	952	27	952		5,871	11
12	HVAC Chiller	2011	95360	3,468	27	3,468		22,253	12
13	Laundry Room-Painting, Tile	2011	7686	279	27	279		1,790	13
14	2nd floor doors	2011	26317	957	27	957		6,061	14
15									15
16	Install cast iron pipe sprinkler	2012	4550	165	27	165		963	16
17	Shower room-tile-painting, plumbing	2012	87763	3,191	27	3,191		16,221	17
18									18
19	Update Sprinkler Heads- Entire Facility	2013	28070	1,021	27	1,021		4,594	19
20	EMR Building Wire- Entire Facility	2013	16538	601	27	601		2,505	20
21									21
22	R/M Reclass: Intstallation of Kitchen Countertop	2014	2799.78		15	187	187	654	22
23	R/M Reclass: Install Elevator Door Restrictor	2014	5250		10	525	525	1,838	23
24	R/M Reclass: Cracked Pavement Sealing (Parking Lot)	2014	3500		15	233	233	816	24
25									25
26	R/M Reclass: Decorating and Tiling- Service entrance ramp doors	2015	3328		15	221	221	664	26
27	R/M Reclass: Cast iron piping and concrete bottom loading ramp	2015	4825		20	241	241	724	27
28	R/M Reclass: Paving on outside parking lot	2015	4600		20	230	230	690	28
29	R/M Reclass: Replace four sprinkler heads in outside canopy	2015	2663		20	133	133	399	29
30	R/M Reclass: Cut out bad turf along curb of back driveway	2015	3535		15	235	235	706	30
31	Update Shower Room in Facility	2015	6100	222	27	222		499	31
32	EMR Building Wire- Entire Facility	2015	3472	126	27	126		326	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,941,306	\$ 59,367		\$ 213,895	\$ 154,528	\$ 4,972,859	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:

01/01/17

Ending:

12/31/17

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	\$ 4,972,859	1
2									2
3									3
4	Update HVAC - Mechanical Room	2016	106,947	3,961	27	3,961		6,878	4
5	Room Renovations - 1st floor chair rails	2016	13,423	498	27	498		498	5
6	R/M reclass: Floor Pipe Repair Kitchen	2017	6,700		20	335	335	335	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18	Real Estate Entity								18
19	1st floor remodel-Carpentry, flooring, electrical, painting	2008	531,230		27	19,317	19,317	193,172	19
20	2nd Floor Remodel-Carpentry, Flooring, Electrical, painting	2008	487,333		27	17,721	17,721	159,491	20
21	Remodel special care units-carpentry, electrical, painting	2008	32,914		27	1,197	1,197	10,774	21
22	3rd floor remodel-carpentry, flooring, electrical, painting	2009	667,142		27	24,260	24,260	210,254	22
23	Parking lot seal and stripe	2011	3,600		27	131	131	820	23
24	Remodel LL Flooring-Carpentry, flooring, electrical	2011	27,575		27	1,003	1,003	6,103	24
25	Kitchen holding tank	2011	11,666		27	424	424	2,897	25
26	Drain tile and pits	2011	8,000		27	291	291	1,843	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,837,835	\$ 63,826		\$ 283,035	\$ 219,209	\$ 5,565,925	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:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,837,835	\$ 63,826		\$ 283,035	\$ 219,209	\$ 5,565,925	1
2									2
3	Mgmt Co.								3
4									4
5	Building-management company	2002	316,883		40	7,044	7,044	147,823	5
6	HVAC, electrical, security system-management company	2003	2,783		30	672	672	2,295	6
7	Key card system-management company	2004	437		20	21	21	293	7
8	VAC TX controls-management company	2005	133		20	6	6	85	8
9	Build Imp-management company	2006	97		20	6	6	72	9
10	Building Improvement Management Co.	2008	14,357		20	167	167	6,129	10
11	Building Improvement Management Co.	2009	2,821		20	52	52	1,301	11
12	Building Improvement Management Co.	2010	2,753		20	51	51	1,182	12
13	Building Improvement Management Co.	2011	1,972		20	90	90	597	13
14	Building Improvement Management Co.	2012	6,670		20	13	13	1,386	14
15	Building Improvement Management Co.	2013	5,148		20	366	366	1,600	15
16	Building Improvement Management Co.	2014	2,786		20	272	272	978	16
17	Building Improvement Management Co.	2015	490		20	58	58	150	17
18	Building Improvement Management Co.	2016	8,084		20	586	586	833	18
19	Building Improvement Management Co.	2017	5,257		20	65	65	99	19
20									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			(287)			287		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,208,506	\$ 63,539		\$ 292,504	\$ 228,965	\$ 5,730,748	34

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

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	\$ 603,132	\$ 33,179	\$ 33,179	\$	5-10	\$ 525,520	71
72	Current Year Purchases	30,884	247	247		7	247	72
73	Fully Depreciated Assets	1,079,395				5-10	1,079,395	73
74	Allocated from Mgmt. Co.	644,384		55,778	55,778	5-7	579,540	74
75	TOTALS	\$ 2,357,795	\$ 33,426	\$ 89,204	\$ 55,778		\$ 2,184,702	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$ -	\$ -	\$		\$	76
77					-	-				77
78					-	-				78
79	Allocated from Mgmt. Co.			57,964	-	2,406	2,406	5	53,936	79
80	TOTALS			\$ 57,964	\$	\$ 2,406	\$ 2,406		\$ 53,936	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)	\$ 11,858,564	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,965	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 384,115	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 287,150	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,969,386	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from Management Company</u>				<u>5,128</u>			6
7	TOTAL				\$ 5,128			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. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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: \$ 104,392 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocated from Management Company</u>			<u>651</u>	20
21	TOTAL		\$	\$ 651	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: 12/31/17

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	5,819
Postage	323
Printer System	3,247
Equipment Rental	44,864
Oxygen	48,573
MGMT Co.	1,566
Total - Line 16	<u>104,392</u>

Facility Name & ID Number Lexington Health Care Center of Streamwood, Inc. # 0037002 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	39(3)	hrs	\$	8,799	\$	526,549	\$	8,799	\$	526,549					1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		5,298		189,012		5,298		189,012					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs		11,904		636,491		11,904		636,491					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39(2)	# of prescripts							399,822					399,822	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Ambulance</u>	39(3)					8,703				8,703					12
13	Other (specify): <u>See Sch 16A</u>	39(2)								9,783					9,783	13
14	TOTAL			\$	26,001	\$	1,360,755	\$	409,605	\$	26,001	\$	1,770,360			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.

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

	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		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	<u>39(2)</u>					<u>8,086</u>		<u>8,086</u>	12
13	Other (specify): <u>DME</u>	<u>39(2)</u>					<u>1,697</u>		<u>1,697</u>	13
14	TOTAL			\$		\$	<u>9,783</u>		<u>9,783</u>	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 & ID Number Lexington Health Care Center of Streamwood, Inc.

0037002

Report Period Beginning: 01/01/17

Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(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	\$ 723,369	\$ 786,534	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>3,151,907</u>)	2,098,640	2,098,640	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	44,470	44,470	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,866,479	\$ 2,929,644	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	67,884	67,884	12
13	Land		234,299	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	1,654,234	3,854,948	15
16	Equipment, at Historical Cost	655,558	2,415,759	16
17	Accumulated Depreciation (book methods)	(1,451,448)	(7,969,386)	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 <u>Rec from Ins Rec</u>)	206,000	206,000	22
23	Other(specify): <u>Mortgage cost, net</u>		39,286	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,132,228	\$ 4,202,348	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,998,707	\$ 7,131,992	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 637,800	\$ 637,800	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,206,000	2,206,000	29
30	Accrued Salaries Payable	511,539	511,539	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,471	26,471	31
32	Accrued Real Estate Taxes(Sch.IX-B)		638,000	32
33	Accrued Interest Payable		37,573	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	18,488,826	5,271,259	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 21,870,636	\$ 9,328,642	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,372,708	9,372,708	39
40	Mortgage Payable		5,137,437	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Professional Liabilities Claims</u>	399,688	399,688	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,772,396	\$ 14,909,833	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 31,643,032	\$ 24,238,475	46
47	TOTAL EQUITY(page 18, line 24)	\$ (27,644,325)	\$ (17,106,483)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,998,707	\$ 7,131,992	48

*(See instructions.)

Facility Name: Lexington Health Care Center of Streamwood, Inc.
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/17

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
00-10140-00	Cash Patient Trust	36,493	36,493
00-12020-00	PA Audit Settlement	-	-
00-13040-00	Sambell Rent Receivable	-	(13,334,949)
00-13200-00	Due From -	-	-
00-13240-00	Due To Lex Fin Svcs I	7,312	7,312
00-13250-00	Due To / From Rehab Care Therapy	24,336	24,336
00-13530-00	Due From -/Royal	-	-
00-13700-00	Sambel Due From LLC 1	-	1,348
00-14530-00	Prepaid Insurance	44,011	44,011
00-14770-00	Escrow - Insurance	(87,456)	(87,456)
00-21040-00	Withholding - Dental Insurance	(2,678)	(2,678)
00-21050-00	Withholding - EP/CI/WI	2,043	2,043
00-21100-00	401K Withholding	(927)	(927)
00-22030-00	Accrued Expenses	68,064	68,064
00-22040-00	Accrued Resident Tax	52,094	52,094
00-22060-00	Accrued Vesta 3% Managemen Fees	3,727,364	3,727,364
00-22120-00	Accrued Rent	13,334,949	13,334,949
00-22140-00	Accrued Insurance	1,473,387	1,473,387
00-22270-00	Due To Patient Trust Fund	(37,729)	(37,729)
00-22330-00	Advance - Biweekly Part A Paym	(98,901)	(98,901)
00-22360-00	Uncollectible Part A Co Pvts	(37,788)	(37,788)
00-23530-00	Due To - Royal Operations	53,566	53,566
00-23720-00	Due To/ From Republic	2,013	2,013
00-23730-00	Due To Bloomingdale	1,073	1,073
00-23750-00	Due To LHCC Elmhurst	317	317
00-23760-00	Due To Lagrange	21,932	21,932
00-23800-00	Due To Schaumburg	298	298
00-23830-00	Due/To From Vesta Management	-	-
00-23850-00	Due/To From	183	183
00-23860-00	Due To/From	-	-
00-24345-00	Sambel Interest Rate Swap Liability	-	88,847
00-22410-00	Due From Cook County (1996 Ret	(67,940)	(67,940)
00-23710-00	Due To Sambell Of Streamwood Lp	(27,190)	(27,190)
00-13709-00	Sambell Due from/to LHCC Streamwood	-	27,187
	Total - Line 36	18,488,826	5,271,259

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (25,073,462)	1
2	Restatements (describe):		2
3	Post closing adjustment	11,179	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (25,062,283)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,582,042)	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)	\$ (2,582,042)	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)	\$ (27,644,325)	24 *

* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 19,022,662	1
2	Discounts and Allowances for all Levels	(9,982,223)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,040,439	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,346,250	6
7	Oxygen	41,112	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,387,362	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	2,070	12
13	Barber and Beauty Care	14,981	13
14	Non-Patient Meals	859	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	652,695	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	163,894	19
20	Radiology and X-Ray	38,692	20
21	Other Medical Services	469,275	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,342,466	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,536	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,536	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)	\$ 14,775,803	30

1		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,862,127	31
32	Health Care	5,852,952	32
33	General Administration	4,416,397	33
B. Capital Expense			
34	Ownership	2,408,047	34
C. Ancillary Expense			
35	Special Cost Centers	2,406,421	35
36	Provider Participation Fee	411,901	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,357,845	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,582,042)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,582,042)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,447,426	44
45	Private Pay - Net Inpatient Revenue	999,386	45
46	Medicare - Net Inpatient Revenue	608,762	46
47	Other-(specify) Managed Care	1,984,865	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,040,439	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: 01/01/17

Ending: 12/31/17

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	1,519	2,017	\$ 112,546	\$ 55.79	1
2	Assistant Director of Nursing	1,844	2,186	99,796	45.64	2
3	Registered Nurses	26,351	35,114	1,108,321	31.56	3
4	Licensed Practical Nurses	33,781	43,372	1,177,431	27.15	4
5	CNAs & Orderlies	105,446	130,306	1,826,755	14.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,104	2,524	52,137	20.66	9
10	Activity Assistants	7,524	8,957	95,256	10.63	10
11	Social Service Workers	8,556	10,268	188,995	18.41	11
12	Dietician	1,925	2,175	57,337	26.36	12
13	Food Service Supervisor	1,909	2,083	53,424	25.65	13
14	Head Cook	939	1,113	23,062	20.71	14
15	Cook Helpers/Assistants	25,672	29,818	318,138	10.67	15
16	Dishwashers					16
17	Maintenance Workers	1,907	2,163	39,286	18.16	17
18	Housekeepers	32,577	38,854	422,627	10.88	18
19	Laundry					19
20	Administrator	1,703	2,219	138,538	62.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,613	9,673	167,875	17.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,820	2,256	46,026	20.40	31
32	Other Health C: See Sch 20A	21,795	26,431	608,569	23.02	32
33	Other(specify) Marketing	2,438	2,711	103,072	38.02	33
34	TOTAL (lines 1 - 33)	287,424	354,242	\$ 6,639,192 *	\$ 18.74	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	Monthly 46,750	9(3)	36
37	Medical Records Consultant	Monthly 796	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 18,582	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 4,721	11(3)	44
45	Social Service Consultant	Monthly 3,775	12(3)	45
46	Other(specify) Pulmonary	Monthly 61,176	10(3)	46
47	Post Acute Consultant	Monthly 1,398	10(3)	47
48	Telemedicine Consultant	Monthly 9,150	10(3)	48
49	TOTAL (lines 35 - 48)	\$ 146,348		49

C. CONTRACT NURSES

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

Facility Name: Lexington Health Care Center of Streamwood, Inc.
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/17

Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Staffing Coordinator	1,531	1,846	21,531	\$ 11.66
Unit Secretary	5,056	6,358	118,208	18.59
Accounts Coordinator	3,032	3,731	50,410	13.51
Admissions	929	1,046	33,911	32.42
MDS	5,207	6,225	207,498	33.33
Clinical Coordinator	1,308	1,658	63,654	38.40
Dietetic Technician	679	775	12,299	15.86
Intake Manager	3,765	4,403	89,636	20.36
Wound Care Coordinator	289	389	11,422	29.34
Total - Line 32 Other Health Care (specify):	21,795	26,431	608,569	23.02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions				
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
<u>Kalsang Youtso</u>	<u>Administrator</u>	<u>0</u>	\$ <u>138,538</u>	<u>Workers' Compensation Insurance</u>	\$	<u>IDPH License Fee</u>	\$ <u>1,990</u>				
				<u>Unemployment Compensation Insurance</u>	<u>56,414</u>	<u>Advertising: Employee Recruitment</u>	<u>5,623</u>				
				<u>FICA Taxes</u>	<u>493,741</u>	<u>Health Care Worker Background Check</u>	<u>2,949</u>				
				<u>Employee Health Insurance</u>	<u>406,729</u>	(Indicate # of checks performed <u>246</u>)	<u>2,949</u>				
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>479</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>5,573</u>				
				<u>401K</u>	<u>32,821</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>8,472</u>				
				<u>Other Employee Benefits</u>	<u>26,396</u>	<u>Employment Fees</u>	<u>109,664</u>				
				<u>Tuition Reimbursement</u>	<u>4,793</u>						
				<u>Uniform Allowance</u>	<u>(626)</u>	<u>See Schedule 21F</u>	<u>23,130</u>				
						<u>Less: Public Relations Expense</u>	()				
						<u>Non-allowable advertising</u>	()				
						<u>Yellow page advertising</u>	()				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>138,538</u>	TOTAL (agree to Schedule V, line 22, col.8)		\$ <u>1,020,268</u>	TOTAL (agree to Sch. V, line 20, col. 8)		\$ <u>163,154</u>		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description			Amount	Description	Line #	Amount	Description			Amount	
<u>Management Fees-Royal Operating</u>			\$ <u>1,449,499</u>	<u>N/A</u>		\$	<u>Out-of-State Travel</u>			\$	
<u>Management Fees-Vesta Mgmt.</u>			<u>441,405</u>				<u>In-State Travel</u>				
<u>Management Fees (Eliminated in Column 7)</u>							<u>Seminar Expense</u>			<u>82</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>1,890,904</u>				<u>Management Company Allocation</u>			<u>957</u>	
(Attach a copy of any management service agreement)							<u>Entertainment Expense</u>			()	
C. Professional Services							TOTAL (agree to Sch. V, line 24, col. 8)			\$ <u>1,039</u>	
Vendor/Payee	Type		Amount								
<u>Royal Management</u>	<u>Legal</u>		\$ <u>4,154</u>								
<u>Serpico, Petrosino</u>	<u>Legal</u>		<u>9,880</u>								
<u>Royal Ops</u>	<u>Legal</u>		<u>877</u>								
<u>Secretary Of State</u>	<u>Legal</u>		<u>100</u>								
<u>Generation Law</u>	<u>Legal</u>		<u>4,594</u>								
<u>Duane Morris LLC</u>	<u>Legal</u>		<u>708</u>								
<u>LFS LLC</u>	<u>Legal</u>		<u>7,237</u>								
<u>RSM US LLP</u>	<u>Accounting</u>		<u>32,829</u>								
<u>RSM US LLP</u>	<u>Accounting</u>		<u>1,125</u>								
<u>AR STR</u>	<u>Collections</u>		<u>(691)</u>								
<u>See Schedule 21C</u>	<u>Various</u>		<u>143,010</u>								
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>203,823</u>	TOTAL			\$				
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Lexington Health Care Center of Streamwood, Inc.
IDPH License ID Number: 0037002
Fiscal Year End: 12/31/17

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Much Shelist	Collections	6,101
Royal Ops	Collections	6,435
Markoff Law	Collections	1,030
RYL	Other Professional	(4,050)
Personnel Planers	Other Professional	1,440
Royal Ops	Other Professional	11,504
LLC	Other Professional	12,799
LFS LLC	Other Professional	40
Royal	401K Administration	34
LLC	401K Administration	9,154
Royal Ops	401K Administration	724
Lawson	Computer Services	8,579
Network Infrastructure	Computer Services	7,732
Ability	Computer Services	271
eHDS	Computer Services	2,567
ICIMS	Computer Services	3,570
Info Constrol	Computer Services	(87)
MHC software	Computer Services	(24)
National Datacare	Computer Services	2,844
On Shift	Computer Services	(111)
Relias	Computer Services	1,871
Royal Management	Computer Services	43,489
Salesforce	Computer Services	(4,594)
Softchoice	Computer Services	2,433
Symbria	Computer Services	400
Royal Management	Computer Services	2,916
Softchoice	Computer Services	1,763
Microsoft Software	Computer Services	10,549
Health MEDX	Computer Services	8,372
RSM	Computer Services	5,259
Total (agree to Schedule V, line 19, column 3)		203,823
Allocated from Management Company Professional Services		202
Less: Non-Allowable Legal Fees		(12,944)
Allocated from Mgmt Co.		
Friedman & Huey	Accounting	144
Illinois Secretary of State	Filing Fees	16
		160
Allocated from Mgmt Co.		
Much Shelist	Legal	1,805
Hinshaw & Culbertson LLP	Legal	248
Duane Morris	Legal	2,130
Serpico, Petrosino	Legal	13
Golan and Christie	Legal	22
RSM	Accounting	1,478
Friedman & Huey	Accounting	790
IL Secretary of State	Filing Fees	52
Gilson Labus & Silverman LLC	Accounting	702
Marcum LLP	Accounting	346
LaSalle Network	Recruiting / Finance	1,242
Pension Administrators, Inc.	401K Administration	(128)
Gene Whitehorn	Medicaid Reimb Specialist	2,017
M Werner Consulting	Financial Consulting	1,034
Eisen Alliance LLC	Workplace Consultant	322
Barry Lazarus	Health Care Consultant	276
Mark Rodeghier	Survey Preparation Consultant	713
Pathway Health Services	Operational & Financial Consulti	2,477
IMEC	Operational & Financial Consulti	6,023
Forest Performance	Performance Consulting	1,844
Reputation.com	Performance Consulting	1,104
Devree Molnar	Strategy/Operations Consulting	155
Steven Wood	Strategy/Operations Consulting	319
Susan Parker	Social Service Consultant	18
Focus Pointe Global	Strategic Planning	1,268
CLIN-SCIENCE RESEARCH	General Business Consulting	417
Provinet Solutions	Technical Consulting	16
ANDRZJ STANKIEWIC	General Business Consulting	99
DLC	Financial Planning & Analysis	1,471
Computer Services	Computer Consulting	38,331
Total (agree to Schedule V, line 19, column 8)		257,845

Facility Nan Lexington Health Care Center of Streamwood, Inc.
IDPH Licen: 0037002
Fiscal Year 12/31/17

Schedule 21F

XIX. SUPPORT SCHEDULES

F. Dues, Fees, Subscriptions and Promotions

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Allocated from Home Office		13,622
IHCA Dues		14,193
Less: Non-Allowable Lobbying Fees		(4,265)
Less: Non-allowable Chamber of Commerce		(420)
Total (agree to Schedule V, line 20, column 8)		<u><u>23,130</u></u>

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 - \$14,193
- (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. \$ 51,956 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 NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO 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. \$ 411,901
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 859
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees