

		FOR BHF USE					

LL1

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>0053710</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Symphony at Aria</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>4600 N Frontage Road</u> <u>Hillside</u> <u>60162</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(708) 544-9933</u> Fax # <u>(708) 544-9966</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ *</td></tr><tr><td rowspan="5">Paid Preparer</td><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ *	Paid Preparer	* Subject to the attached Accountants Consulting Report (Date) _____	(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											
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____ *																								
Paid Preparer	* Subject to the attached Accountants Consulting Report (Date) _____																								
	(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																								
Date of Initial License for Current Owners: <u>9/28/2012</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "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: _____																									

Facility Name & ID Number Symphony at Aria

0053710 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	198	Skilled (SNF)	198	72,468
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	198	TOTALS	198	72,468

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		12,120	12,120	8
9	SNF/PED				9
10	ICF	31,816	1,866	15,808	49,490
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	31,816	1,866	27,928	61,610

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.02%

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) N/A

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 09/28/2012

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 09/28/2012 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 198 and days of care provided 12,120

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Symphony at Aria # 0053710 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	343,141	39,376	37,367	419,884		419,884		419,884			1
2	Food Purchase		327,047		327,047		327,047	(99)	326,948			2
3	Housekeeping	315,357	65,047		380,404		380,404		380,404			3
4	Laundry	61,154	10,912	23,569	95,635		95,635		95,635			4
5	Heat and Other Utilities			277,309	277,309		277,309	(3,060)	274,249			5
6	Maintenance	57,355		167,243	224,598		224,598	26,468	251,066			6
7	Other (specify):*							3,358	3,358			7
8	TOTAL General Services	777,007	442,382	505,488	1,724,877		1,724,877	26,667	1,751,544			8
	B. Health Care and Programs											
9	Medical Director			76,675	76,675		76,675		76,675			9
10	Nursing and Medical Records	4,164,786	246,652	98,682	4,510,120		4,510,120	129,180	4,639,300			10
10a	Therapy	41,194		30,369	71,563		71,563	(569)	70,994			10a
11	Activities	157,287	18,142	2,200	177,629		177,629		177,629			11
12	Social Services	197,250			197,250		197,250		197,250			12
13	CNA Training											13
14	Program Transportation			60,292	60,292		60,292	(7,356)	52,936			14
15	Other (specify):*							20,057	20,057			15
16	TOTAL Health Care and Programs	4,560,517	264,794	268,218	5,093,529		5,093,529	141,312	5,234,841			16
	C. General Administration											
17	Administrative	134,384		854,104	988,488		988,488	(817,300)	171,188			17
18	Directors Fees											18
19	Professional Services			358,494	358,494		358,494	31,210	389,704			19
20	Dues, Fees, Subscriptions & Promotions			73,889	73,889		73,889	(8,065)	65,824			20
21	Clerical & General Office Expenses	278,818	1,656	852,930	1,133,404		1,133,404	(444,852)	688,552			21
22	Employee Benefits & Payroll Taxes			1,125,533	1,125,533		1,125,533		1,125,533			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,774	1,774		1,774	1,201	2,975			24
25	Other Admin. Staff Transportation			6,077	6,077		6,077	2,977	9,054			25
26	Insurance-Prop.Liab.Malpractice			482,881	482,881		482,881	3,481	486,362			26
27	Other (specify):*							46,357	46,357			27
28	TOTAL General Administration	413,202	1,656	3,755,682	4,170,540		4,170,540	(1,184,989)	2,985,551			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,750,726	708,832	4,529,388	10,988,946		10,988,946	(1,017,010)	9,971,936			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			19,472	19,472		19,472	570,294	589,766			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			125,555	125,555		125,555	(350)	125,205			32
33	Real Estate Taxes			825,463	825,463		825,463	(87,884)	737,579			33
34	Rent-Facility & Grounds			2,491,832	2,491,832		2,491,832	(2,485,861)	5,971			34
35	Rent-Equipment & Vehicles			66,287	66,287		66,287	5,796	72,083			35
36	Other (specify):*											36
37	TOTAL Ownership			3,528,609	3,528,609		3,528,609	(1,998,006)	1,530,603			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		621,189	2,358,051	2,979,240		2,979,240	(14,439)	2,964,801			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			408,360	408,360		408,360		408,360			42
43	Other (specify):*	52,004		141,768	193,772		193,772	(193,772)	0			43
44	TOTAL Special Cost Centers	52,004	621,189	2,908,179	3,581,372		3,581,372	(208,211)	3,373,161			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,802,730	1,330,021	10,966,176	18,098,927		18,098,927	(3,223,226)	14,875,701			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	(5,109)	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	601,909	30		9
10	Interest and Other Investment Income	(350)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(99)	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	(58,802)	21		18
19	Entertainment				19
20	Contributions	(14,950)	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	(424,060)	21		24
25	Fund Raising, Advertising and Promotional	(1,448)	20		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	(3,055,067)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,957,976)		\$	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)	(265,251)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (265,251)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,223,227)		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

Symphony at Aria

	ID#	0053710
Report Period Beginning:		01/01/16
Ending:		12/31/16

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Medicare Sequestration	\$ (232,876)	21	1
2	Jury Duty Income	(17)	10	2
3	Marketing	(715)	43	3
4	Guest Relations	(51,289)	43	4
5	Bank Charges	(1,025)	21	5
6	Marketing Consultant	(101,858)	43	6
7	Marketing Services	(39,386)	43	7
8	Main Street Sale/Leaseback Arrangement	(2,491,832)	34	8
9	PAC Dues	(6,976)	20	9
10	Non Allowable Legal Fees	(6,115)	19	10
11	Intermedia Marketing	(524)	43	11
12	Additional R&M	8,752	06	12
13	Day Care Allocation - Real Estate	(92,459)	33	13
14	Day Care Allocation - Depreciation	(33,455)	30	14
15	Capitalized R&M	(5,293)	06	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	(3,055,067)		49

Symphony at Aria

	ID#	0053710
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 Aria # 0053710 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	(99)											(99)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,109)		2,049									(3,060)	5
6	Maintenance	3,460		23,009									26,468	6
7	Other (specify):*			3,358									3,358	7
8	TOTAL General Services	(1,749)		28,416									26,667	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)		129,197									129,180	10
10a	Therapy				(569)								(569)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation						(7,356)						(7,356)	14
15	Other (specify):*			20,057									20,057	15
16	TOTAL Health Care and Programs	(17)		149,254	(569)		(7,356)						141,312	16
	C. General Administration													
17	Administrative			(817,300)									(817,300)	17
18	Directors Fees													18
19	Professional Services	(6,115)		37,326									31,210	19
20	Fees, Subscriptions & Promotions	(23,374)		15,309									(8,065)	20
21	Clerical & General Office Expenses	(716,763)		271,911									(444,852)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,201									1,201	24
25	Other Admin. Staff Transportation			2,977									2,977	25
26	Insurance-Prop.Liab.Malpractice			3,481									3,481	26
27	Other (specify):*			46,357									46,357	27
28	TOTAL General Administration	(746,252)		(438,738)									(1,184,989)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(748,017)		(261,068)	(569)		(7,356)						(1,017,010)	29

Summary B

12/31/16

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	568,454		1,840									570,294	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(350)											(350)	32
33	Real Estate Taxes	(92,459)		4,575									(87,884)	33
34	Rent-Facility & Grounds	(2,491,832)		5,971									(2,485,861)	34
35	Rent-Equipment & Vehicles			5,796									5,796	35
36	Other (specify):*													36
37	TOTAL Ownership	(2,016,187)		18,181									(1,998,006)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(14,439)							(14,439)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(193,772)											(193,772)	43
44	TOTAL Special Cost Centers	(193,772)				(14,439)							(208,211)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,957,976)		(242,887)	(569)	(14,439)	(7,356)						(3,223,226)	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

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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%	\$ 2,049	\$	2,049 15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	18,758		18,758 16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	4,251		4,251 17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,358		3,358 18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	129,197		129,197 19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	20,057		20,057 20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	36,804		36,804 21
22	V	17	ADMINISTRATIVE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%			
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	37,326		37,326 23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	15,309		15,309 24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	241,802		241,802 25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	30,109		30,109 26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,201		1,201 27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	2,977		2,977 28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,481		3,481 29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	46,357		46,357 30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,840		1,840 31
32	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	4,575		4,575 32
33	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	5,971		5,971 33
34	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	2,581		2,581 34
35	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,215		3,215 35
36	V								36
37	V	17	MANAGEMENT FEE	854,104	MAESTRO CONSULTING SERVICES LLC	100.00%			(854,104) 37
38	V								38
39	Total			\$ 854,104			\$ 611,217	\$ *	(242,887) 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	10A	Respiratory Services	\$ 4,711	Integra Respiratory Service, LLC		\$ 4,142	\$ (569)	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			\$ 4,711			\$ 4,142	\$ * (569)	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.

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	39	DME & Medical Supplies	\$ 142,536	Integra Healthcare Equipment LLC		\$ 128,097	\$ (14,439)	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			\$ 142,536			\$ 128,097	\$ * (14,439)	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	\$ 55,767	Lifeline Ambulance, LLC		\$ 48,411	\$ (7,356)	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			\$ 55,767			\$ 48,411	\$ * (7,356)	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	\$ 150,707	MAPLE LEAF INSURANCE	100.00%	\$ 150,707	\$	15
16	V	26	Liability Insurance	360,495	MAPLE LEAF INSURANCE	100.00%	360,495		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			\$ 511,202			\$ 511,202	\$ *	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	<u>ARIA HILL LLC</u>	<u>55.00%</u>	<u>CALIFORNIA GARDENS</u>	<u>CHICAGO</u>	<u>MAESTRO CONSULTING SERV</u>	<u>LINCOLNWOOD</u>	<u>MANAGEMENT</u>	1
2	<u>TAM023 CONSULTING</u>	<u>5.00%</u>	<u>MAPLECREST CARE CENTRE</u>	<u>BELVIDERE</u>	<u>7257 N. LINCOLN AVENUE</u>	<u>LINCOLNWOOD</u>	<u>BUILDING RENTAL</u>	2
3	<u>IBEX MANAGEMENT SERVICES</u>	<u>20.00%</u>	<u>MCKINLEY COURT</u>	<u>DECATUR</u>	<u>MAPLELEAF INSURANCE</u>	<u>GRAND CAYMAN</u>	<u>LIABILITY/WORK COMP IN</u>	3
4	<u>JMD VENTURES LLC</u>	<u>20.00%</u>	<u>MONROE PAVILION</u>	<u>CHICAGO</u>	<u>INTEGRA HEALTHCARE EQUIP</u>	<u>ELMHURST</u>	<u>DME & MEDICAL SUPPLIES</u>	4
5			<u>NORTHWOODS CARE CENTRE</u>	<u>BELVIDERE</u>	<u>INTEGRA RESPIRATORY SERV</u>	<u>ELMHURST</u>	<u>RESPIRATORY SERVICES</u>	5
6			<u>SYCAMORE VILLAGE</u>	<u>SWANSEA</u>	<u>LIFELINE AMBULANCE</u>	<u>CHICAGO</u>	<u>AMBULANCE</u>	6
7			<u>SYMPHONY AT 87TH STREET</u>	<u>CHICAGO</u>				7
8			<u>SYMPHONY AT MIDWAY</u>	<u>CHICAGO</u>				8
9			<u>SYMPHONY AT THE TILLERS</u>	<u>OSWEGO</u>				9
10			<u>SYMPHONY OF BRONZEVILLE</u>	<u>CHICAGO</u>				10
11			<u>SYMPHONY OF BUFFALO GROVE</u>	<u>BUFFALO GROVE</u>				11
12			<u>SYMPHONY OF CHESTERTON</u>	<u>CHESTERTON, IN</u>				12
13			<u>SYMPHONY OF CHICAGO WEST</u>	<u>CHICAGO</u>				13
14			<u>SYMPHONY OF CRESTWOOD</u>	<u>CRESTWOOD</u>				14
15			<u>SYMPHONY OF CROWN POINT</u>	<u>CROWN POINT, IN</u>				15
16			<u>SYMPHONY OF DECATUR</u>	<u>DECATUR</u>				16
17			<u>SYMPHONY OF DYER</u>	<u>DYER, IN</u>				17
18			<u>SYMPHONY OF EVANSTON</u>	<u>EVANSTON</u>				18
19			<u>SYMPHONY OF GLENDALE</u>	<u>GLENDALE, WI</u>				19
20			<u>SYMPHONY OF HANOVER PARK</u>	<u>HANOVER PARK</u>				20
21			<u>SYMPHONY OF JOLIET</u>	<u>JOLIET</u>				21
22			<u>SYMPHONY OF LINCOLN</u>	<u>LINCOLN</u>				22
23			<u>SYMPHONY OF LINCOLN PARK</u>	<u>CHICAGO</u>				23
24			<u>SYMPHONY OF MORGAN PARK</u>	<u>CHICAGO</u>				24
25			<u>SYMPHONY OF ORCHARD VALLEY</u>	<u>AURORA</u>				25
26			<u>SYMPHONY OF SOUTH SHORE</u>	<u>CHICAGO</u>				26
27			<u>SYMPHONY RESIDENCES OF LINCOLN PARK</u>	<u>CHICAGO</u>				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	N/A								\$		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 Aria # 0053710 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 Aria # 0053710 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	\$ 72,468	\$ 2,049	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	475,288	72,468	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711		72,468	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090		72,468	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	3,273,643	72,468	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220		72,468	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	932,558	72,468	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28			72,468	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768		72,468	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900		72,468	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	6,126,863	72,468	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920		72,468	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439		72,468	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434		72,468	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214		72,468	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614		72,468	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621		72,468	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912		72,468	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288		72,468	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399		72,468	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453		72,468	21
22									22
23									23
24									24
25	TOTALS					\$ 15,487,256	\$ 10,808,353	\$ 611,218	25

Facility Name & ID Number Symphony at Aria # 0053710 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 Respiratory Service LLC
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	10A Respiratory Services	Direct Allocation			\$	\$		\$ 4,142	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				\$	\$		\$ 4,142	25

Facility Name & ID Number Symphony at Aria # 0053710 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, LLC
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 & Medical Supplies	Direct Allocation			\$	\$		\$ 128,097	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					\$	\$		\$ 128,097	25

Facility Name & ID Number Symphony at Aria # 0053710 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. Wabash Avenue
City / State / Zip Code Chicago, IL 60616
Phone Number (312) 949-9595
Fax Number (312) 949-9262

	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	14	Transportation	Direct Allocation		\$	\$		\$ 48,411	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				\$	\$		\$ 48,411	25

Facility Name & ID Number Symphony at Aria # 0053710 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		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	22	Workers Compensation	Direct Allocation			\$	\$		\$ 150,707	1
2	26	Liability Insurance	Direct Allocation						360,495	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					\$	\$		\$ 511,202	25

Facility Name & ID Number Symphony at Aria # 0053710 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 Aria # 0053710 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 Aria # 0053710 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 Aria # 0053710 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							\$				\$	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	RCA		X	Note Payable				287,827				6
7	The Private Bank		X	Line of Credit							125,555	7
8					-							8
9	TOTAL Facility Related						\$	\$ 287,827			\$ 125,555	9
	B. Non-Facility Related*											
10	Interest Income		X								(350)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						\$	\$			\$ (350)	14
15	TOTALS (line 9+line14)						\$	\$ 287,827			\$ 125,205	15

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

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

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

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

B. Real Estate Taxes

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 Aria</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0053710</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	(847) 236-6300	FAX #:	(847) 236-6301

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.

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.

RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

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.

FACILITY NAME	<u>Symphony at Aria</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0053710</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,306

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 2

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).
Hillside Montessori School - Child Day Care

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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		2012	\$ 1,200,000	1
2	Allocated from Maestro Consulting/7257 Lincoln		2004	6,315	2
3	TOTALS			\$ 1,206,315	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	198		2012	1997	\$ 9,076,289	\$	35	\$ 259,323	\$ 259,323	\$ 1,059,179	4
5	Day Care Allocation					(33,455)			33,455		5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2012		36,080		20	1,503	1,503	7,087	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											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)								67
68	Related Party Allocations (Pages 12H & 12I)		94,705	1,649		3,441	1,792	38,898	68
69	Financial Statement Depreciation			19,472			(19,472)		69
70	TOTAL (lines 4 thru 69)		\$ 9,207,074	\$ (12,334)		\$ 264,267	\$ 276,601	\$ 1,105,164	70

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

Facility Name & ID Number Symphony at Aria

0053710

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	Totals from Page 12A, Carried Forward		\$ 9,207,074	\$ (12,334)		\$ 264,267	\$ 276,601	\$ 1,105,164	1
2	4 Cctv Cameras	2013	3,400		20	567	567	2,323	2
3	Outlets For Tvs, Installed Wall Mounts, Overhead Lights	2013	4,000		20	667	667	2,733	3
4	15 Cctvs	2013	7,490		20	1,248	1,248	4,744	4
5	Fire Alarm Work. Upgrade Motherboard, Intellignet Loop Interfa	2013	17,895		20	746	746	2,610	5
6	Chiller Unit Repairs	2013	4,310		20	180	180	665	6
7	Resident Rms,Bathrms,Hallways-Roofing,Painting,Wiring,Floorin	2013	698,212		20	29,092	29,092	128,006	7
8	Asphalt Curbs, Landscaping	2013	92,444		20	3,852	3,852	16,948	8
9	Coffee Station & Dining Room Bistro	2014	9,300		20	388	388	1,240	9
10	2 Boiler Pump Replacements	2014	4,084		20	170	170	545	10
11	Stained Concrete Sidewalk Installation	2014	4,760		20	264	264	714	11
12	Trane Chiller	2014	12,249		20	510	510	1,276	12
13	Card Reader Replacement Panel	2014	3,325		20	139	139	374	13
14	Electrical Work - Fire Alarm System	2014	5,250		20	219	219	503	14
15	Doors, Frames And Sideliters	2015	2,622		20	11	11	22	15
16	Install 2 Fans On Boiler	2015	3,485		20	581	581	1,162	16
17	Chiler - Leak Repair	2015	7,420		20	371	371	742	17
18	Cubicle Curtains	2016	7,562		20	378	378	378	18
19	Install 2 Pit Ladder In Elevator	2016	4,562		20	228	228	228	19
20	Chiller Repair	2016	5,049		20	252	252	252	20
21	Chiller Replacement	2016	110,000		20	5,500	5,500	5,500	21
22	Install 15 Sprinkler System	2016	6,823		20	341	341	341	22
23	Repair Heating Pallet In 2Nd Floor Pt. Replace Thermostat, Comp	2016	2,793		20	140	140	140	23
24	Furnish & Install New Submersible Motor For Elevator 1/Contact	2016	2,500		20	125	125	125	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)		\$ 10,226,609	\$ (12,334)		\$ 310,235	\$ 322,569	\$ 1,276,734	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 12B, Carried Forward		\$ 10,226,609	\$ (12,334)		\$ 310,235	\$ 322,569	\$ 1,276,734	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,226,609	\$ (12,334)		\$ 310,235	\$ 322,569	\$ 1,276,734	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 12C, Carried Forward		\$ 10,226,609	\$ (12,334)		\$ 310,235	\$ 322,569	\$ 1,276,734	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,226,609	\$ (12,334)		\$ 310,235	\$ 322,569	\$ 1,276,734	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 12D, Carried Forward		\$ 10,226,609	\$ (12,334)		\$ 310,235	\$ 322,569	\$ 1,276,734	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,226,609	\$ (12,334)		\$ 310,235	\$ 322,569	\$ 1,276,734	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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		\$	\$		\$	\$	\$	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 12F, Carried Forward		\$	\$		\$	\$	\$	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Symphony at Aria

0053710

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 Maestro Consulting/7257 Lincoln	2004	56,831	1,457	35	1,624	167	21,312	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Maestro Consulting Services	2003	462		20	23	23	303	9
10	Allocated from Maestro Consulting Services	2004	9,385		20	509	509	5,972	10
11	Allocated from Maestro Consulting Services	2005	556		20	28	28	330	11
12	Allocated from Maestro Consulting Services	2006	754		20	38	38	391	12
13	Allocated from Maestro Consulting Services	2008	795		20	40	40	328	13
14	Allocated from Maestro Consulting Services	2009	12,804		20	601	601	4,872	14
15	Allocated from Maestro Consulting Services	2010	1,968		20	98	98	640	15
16	Allocated from Maestro Consulting Services	2011	106		20	5	5	31	16
17	Allocated from Maestro Consulting Services	2012	118		20	6	6	28	17
18	Allocated from Maestro Consulting Services	2014	1,480		20	74	74	193	18
19	Allocated from Maestro Consulting Services	2015	416		20	21	21	28	19
20	Allocated from Maestro Consulting Services	2016	1,824	71	20	71		71	20
21									21
22	Allocated from Maestro Consulting/7257 Lincoln	2015	896	85	20	60	(25)	80	22
23	Allocated from Maestro Consulting/7257 Lincoln	2005	5,181	36	20	186	150	3,613	23
24	Allocated from Maestro Consulting/7257 Lincoln	2004	1,129		20	57	57	706	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)		\$ 94,705	\$ 1,649		\$ 3,441	\$ 1,792	\$ 38,898	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 12H, Carried Forward		\$ 94,705	\$ 1,649		\$ 3,441	\$ 1,792	\$ 38,898	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 94,705	\$ 1,649		\$ 3,441	\$ 1,792	\$ 38,898	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	\$1,499,231	\$	\$273,186	\$273,186	10	\$1,150,094	71
72	Current Year Purchases	41,919	191	4,185	3,994	10	4,216	72
73	Fully Depreciated Assets	32,737		134	134	10	54,167	73
74								74
75	TOTALS	\$1,573,886	\$191	\$277,504	\$277,313		\$1,208,476	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		Ford E350	2015	\$9,783	\$	\$1,957	\$1,957	5	\$3,913	76
77		Allocated from Maestro Consulti	2016	350		70	70	5	350	77
78										78
79										79
80	TOTALS			\$10,133	\$	\$2,027	\$2,027		\$4,263	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$13,016,943	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$(12,143)	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$589,766	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$601,909	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,489,473	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	\$7,275	92
93			93
94			94
95		\$7,275	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?
If NO, see instructions.
- ☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		198		\$2,491,832			3
4	Additions				(2,491,832)			4
5	Allocated from Maestro Consulting				5,971			5
6								6
7	TOTAL		198		\$5,971			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?
16. Rental Amount for movable equipment: \$52,124Description: 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	Facility	2012 Ford Bus	\$	15,647	17
18	Allocated from Maestro Consulting			3,215	18
19	Van Rental			1,097	19
20					20
21	TOTAL		\$-	\$19,959	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 EndingAnnual 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
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 810,247	\$		\$ 810,247	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			368,165			368,165	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			992,211			992,211	4
5	Physician Care	39 - 03	visits			90			90	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				431,858		431,858	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					187,338	189,331		376,669	13
14	TOTAL			\$		\$ 2,358,051	\$ 621,189		\$ 2,979,240	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	\$ 3,442	\$	1
2	Cash-Patient Deposits	22,367		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,954,359		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,970		6
7	Other Prepaid Expenses	167,918		7
8	Accounts Receivable (owners or related parties)	476,446		8
9	Other(specify): <u>See Attached Schedule</u>	502,345		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,188,847	\$	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	12,575		15
16	Equipment, at Historical Cost	180,163		16
17	Accumulated Depreciation (book methods)	(19,473)		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>	7,275		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 180,540	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,369,387	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,947,664	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,367		28
29	Short-Term Notes Payable	287,827		29
30	Accrued Salaries Payable	228,137		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,991		31
32	Accrued Real Estate Taxes(Sch.IX-B)	834,435		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>	679,676		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,034,097	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,034,097	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (664,710)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,369,387	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 122,402	1
2	Restatements (describe):		2
3	Equity Restatement	10,541	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 132,943	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(797,653)	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)	\$ (797,653)	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)	\$ (664,710)	24 *

* This must agree with page 17, line 47.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,305,823	1
2	Discounts and Allowances for all Levels	(399,911)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,905,912	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,389,060	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,389,060	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	4,843	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	921	19
20	Radiology and X-Ray		20
21	Other Medical Services	171	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,935	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	350	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 350	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,301,274	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,724,877	31
32	Health Care	5,093,529	32
33	General Administration	4,170,540	33
	B. Capital Expense		
34	Ownership	3,528,609	34
	C. Ancillary Expense		
35	Special Cost Centers	3,173,012	35
36	Provider Participation Fee	408,360	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,098,927	40
41	Income before Income Taxes (line 30 minus line 40)**	(797,653)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (797,653)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,199,831	44
45	Private Pay - Net Inpatient Revenue	361,697	45
46	Medicare - Net Inpatient Revenue	6,488,980	46
47	Other-(specify) Managed Care	1,355,011	47
48	Other-(specify) Hospice	500,393	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,905,912	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	1,898	2,067	\$ 114,263	\$ 55.28	1
2	Assistant Director of Nursing	2,077	2,273	107,629	47.35	2
3	Registered Nurses	40,698	45,398	1,391,450	30.65	3
4	Licensed Practical Nurses	42,909	47,230	1,239,325	26.24	4
5	CNAs & Orderlies	90,198	99,341	1,273,546	12.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,366	3,698	41,194	11.14	8
9	Activity Director	1,714	1,935	47,588	24.59	9
10	Activity Assistants	9,999	11,036	109,699	9.94	10
11	Social Service Workers	5,383	5,652	168,778	29.86	11
12	Dietician					12
13	Food Service Supervisor	1,758	1,961	56,492	28.81	13
14	Head Cook	4,507	4,729	73,587	15.56	14
15	Cook Helpers/Assistants	19,825	21,741	213,062	9.80	15
16	Dishwashers					16
17	Maintenance Workers	2,493	2,738	57,355	20.95	17
18	Housekeepers	24,549	27,614	315,357	11.42	18
19	Laundry	4,590	5,309	61,154	11.52	19
20	Administrator	1,937	2,066	134,384	65.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,788	2,073	67,896	32.75	23
24	Clerical	9,111	10,015	210,922	21.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,572	1,749	38,573	22.05	31
32	Other Health Care(specify)					32
33	Other(specify)	2,441	2,667	80,476	30.17	33
34	TOTAL (lines 1 - 33)	272,813	301,292	\$ 5,802,730 *	\$ 19.26	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	Monthly	\$ 37,367	01-03	35
36	Medical Director	Monthly	76,675	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	21,625	10-03	38
39	Pharmacist Consultant	Monthly	72,031	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	30,369	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 Consultant	Monthly	5,026	10-03	47
48					48
49	TOTAL (lines 35 - 48)	40	\$ 245,293		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 Aria
---------------------------	------------------

0053710

Report Period Beginning: 01/01/16

Ending: 12/31/16

Facility Name & ID Number		Symphony at Aria		STATE OF ILLINOIS	#	0053710	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: \$21,139							
(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.			\$ None Line N/A							
(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 NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			X Aria Post Acute Care #52019							
(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.			\$ 408,360							
(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.			Yes							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?			\$ N/A 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% Ln 14							
	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							