

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: <u>0053728</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Symphony at 87th Street</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</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.	
Address: <u>2940 West 87th St</u> <u>Chicago</u> <u>60652</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>			
Telephone Number: <u>(773) 434-8787</u> Fax # <u>(773) 434-8717</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>11/1/2015</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ INDIVIDUAL	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ CORPORATION	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ * _____ (Date) _____	
		* Subject to the attached Accountants Consulting Report	
		Paid Preparer	
		(Print Name and Title) _____	
		(Firm Name & Address) <u>Marcum, LLP</u>	
		<u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE	
		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES	
		201 S. Grand Avenue East	
		Springfield, IL 62763-0001	
		Phone # (217) 782-1630	

Facility Name & ID Number Symphony at 87th Street

0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	210	Skilled (SNF)	210	76,860
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	210	TOTALS	210	76,860

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
8	SNF		26,527	26,527	8
9	SNF/PED				9
10	ICF	32,065	3,434	6,782	42,281
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	32,065	3,434	33,309	68,808

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.52%

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 ☒

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 07/01/1999

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 210 and days of care provided 12,570

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16
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	383,993	51,594	21,663	457,250		457,250		457,250			1
2	Food Purchase		490,635		490,635	(43,280)	447,356	(245)	447,111			2
3	Housekeeping		393,265		393,265		393,265		393,265			3
4	Laundry		203,766	33,224	236,990		236,990		236,990			4
5	Heat and Other Utilities			216,918	216,918		216,918	(8,340)	208,578			5
6	Maintenance	75,966		207,605	283,571		283,571	19,908	303,479			6
7	Other (specify):*							3,562	3,562			7
8	TOTAL General Services	459,959	1,139,260	479,410	2,078,629	(43,280)	2,035,350	14,885	2,050,234			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	5,065,291	319,943	68,590	5,453,824		5,453,824	136,227	5,590,051			10
10a	Therapy	31,208		45,098	76,306		76,306		76,306			10a
11	Activities	167,813	16,283	2,200	186,296		186,296		186,296			11
12	Social Services	240,130			240,130		240,130		240,130			12
13	CNA Training											13
14	Program Transportation			39,726	39,726		39,726	(5,231)	34,495			14
15	Other (specify):*							21,273	21,273			15
16	TOTAL Health Care and Programs	5,504,442	336,226	175,114	6,015,782		6,015,782	152,269	6,168,051			16
	C. General Administration											
17	Administrative	186,580		1,023,600	1,210,180		1,210,180	(984,565)	225,615			17
18	Directors Fees											18
19	Professional Services			398,577	398,577		398,577	20,166	418,743			19
20	Dues, Fees, Subscriptions & Promotions			78,522	78,522		78,522	(10,694)	67,828			20
21	Clerical & General Office Expenses	281,665	3,153	1,123,168	1,407,986		1,407,986	(714,252)	693,734			21
22	Employee Benefits & Payroll Taxes			1,121,808	1,121,808	43,280	1,165,088		1,165,088			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,458	3,458		3,458	1,274	4,732			24
25	Other Admin. Staff Transportation			127	127		127	3,157	3,284			25
26	Insurance-Prop.Liab.Malpractice			639,942	639,942		639,942	3,692	643,634			26
27	Other (specify):*							49,167	49,167			27
28	TOTAL General Administration	468,245	3,153	4,389,202	4,860,600	43,280	4,903,880	(1,632,055)	3,271,825			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,432,646	1,478,639	5,043,726	12,955,011		12,955,011	(1,464,901)	11,490,110			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,526	4,526		4,526	368,111	372,637			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,885	128,885		128,885		128,885			32
33	Real Estate Taxes			457,706	457,706		457,706	4,852	462,558			33
34	Rent-Facility & Grounds			2,649,604	2,649,604		2,649,604	(2,643,271)	6,333			34
35	Rent-Equipment & Vehicles			65,222	65,222		65,222	6,147	71,369			35
36	Other (specify):*											36
37	TOTAL Ownership			3,305,943	3,305,943		3,305,943	(2,264,161)	1,041,782			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		717,173	2,310,298	3,027,471		3,027,471	(10,734)	3,016,737			39
40	Barber and Beauty Shops			177	177		177		177			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			456,509	456,509		456,509		456,509			42
43	Other (specify):*	53,768		155,254	209,022		209,022	(209,022)	(0)			43
44	TOTAL Special Cost Centers	53,768	717,173	2,922,238	3,693,179		3,693,179	(219,756)	3,473,423			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,486,414	2,195,812	11,271,907	19,954,133		19,954,133	(3,948,818)	16,005,315			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,513)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	366,160	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(245)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,731)	21		18
19	Entertainment				19
20	Contributions	(17,950)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(774,972)	21		24
25	Fund Raising, Advertising and Promotional				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	(3,112,263)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,557,514)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(391,304)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (391,304)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,948,818)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#

0053728

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Guest Relations	\$ (53,768)	43	1
2	Advertsing and Promo.	(1,683)	20	2
3	Marketing Consultant	(118,883)	43	3
4	Marketing Services	(36,371)	43	4
5	Bank Charges	(1,366)	21	5
6	Patient Needs	(800)	10	6
7	Medicare 2% Sequester	(218,573)	21	7
8	Sale/Leaseback arrangement	(2,649,604)	34	8
9	Additional R&M	2,258	06	9
10	Non-Allowable Legal	(19,422)	19	10
11	PAC Dues	(7,298)	20	11
12	Capitalized R&M	(6,753)	06	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	(3,112,263)		49

ID#

0053728

Report Period Beginning:

01/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

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													1
2	Food Purchase	(245)											(245)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(10,513)		2,173									(8,340)	5
6	Maintenance	(4,495)		24,403									19,908	6
7	Other (specify):*			3,562									3,562	7
8	TOTAL General Services	(15,253)		30,138									14,885	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(800)		137,027									136,227	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation						(5,231)						(5,231)	14
15	Other (specify):*			21,273									21,273	15
16	TOTAL Health Care and Programs	(800)		158,300			(5,231)						152,269	16
	C. General Administration													
17	Administrative			(984,565)									(984,565)	17
18	Directors Fees													18
19	Professional Services	(19,422)		39,588									20,166	19
20	Fees, Subscriptions & Promotions	(26,931)		16,237									(10,694)	20
21	Clerical & General Office Expenses	(1,002,642)		288,390									(714,252)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,274									1,274	24
25	Other Admin. Staff Transportation			3,157									3,157	25
26	Insurance-Prop.Liab.Malpractice			3,692									3,692	26
27	Other (specify):*			49,167									49,167	27
28	TOTAL General Administration	(1,048,995)		(583,060)									(1,632,055)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(1,065,048)		(394,622)			(5,231)						(1,464,901)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	366,160		1,951									368,111	30
31	Amortization of Pre-Op. & Org.													31
32	Interest													32
33	Real Estate Taxes			4,852									4,852	33
34	Rent-Facility & Grounds	(2,649,604)		6,333									(2,643,271)	34
35	Rent-Equipment & Vehicles			6,147									6,147	35
36	Other (specify):*													36
37	TOTAL Ownership	(2,283,444)		19,283									(2,264,161)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(10,734)							(10,734)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(209,022)											(209,022)	43
44	TOTAL Special Cost Centers	(209,022)				(10,734)							(219,756)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,557,514)		(375,339)		(10,734)	(5,231)						(3,948,818)	45

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

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	MAESTRO CONSULTING SERVICES LLC	100.00%	\$ 2,173	\$	2,173 15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	19,894		19,894 16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	4,509		4,509 17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,562		3,562 18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	137,027		137,027 19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	21,273		21,273 20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	39,035		39,035 21
22	V	17	ADMINISTRATIVE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%			
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	39,588		39,588 23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	16,237		16,237 24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	256,456		256,456 25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	31,934		31,934 26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,274		1,274 27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	3,157		3,157 28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,692		3,692 29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	49,167		49,167 30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,951		1,951 31
32	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	4,852		4,852 32
33	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	6,333		6,333 33
34	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	2,737		2,737 34
35	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,409		3,409 35
36	V								36
37	V	17	Management Fee	1,023,600					(1,023,600) 37
38	V								38
39	Total			\$ 1,023,600			\$ 648,261	\$ *	(375,339) 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	22	Workers Compensation	\$ 236,537	Maple Leaf Insurance		\$ 236,537	\$	15
16	V	26	Liability Insurance	382,343	Maple Leaf Insurance		382,343		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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								38
39	Total			\$ 618,880			\$ 618,880	\$ *	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	39	DME and Medical Supplies	\$ 105,963	Integra Healthcare Equipment		\$ 95,229	\$ (10,734)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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								38
39	Total			\$ 105,963			\$ 95,229	\$ * (10,734)	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	14	Transportation	\$ 39,658	Lifeline Ambulance		\$ 34,427	\$ (5,231)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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								38
39	Total			\$ 39,658			\$ 34,427	\$ * (5,231)	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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								38
39	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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								38
39	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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								38
39	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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								38
39	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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								38
39	Total			\$			\$	\$ *	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			SYMPHONY OF DECATUR	DECATUR				1
2	SymcareHealthcare, LLC	99.9900%	SYMPHONY OF DEERBROOK	DEERBROOK	MAESTRO CONSULTING SERV	LINCOLNWOOD	Bookkeeping	2
3	Symcare HMG, LLC	0.0100%	SYMPHONY OF COUNTRYSIDE	AURORA	7257 N. LINCOLN AVENUE	LINCOLNWOOD	Building Rental	3
4			SYMPHONY OF CRESTWOOD	CRESTWOOD	MAPLELEAF INSURANCE	GRAND CAYMAN	Liability Insurance	4
5			SYMPHONY OF MAPLE CREST	BELVIDERE	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	5
6			SYMPHONY OF LINCOLN	LINCOLN	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERV.	6
7			SYMPHONY OF MCKINLEY	DECATUR	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	7
8			SYMPHONY OF NORTHWOODS	BELVIDERE				8
9			SYMPHONY OF SYCAMORE	QUINCY				9
10			SYMPHONY AT THE TILLERS	OSWEGO				10
11			SYMPHONY OF EVANSTON	EVANSTON				11
12			SEVEN OAKS	GLENDALE, WISC				12
13			SYMPHONY OF DYER	DYER, IN				13
14			SYMPHONY OF CHESTERTON	CHESTERTON, IN				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, IN				15
16			SYMPHONY ARIA	HILLSIDE				16
17			SYMPHONY BRONZEVILLE PARK	CHICAGO				17
18			SYMPHONY BUFFALO GROVE	BUFFALO GROVE				18
19			SYMPHONY IVY	CHICAGO				19
20			SYMPHONY JACKSON SQUARE	CHICAGO				20
21			SYMPHONY LINCOLN PARK	CHICAGO				21
22			SYMPHONY MIDWAY	CHICAGO				22
23			SYMPHONY PARK SOUTH	CHICAGO				23
24			SYMPHONY SOUTH SHORE	CHICAGO				24
25			CLAREMONT HANOVER PARK	HANOVER PARK				25
26			CALIFORNIA GARDENS	CHICAGO				26
27			MONROE CORP	CHICAGO				27
28								28
29								29
30								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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								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

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$		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 Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization MAESTRO CONSULTING SERVICES LLC
Street Address 7257 N. LINCOLN AVENUE
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (847) 933-2600
Fax Number (847) 933-2601

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,836,222	28	\$ 51,919	\$	76,860	\$ 2,173	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	475,288	76,860	19,894	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711		76,860	4,509	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090		76,860	3,562	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	3,273,643	76,860	137,027	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220		76,860	21,273	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	932,558	76,860	39,035	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28			76,860		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768		76,860	39,588	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900		76,860	16,237	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	6,126,863	76,860	256,456	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920		76,860	31,934	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439		76,860	1,274	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434		76,860	3,157	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214		76,860	3,692	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614		76,860	49,167	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621		76,860	1,951	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912		76,860	4,852	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288		76,860	6,333	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399		76,860	2,737	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453		76,860	3,409	21
22										22
23										23
24										24
25	TOTALS					\$ 15,487,256	\$ 10,808,353		\$ 648,260	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Maple Leaf Insurance
Street Address PO Box 69,720 West Bay Rd
City / State / Zip Code Grand Cayman, KY1-1102
Phone Number ()
Fax Number ()

	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	22	Workers Compensation	Direct Allocation			\$	\$		\$ 236,537	1
2	26	Liability Insurance	Direct Allocation						382,343	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 618,880	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Integra Healthcare Equipment
Street Address 747 church Road
City / State / Zip Code Elmhurst, IL 60126
Phone Number (630-834-3700
Fax Number (630-834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME and Medical Equipment	Direct Allocation			\$	\$		\$ 95,229	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 95,229	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Lifeline Ambulance, LLC
Street Address 2424 S. Wasbash Ave
City / State / Zip Code Chicago, IL 60616
Phone Number (312-949-9595
Fax Number (312-949-9262

	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	14	Transportation	Direct Allocation			\$	\$		\$ 34,427	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 34,427	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Intercompany Loans						\$		\$			\$		1					
2														2					
3														3					
4														4					
5					-									5					
	Working Capital																		
6	Private Bank		X	Line of Credit								128,885		6					
7	Note Payable-RCA							244,869						7					
8					-									8					
9	TOTAL Facility Related						\$		\$	244,869			\$	128,885	9				
	B. Non-Facility Related*																		
10														10					
11														11					
12														12					
13					-									13					
14	TOTAL Non-Facility Related						\$		\$				\$		14				
15	TOTALS (line 9+line14)						\$		\$	244,869			\$	128,885	15				

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$					8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$					15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.				\$	456,829 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.)				\$	460,747 2
3. Under or (over) accrual (line 2 minus line 1).				\$	3,918 3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	458,640 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.)				\$	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.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	462,558 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	403,152	8	
		2012	446,442	9	
		2013	424,905	10	
		2014	433,464	11	
		2015	455,895	12	
Beginning accrual on line 1 was adjusted since the ending accrual on the 2015 cost report only represented 2 months.					
Allocated from Maestro Consulting = \$4852					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

FACILITY NAME	<u>Symphony at 87th Street</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0053728</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-6300</u>	FAX #:	<u>(847) 236-6301</u>

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

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.)

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates

RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Symphony at 87th Street</u>	COUNTY	<u>Cook</u>
---------------	--------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0053728

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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?

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

C. Tax Bills

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

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

A. Square Feet: 66,911

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 4

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).

None

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:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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	Facility	51,162		1994		\$ 143,613	
	2	Allocated from 7257 N. Lincoln Ave		2004		6,697		2
	3	TOTALS		51,162		\$ 150,310		3

Facility Name & ID Number Symphony at 87th Street

0053728

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	210			1999	\$ 8,930,998	\$	39 #	\$ 223,306	\$ 223,306	\$ 3,949,348	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1999	89,068		20	4,434	4,434	77,246	9	
10	Various			2000	45,130		20	1,174	1,174	19,358	10	
11	Various			2001	40,213		20	2,011	2,011	30,897	11	
12	Various			2002	12,014		20	344	344	10,173	12	
13	Various			2003	20,012		20	795	795	14,899	13	
14	Various			2004	27,005		20	244	244	26,395	14	
15	Various			2005	16,125		20	75	75	15,463	15	
16	Various			2006	109,609		20	3,075	3,075	109,608	16	
17	Various			2010	320,346		20	29,837	29,837	202,705	17	
18	Various			2011	169,484		20	14,484	14,484	102,970	18	
19	Various			2012	43,995		20	6,783	6,783	31,403	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	

*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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	783,631			39,182	39,182	314,868	67
68	Related Party Allocations (Pages 12H & 12I)	100,446	1,749		3,647	1,898	41,255	68
69	Financial Statement Depreciation		4,526			(4,526)		69
70	TOTAL (lines 4 thru 69)	\$ 10,708,076	\$ 6,275		\$ 329,390	\$ 323,116	\$ 4,946,588	70

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

Facility Name & ID Number Symphony at 87th Street

0053728

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,708,076	\$ 6,275		\$ 329,390	\$ 323,116	\$ 4,946,588	1
2	Installed 4" And 6" Check Valves And Cast Iron Pipe For Pump S	2015	12,450		20	623	623	1,245	2
3	Patched Cracks On Roof	2015	3,500		20	175	175	350	3
4	Custom Built Backsplash For 2Nd And 3Rd Floor Dinning Room	2015	2,982		20	149	149	298	4
5	Door & Window Replacement	2016	3,799		20	190	190	190	5
6	Roof Repair	2016	20,210		20	1,011	1,011	1,011	6
7	Hvac Repair	2016	4,227		20	423	423	423	7
8	Fan Coil Motor	2016	2,526		20	253	253	253	8
9									9
10									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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,757,770	\$ 6,275		\$ 332,213	\$ 325,938	\$ 4,950,357	34

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

XI. OWNERSHIP COSTS (continued)

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

1 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		\$ 10,757,770	\$ 6,275		\$ 332,213	\$ 325,938	\$ 4,950,357	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,757,770	\$ 6,275		\$ 332,213	\$ 325,938	\$ 4,950,357	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,757,770	\$ 6,275		\$ 332,213	\$ 325,938	\$ 4,950,357	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,757,770	\$ 6,275		\$ 332,213	\$ 325,938	\$ 4,950,357	34

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

XI. OWNERSHIP COSTS (continued)

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

1		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 12D, Carried Forward		\$ 10,757,770	\$ 6,275		\$ 332,213	\$ 325,938	\$ 4,950,357	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,757,770	\$ 6,275		\$ 332,213	\$ 325,938	\$ 4,950,357	34

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

Facility Name & ID Number Symphony at 87th Street

0053728

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2005	96,496		20	4,825	4,825	83,028	9
10	Built In Kitchen Unit/Cabinet/Table Legs And Sink	2007	10,200		20	510	510	5,950	10
11	Replace Built-In Cabinets And Credenza Unit	2007	9,800		20	490	490	5,635	11
12	2Nd Floor - Sink	2007	4,800		20	240	240	2,760	12
13	3Rd Floor - Assisted Bathing Area	2007	5,200		20	260	260	2,990	13
14	150 Yds Tranquility Dandelion - Wall Covering	2007	2,546		20	127	127	1,950	14
15	2Nd Floor Dinning Room - Electrical	2007	3,500		20	175	175	2,013	15
16	3Rd Floor Dinning Room - Electrical	2007	3,500		20	175	175	2,013	16
17	Basement Corridor	2007	2,750		20	138	138	1,585	17
18	Lobby/Large Main Office - Carpeting	2007	8,578		20	429	429	5,372	18
19	Door Upgrades & R&M	2007	4,301		20	215	215	2,473	19
20	Replace Ejector Pumps For Flood Control System	2007	3,700		20	185	185	2,004	20
21	Vct Tiles For Bathroom	2008	4,656		20	233	233	2,097	21
22	Upholestered Cornice And Roller Shades; Remove Existing Window	2008	8,647		20	432	432	3,889	22
23	Material & Labor For Power Supply & Switch For Airconditioning	2008	5,726		20	286	286	2,575	23
24	Installation: Sprinkler, Ddc Valve, Expansion Tank & Antifreeze	2008	7,665		20	383	383	3,448	24
25	Replacement Motor & Compressor And Refrigerant Of Freezer	2008	5,368		20	268	268	2,413	25
26	Telephone System Tadrion	2008	23,739		20	1,187	1,187	10,683	26
27	Motor Conversion	2008	2,965		20	148	148	1,333	27
28	130 Ft Of Sdr35 Drain Tile	2008	8,910		20	446	446	4,013	28
29	Asphalt Repair Work Sealing And Striping	2008	7,600		20	380	380	3,400	29
30	Prime And Paint Outside Railings, Repair Walls, Paint Payroll Office	2008	3,220		20	161	161	1,449	30
31	Painting - 2Nd Floor Doorframes And Dining Room	2008	2,970		20	149	149	1,340	31
32	Plaster, Prime, And Paint 3Rd Floor Dining Rm Walls, Window Sills	2008	10,600		20	530	530	4,770	32
33	Part & Labor to repair Fire Sprinkler System	2009	4,224		20	211	211	1,688	33
34	TOTAL (lines 1 thru 33)		\$ 251,661	\$		\$ 12,583	\$ 12,583	\$ 160,871	34

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

Facility Name & ID Number Symphony at 87th Street

0053728

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 12F, Carried Forward		\$ 251,661	\$			\$ 12,583	\$ 12,583	\$ 160,871	1
2	Core Glosswhite Tile	2009	2,753			20	138	138	1,104	2
3	Paint & Remodeling of 7 Shower Rooms	2009	17,363			20	868	868	6,944	3
4	Flooring	2011	194,042			20	9,702	9,702	58,212	4
5	Casework/Countertops	2011	68,125			20	3,406	3,406	20,436	5
6	Demolition/Carpentry	2011	74,500			20	3,725	3,725	22,350	6
7	Buildout	2011	65,045			20	3,252	3,252	19,512	7
8	Wallpaper/Paint	2011	59,430			20	2,972	2,972	17,832	8
9	VCT Tile Removal & Installation-Resident Rooms 1st,2nd & 3rd FL	2014	44,000			20	2,200	2,200	6,600	9
10	Install New Vinyl Base in Resident Rooms with New Tiles-1,2&3rd F	2014	3,900			20	195	195	585	10
11	2nd Floor - Replaced Wood Door and Window	2014	2,812			20	141	141	422	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
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23										23
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25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34	TOTAL (lines 1 thru 33)		\$ 783,631	\$			\$ 39,182	\$ 39,182	\$ 314,868	34

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

Facility Name & ID Number Symphony at 87th Street

0053728

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Avenue	2004	60,275	1,545	20	1,722	177	22,603	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Maestro Consulting	2003	490		20	25	25	322	9
10	Allocated from Maestro Consulting	2004	9,954		20	540	540	6,334	10
11	Allocated from Maestro Consulting	2005	590		20	30	30	350	11
12	Allocated from Maestro Consulting	2006	800		20	40	40	415	12
13	Allocated from Maestro Consulting	2008	843		20	42	42	348	13
14	Allocated from Maestro Consulting	2009	13,580		20	637	637	5,167	14
15	Allocated from Maestro Consulting	2010	2,087		20	104	104	679	15
16	Allocated from Maestro Consulting	2011	113		20	6	6	33	16
17	Allocated from Maestro Consulting	2012	126		20	6	6	30	17
18	Allocated from Maestro Consulting	2014	1,570		20	78	78	205	18
19	Allocated from Maestro Consulting	2015	441		20	22	22	29	19
20	Allocated from Maestro Consulting	2016	1,934	75	20	75		75	20
21									21
22	Allocated from 7257 Lincoln	2015	950	90	20	63	(27)	84	22
23	Allocated from 7257 Lincoln	2005	5,495	39	20	197	158	3,832	23
24	Allocated from 7257 Lincoln	2004	1,198		20	60	60	749	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 100,446	\$ 1,749		\$ 3,647	\$ 1,898	\$ 41,255	34

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

XI. OWNERSHIP COSTS (continued)

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

1		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 12H, Carried Forward		\$100,446	\$1,749		\$3,647	\$1,898	\$41,255	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$100,446	\$1,749		\$3,647	\$1,898	\$41,255	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	\$369,718	\$	\$37,382	\$37,382	10	\$266,772	71
72	Current Year Purchases	29,080	202	2,900	2,698	10	2,933	72
73	Fully Depreciated Assets	1,968,987		142	142	10	1,991,717	73
74								74
75	TOTALS	\$2,367,785	\$202	\$40,424	\$40,222		\$2,261,421	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		Allocated from Maestro Consulti	2016	\$371	\$	\$	\$	5	\$371	76
77										77
78										78
79										79
80	TOTALS			\$371	\$	\$	\$		\$371	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$13,276,236	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$6,477	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$372,637	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$366,160	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,212,149	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					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$36,195	92
93			93
94			94
95		\$36,195	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: Main Street (Sale / Leaseback Arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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:				\$ 2,649,604			3
4	Additions				(2,649,604)			4
5	Allocated from Maestro				6,333			5
6								6
7	TOTAL				\$ 6,333			7

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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: \$ 67,959 Description: See Attached Schedule
- (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	Allocated from Maestro			3,409	18
19					19
20					20
21	TOTAL		\$ -	\$ 3,409	21

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. /2017	\$
13. /2018	\$
14. /2019	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

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	

- (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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 983,650	\$		\$ 983,650	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			201,910			201,910	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			964,469			964,469	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				527,112		527,112	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					160,269	190,061		350,330	13
14	TOTAL			\$		\$ 2,310,298	\$ 717,173		\$ 3,027,471	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$	1
2	Cash-Patient Deposits	22,596		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,056,340		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,410		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	611,128		8
9	Other(specify): <u>See Attached Schedule</u>	271,643		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,063,117	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	24,009		15
16	Equipment, at Historical Cost	29,521		16
17	Accumulated Depreciation (book methods)	(4,526)		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>See Attached Schedule</u>	277,195		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 326,199	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,389,316	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,469,224	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,596		28
29	Short-Term Notes Payable	244,869		29
30	Accrued Salaries Payable	138,184		30
31	Accrued Taxes Payable (excluding real estate taxes)	93,126		31
32	Accrued Real Estate Taxes(Sch.IX-B)	458,640		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	823,870		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,250,509	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	230,827		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 230,827	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,481,336	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 907,980	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,389,316	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 109,720	1
2	Restatements (describe):		2
3	Equity Restatement	68,972	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 178,692	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	729,288	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)	\$ 729,288	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)	\$ 907,980	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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 20,246,046	1
2	Discounts and Allowances for all Levels	(249,151)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,996,895	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	661,132	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 661,132	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,434	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	456	19
20	Radiology and X-Ray		20
21	Other Medical Services	20,504	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 25,394	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 20,683,421	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,078,629	31
32	Health Care	6,015,782	32
33	General Administration	4,860,600	33
	B. Capital Expense		
34	Ownership	3,305,943	34
	C. Ancillary Expense		
35	Special Cost Centers	3,236,670	35
36	Provider Participation Fee	456,509	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,954,133	40
41	Income before Income Taxes (line 30 minus line 40)**	729,288	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 729,288	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,314,765	44
45	Private Pay - Net Inpatient Revenue	735,769	45
46	Medicare - Net Inpatient Revenue	7,107,011	46
47	Other-(specify) Managed Care	3,906,217	47
48	Other-(specify) Hospice	933,133	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 19,996,895	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

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	1,970	2,257	\$ 130,397	\$ 57.77	1
2	Assistant Director of Nursing	1,954	2,115	87,875	41.55	2
3	Registered Nurses	33,996	37,005	1,258,159	34.00	3
4	Licensed Practical Nurses	67,598	72,687	2,010,516	27.66	4
5	CNAs & Orderlies	126,392	134,881	1,540,459	11.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,865	2,085	31,208	14.97	8
9	Activity Director	2,947	3,307	68,815	20.81	9
10	Activity Assistants	7,907	9,492	98,998	10.43	10
11	Social Service Workers	10,099	11,221	240,130	21.40	11
12	Dietician					12
13	Food Service Supervisor	3,468	3,575	83,881	23.46	13
14	Head Cook	3,272	3,502	77,962	22.26	14
15	Cook Helpers/Assistants	18,595	19,845	222,150	11.19	15
16	Dishwashers					16
17	Maintenance Workers	3,496	4,192	75,966	18.12	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	3,147	2,323	186,580	80.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,888	15,940	281,665	17.67	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	2,572	2,722	37,885	13.92	31
32	Other Health Care(specify)					32
33	Other(specify)	2,560	2,645	53,768	20.33	33
34	TOTAL (lines 1 - 33)	306,726	329,794	\$ 6,486,414 *	\$ 19.67	34

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	458	\$ 21,663	01-03	35
36	Medical Director	Monthly	19,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	77	4,218	10-03	38
39	Pharmacist Consultant	Monthly	40,372	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	12,498	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,200	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric	Monthly	32,600	10a-03	47
48	Orthopedic Surgeon	Monthly	24,000	10-03	48
49	TOTAL (lines 35 - 48)	575	\$ 157,051		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number		Symphony at 87th Street		STATE OF ILLINOIS	#	0053728	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			Yes							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			Yes ICLTC \$22,116							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			Yes Yes							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			No N/A							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			Yes 10 Years							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ 268 Line 10							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			Yes							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			Yes 11/1/15							
(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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			Renaissance at 87th St., IDPH 0042093, Date 11/01/15							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ 456,509							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			No							
(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? 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.			No							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?			\$ 43,280 No Indicate the amount. \$ N/A							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			No							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			No \$ N/A							
	c. What percent of all travel expense relates to transportation of nurses and patients?			100% LN1							
	d. Have vehicle usage logs been maintained?			N/A							
	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? Indicate the amount of income earned from providing such transportation during this reporting period.			No \$ N/A							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			No 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. Attach invoices and a summary of services for all architect and appraisal fees			Yes							