

		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: 0053686

Facility Name: Symphony of Chicago West

Address: 5130 W Jackson Blvd Chicago 60644
Number City Zip Code

County: Cook

Telephone Number: (773) 921-8000 Fax # (773) 921-3980

HFS ID Number:

Date of Initial License for Current Owners: 7/1/1994

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Symphony of Chicago West

0053686 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	234	234	85,644	1
2	Skilled (SNF)			2
3	Skilled Pediatric (SNF/PED)			3
4	Intermediate (ICF)			4
5	Intermediate/DD			5
6	Sheltered Care (SC)			6
7	ICF/DD 16 or Less			7
234	TOTALS	234	85,644	7

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		27,311	27,311	8
9	SNF/PED				9
10	ICF	38,496	1,199	14,455	10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	38,496	1,199	41,766	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.12%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

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

YES ☒ NO ☐

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

Date started 07/01/1994

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

YES ☒ Date 07/01/1994 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 234 and days of care provided 5,625

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 of Chicago West # 0053686 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	325,355	33,867	38,214	397,436		397,436		397,436			1
2	Food Purchase		440,810		440,810		440,810	(65)	440,745			2
3	Housekeeping		327,505		327,505		327,505		327,505			3
4	Laundry		179,172	18,186	197,358		197,358		197,358			4
5	Heat and Other Utilities			371,114	371,114		371,114	(35,110)	336,004			5
6	Maintenance	76,509		273,301	349,810		349,810	19,581	369,391			6
7	Other (specify):*							3,969	3,969			7
8	TOTAL General Services	401,864	981,354	700,815	2,084,033		2,084,033	(11,626)	2,072,407			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	4,259,367	408,193	43,101	4,710,661		4,710,661	151,253	4,861,914			10
10a	Therapy	42,233		44,359	86,592		86,592		86,592			10a
11	Activities	137,238	2,881	2,420	142,539		142,539		142,539			11
12	Social Services	222,101		13,640	235,741		235,741		235,741			12
13	CNA Training											13
14	Program Transportation			27,885	27,885		27,885	(3,897)	23,988			14
15	Other (specify):*							23,704	23,704			15
16	TOTAL Health Care and Programs	4,660,939	411,074	173,405	5,245,418		5,245,418	171,060	5,416,478			16
	C. General Administration											
17	Administrative	201,858		868,755	1,070,613		1,070,613	(928,641)	141,972			17
18	Directors Fees											18
19	Professional Services			353,431	353,431	(3,693)	349,738	25,585	375,322			19
20	Dues, Fees, Subscriptions & Promotions			58,004	58,004		58,004	(5,926)	52,078			20
21	Clerical & General Office Expenses	247,465	1,624	398,044	647,133		647,133	(8,151)	638,982			21
22	Employee Benefits & Payroll Taxes			976,036	976,036		976,036		976,036			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,682	3,682		3,682	1,420	5,102			24
25	Other Admin. Staff Transportation			3,505	3,505		3,505	3,518	7,023			25
26	Insurance-Prop.Liab.Malpractice			616,617	616,617		616,617	4,114	620,731			26
27	Other (specify):*							54,786	54,786			27
28	TOTAL General Administration	449,323	1,624	3,278,074	3,729,021	(3,693)	3,725,328	(853,295)	2,872,033			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,512,126	1,394,052	4,152,294	11,058,472	(3,693)	11,054,779	(693,860)	10,360,918			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			3,500	3,500		3,500	271,565	275,065			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			145,846	145,846		145,846	(3,475)	142,371			32
33	Real Estate Taxes			435,474	435,474	3,693	439,167	(28,227)	410,941			33
34	Rent-Facility & Grounds			2,772,321	2,772,321		2,772,321	(2,765,265)	7,056			34
35	Rent-Equipment & Vehicles			31,370	31,370		31,370	6,849	38,219			35
36	Other (specify):*											36
37	TOTAL Ownership			3,388,511	3,388,511	3,693	3,392,204	(2,518,552)	873,652			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		384,995	1,699,870	2,084,865		2,084,865	(16,866)	2,067,999			39
40	Barber and Beauty Shops			63	63		63		63			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			589,015	589,015		589,015		589,015			42
43	Other (specify):*	50,136		177,563	227,699		227,699	(227,699)	(0)			43
44	TOTAL Special Cost Centers	50,136	384,995	2,466,511	2,901,642		2,901,642	(244,565)	2,657,077			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,562,262	1,779,047	10,007,316	17,348,625		17,348,625	(3,456,978)	13,891,647			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,485)	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	272,240	30		9
10	Interest and Other Investment Income	(3,475)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(65)	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	(15,038)	21		18
19	Entertainment				19
20	Contributions	(12,700)	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	(220,854)	21		24
25	Fund Raising, Advertising and Promotional	(3,374)	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	(3,189,344)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,183,095)		\$	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)	(273,882)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (273,882)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,456,977)		37

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

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

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

Report Period Beginning:

ID#0053686

Ending:

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Veterans Expense	\$ (1,194)	10	1
2	Patient Needs	(240)	10	2
3	Theft and Damage Loss	(157)	21	3
4	Guest Relations	(50,136)	43	4
5	Marketing Consultant	(115,637)	43	5
6	Marketing Services	(61,926)	43	6
7	Bank Charges	(912)	21	7
8	Sequestration	(92,065)	21	8
9	Clinical Allocation - Utilities	(27,047)	05	9
10	Additional R&M	6,956	06	10
11	Capitalized R&M	(14,567)	06	11
12	Non-Care Depreciation	(2,849)	30	12
13	PAC Dues	(7,944)	20	13
14	Rent for Sale/Leaseback Agreement	(2,772,321)	34	14
15	Clinical Allocation - Real Estate	(33,633)	33	15
16	Non-Allowable Legal	(18,891)	19	16
17	Appraisal Fee	3,693	19	17
18	Other Unclassified Income	(474)	21	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	(3,189,344)		49

ID#0053686

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

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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.

☒ 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%	\$ 2,422	\$	2,422 15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	22,168		22,168 16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	5,024		5,024 17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,969		3,969 18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	152,687		152,687 19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	23,704		23,704 20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	43,496		43,496 21
22	V	17	ADMINISTRATIVE EXPENSES	972,137	MAESTRO CONSULTING SERVICES LLC	100.00%			(972,137) 22
23	V	19	PROFESSIONAL FEES	3,330	MAESTRO CONSULTING SERVICES LLC	100.00%	44,112		40,782 23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	18,092		18,092 24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	285,766		285,766 25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	35,584		35,584 26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,420		1,420 27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	3,518		3,518 28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,114		4,114 29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	54,786		54,786 30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	2,174		2,174 31
32	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	5,406		5,406 32
33	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	7,056		7,056 33
34	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	3,050		3,050 34
35	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,799		3,799 35
36	V								36
37	V								37
38	V								38
39	Total			\$ 975,467			\$ 722,347	\$ *	(253,119) 39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & Medical Supplies	\$ 166,498	Integra Healthcare Equipment LLC		\$ 149,632	\$ (16,866)	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			\$ 166,498			\$ 149,632	\$ * (16,866)	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	\$ 29,542	Lifeline Ambulance LLC		\$ 25,645	\$ (3,897)	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			\$ 29,542			\$ 25,645	\$ * (3,897)	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	\$ 175,745	MAPLE LEAF INSURANCE		\$ 175,745	\$	15
16	V	26	Liability Insurance	396,922	MAPLE LEAF INSURANCE		396,922		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			\$ 572,667			\$ 572,667	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SYMCARE HEALTHCARE, LLC	99.99%	CALIFORNIA GARDENS	CHICAGO	MAESTRO CONSULTING SERV	LINCOLNWOOD	MANAGEMENT	1
2	SYMCARE HMG, LLC	0.01%	MAPLECREST CARE CENTRE	BELVIDERE	7257 N. LINCOLN AVENUE	LINCOLNWOOD	BUILDING RENTAL	2
3			MCKINLEY COURT	DECATUR	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY/WORK COMP IN	3
4			MONROE PAVILION	CHICAGO	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	4
5			NORTHWOODS CARE CENTRE	BELVIDERE	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERVICES	5
6			SYCAMORE VILLAGE	SWANSEA	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	6
7			SYMPHONY ARIA	HILLSIDE				7
8			SYMPHONY AT 87TH STREET	CHICAGO				8
9			SYMPHONY AT MIDWAY	CHICAGO				9
10			SYMPHONY AT THE TILLERS	OSWEGO				10
11			SYMPHONY OF BRONZEVILLE	CHICAGO				11
12			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				12
13			SYMPHONY OF CHESTERTON	CHESTERTON, IN				13
14			SYMPHONY OF CRESTWOOD	CRESTWOOD				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, IN				15
16			SYMPHONY OF DECATUR	DECATUR				16
17			SYMPHONY OF DYER	DYER, IN				17
18			SYMPHONY OF EVANSTON	EVANSTON				18
19			SYMPHONY OF GLENDALE	GLENDALE, WI				19
20			SYMPHONY OF HANOVER PARK	HANOVER PARK				20
21			SYMPHONY OF JOLIET	JOLIET				21
22			SYMPHONY OF LINCOLN	LINCOLN				22
23			SYMPHONY OF LINCOLN PARK	CHICAGO				23
24			SYMPHONY OF MORGAN PARK	CHICAGO				24
25			SYMPHONY OF ORCHARD VALLEY	AURORA				25
26			SYMPHONY OF SOUTH SHORE	CHICAGO				26
27			SYMPHONY RESIDENCES OF LINCOLN PARK	CHICAGO				27
28								28
29								29
30								30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 of Chicago West # 0053686 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

Ending: 12/31/16

(847) 933-2601

	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	5	UTILITIES	AVAIL. CENSUS DAYS	1,836,222	28	\$ 51,919	\$	85,644	\$ 2,422	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	475,288	85,644	22,168	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711		85,644	5,024	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090		85,644	3,969	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	3,273,643	85,644	152,687	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220		85,644	23,704	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	932,558	85,644	43,496	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28			85,644		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768		85,644	44,112	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900		85,644	18,092	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	6,126,863	85,644	285,766	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920		85,644	35,584	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439		85,644	1,420	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434		85,644	3,518	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214		85,644	4,114	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614		85,644	54,786	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621		85,644	2,174	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912		85,644	5,406	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288		85,644	7,056	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399		85,644	3,050	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453		85,644	3,799	21
22										22
23										23
24										24
25	TOTALS					\$ 15,487,256	\$ 10,808,353		\$ 722,347	25

Facility Name & ID Number Symphony of Chicago West # 0053686 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			\$	\$		\$ 149,632	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					\$	\$		\$ 149,632	25

Facility Name & ID Number Symphony of Chicago West # 0053686 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		\$	\$		\$ 25,645	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				\$	\$		\$ 25,645	25

Facility Name & ID Number Symphony of Chicago West # 0053686 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			\$	\$		\$ 175,745	1
2	26	Liability Insurance	Direct Allocation						396,922	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					\$	\$		\$ 572,667	25

Facility Name & ID Number Symphony of Chicago West # 0053686 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 of Chicago West # 0053686 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 of Chicago West # 0053686 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

Ending: 12/31/16

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 of Chicago West # 0053686 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	The Private Bank		X	Note Payable			\$	3,350,217			\$	145,846	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	RCA		X	Note Payable				157,927					6
7													7
8					-								8
9	TOTAL Facility Related						\$	3,508,144			\$	145,846	9
	B. Non-Facility Related*												
10	Interest Income		X								(3,475)		10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(3,475)	14
15	TOTALS (line 9+line14)						\$	3,508,144			\$	142,371	15

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	431,917	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	420,214	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(11,703)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	418,950	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	3,693	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	410,941	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	305,520	8	
		2012	333,859	9	
		2013	341,563	10	
		2014	348,840	11	
		2015	414,808	12	
2016 Accrual: \$414,808 x 1.01 = \$418,950					
*The beginning accrual on line 1 was adjusted since the ending accrual on the 2015 cost report only represents 2 months.					
Allocated from Maestro Consulting Services: \$5,406					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Symphony of Chicago West</u>	COUNTY	<u>Cook</u>
---------------	---------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0053686

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	16-16-209-002-0000	Long Term Care Property	\$ 448,440.85	\$ 414,807.79
2.	10-27-319-028-0000	Home Office Allocation	\$ 95,270.31	\$ 4,443.54
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 543,711.16	\$ 419,251.33

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Symphony of Chicago West

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0053686

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	89,364	1987	\$ 71,619	1
2	Allocated from Maestro 7257 Lincoln			7,463	2
3	TOTALS	89,364		\$ 79,082	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	234			1980	\$ 3,173,042	\$	39	\$ 81,360	\$ 81,360	\$ 2,584,347	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1987	198,972		20			198,972	9	
10	Various			1988	17,097		20			17,097	10	
11	Various			1989	19,023		20			19,023	11	
12	Various			1990	33,869		20			33,869	12	
13	Various			1991	10,518		20			10,518	13	
14	Various			1993	3,315		20			3,315	14	
15	Various			1994	110,244		20			110,244	15	
16	Various			1995	57,890		20	4	4	57,888	16	
17	Various			1996	131,988		20	3,135	3,135	131,849	17	
18	Various			1997	126,299		20	6,219	6,219	122,280	18	
19	Various			1998	35,115		20	1,756	1,756	32,532	19	
20	Various			1999	67,125		20	3,356	3,356	58,738	20	
21	Various			2000	182,497		20	9,125	9,125	152,713	21	
22	Various			2001	24,742		20	1,237	1,237	19,238	22	
23	Various			2002	119,751		20			119,751	23	
24	Various			2003	107,313		20	989	989	104,183	24	
25	Various			2004	9,849		20	76	76	9,672	25	
26	Various			2005	170,025		20	5,427	5,427	127,298	26	
27	Various			2006	347,480		20	15,426	15,426	327,474	27	
28	Various			2007	2,721		20	272	272	2,517	28	
29	Various			2008	2,900		20	290	290	2,513	29	
30	Various			2009	136,688		20	12,108	12,108	105,789	30	
31	Various			2010	35,779		20	2,601	2,601	24,604	31	
32	Various			2011	350,322		20	34,853	34,853	200,785	32	
33	Various			2012	10,373		20	911	911	3,897	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)	610,839			31,719	31,719	235,627	67
68	Related Party Allocations (Pages 12H & 12I)	111,928	1,949		4,064	2,115	45,968	68
69	Financial Statement Depreciation		651			(651)		69
70	TOTAL (lines 4 thru 69)	\$ 6,207,703	\$ 2,600		\$ 214,929	\$ 212,329	\$ 4,862,700	70

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

Facility Name & ID Number Symphony of Chicago West

0053686

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		\$ 6,207,703	\$ 2,600		\$ 214,929	\$ 212,329	\$ 4,862,700	1
2	Sprinkler System-Replaced 4" Check Valve	2013	2,752		20	138	138	447	2
3	Skylight Glass Replacement	2014	7,380		20	738	738	1,968	3
4	Parking Lot Paving	2014	13,250		20	883	883	2,356	4
5	Fire Alarm System	2014	9,655		20	1,379	1,379	3,448	5
6	Electrical Outlets	2014	5,300		20	530	530	1,237	6
7	Plumbing-Replace P-Trap In Boiler Room, Replace Corridor Pipe	2014	20,945		20	2,095	2,095	4,887	7
8	Replace Door Operators On 3 Elevators	2014	36,600		20	1,830	1,830	3,965	8
9	Repaired Elevators	2015	7,578		20	379	379	758	9
10	Demolition Of Existing Walk-In Freezer/Cooler/Electrical	2015	7,240		20	362	362	724	10
11	Electrical Services For Walk-In Freezer/Cooler	2015	3,200		20	160	160	320	11
12	New Door Frame And New Glass Doors At Main Entrance	2015	11,580		20	579	579	1,158	12
13	New Walk-In Cooler/Freezer	2015	18,318		20	916	916	1,832	13
14	Wired Call System	2015	86,995		20	4,350	4,350	8,699	14
15	Furnish/Install New Pump And Pump Motor Valve And Tank	2016	10,450		20	523	523	523	15
16	Plumbing - 1St/2Nd Floor Drain And Piping	2016	2,750		20	138	138	138	16
17	Roof Work - Repair Leaks Rooms 416/430, Lower Roof Leaks - Ea	2016	3,800		20	190	190	190	17
18	Wired Nurse Call System	2016	7,248		20	362	362	362	18
19	3 Elevators - Furnish And Apply Car Top Hand Rails	2016	3,732		20	187	187	187	19
20	Electrical Work - Replace/Rewire Disconnect, Supply New Fuse Dis	2016	4,620		20	231	231	231	20
21	Plumbing - Camera And Rod Kitchen Waste Lines	2016	3,630		20	182	182	182	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)		\$ 6,474,726	\$ 2,600		\$ 231,079	\$ 228,479	\$ 4,896,311	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,474,726	\$ 2,600		\$ 231,079	\$ 228,479	\$ 4,896,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 6,474,726	\$ 2,600		\$ 231,079	\$ 228,479	\$ 4,896,311	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		\$6,474,726	\$2,600		\$231,079	\$228,479	\$4,896,311	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
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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)		\$6,474,726	\$2,600		\$231,079	\$228,479	\$4,896,311	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$6,474,726	\$2,600		\$231,079	\$228,479	\$4,896,311	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)		\$6,474,726	\$2,600		\$231,079	\$228,479	\$4,896,311	34

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	11,647		20	582	582	9,907	9
10	Various	2005	61,061		20	3,053	3,053	39,369	10
11	Universal Wide Style Handrail	2007	3,458		20	173	173	1,730	11
12	Furnish Hardware - Audio And Video Cable	2007	2,500		20	125	125	1,250	12
13	Duro Last Roofing System	2007	17,750		20	888	888	8,877	13
14	Fire Alram (Repair)	2007	4,364		20	218	218	2,182	14
15	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	197	197	1,970	15
16	Walkway	2007	5,500		20	275	275	2,750	16
17	Renovated Parking Lot	2007	6,800		20	340	340	3,400	17
18	Fire Alarm Control Panel	2007	9,252		20	463	463	4,627	18
19	Duro Lasting Roof Work	2007	17,750		20	888	888	8,877	19
20	Bristol/Modules For Chiller	2007	5,832		20	292	292	2,917	20
21	Compresor Replacer	2007	2,823		20	141	141	1,410	21
22	Telephone System	2008	21,774		20	2,177	2,177	19,596	22
23	Digital Video Multiplexer Recorder, Color Dome Camera	2008	2,693		20	135	135	1,212	23
24	Elevator Car Doors	2008	3,875		20	194	194	1,745	24
25	Furnish and Install Insulated Glass Window	2008	25,820		20	1,291	1,291	11,619	25
26	Furnish and Install Solid Iron Fence	2008	4,860		20	243	243	2,187	26
27	Upholster Cornice & Roller Shades and Re-install	2008	27,819		20	1,391	1,391	12,519	27
28	Vinyl Floor Tile and Cove Base	2008	9,800		20	490	490	4,410	28
29	Tile work, Wallcoverings	2008	47,481		20	2,374	2,374	21,366	29
30	Renovation - Wallcoverings / Flooring / 1st & 2nd Floor	2008	29,588		20	1,479	1,479	13,314	30
31	Replacing Exit Faces and Lightbox Lexan Faces	2008	9,670		20	484	484	4,353	31
32	Capital Report Reconciliation	2008	(300)		20	(15)	(15)	(135)	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 335,757	\$		\$ 17,877	\$ 17,877	\$ 181,452	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 12F, Carried Forward		\$ 335,757	\$		\$ 17,877	\$ 17,877	\$ 181,452	1
2	K-020 IDPH Corrections-Demo & Carpentry, Painting,HVAC,								2
3	Plumbing - All Resident Rooms and Doctor Office Next Door	2012	85,025		20	4,251	4,251	21,257	3
4	Remove and Install Data Cables	2013	6,500		20	413	413	1,654	4
5	Remove and Installed Nre Fire Alarm Control Panel	2013	37,210		20	1,861	1,861	7,442	5
6	RECEPTACLES FOR KIOSKS	2013	4,055		20	203	203	812	6
7	SPRINKLER HEAD INSTALLATION	2013	2,850		20	143	143	570	7
8	Removed and Installed Cedar Fence on East & South Side of Building	2013	23,055		20	1,153	1,153	4,612	8
9	FIRE ALARM SYSTEM	2013	7,416		20	371	371	1,484	9
10	Install 15 Openings Power Outlets In 2Nd Flr Rooms For Wall Mount	2014	2,550		20	128	128	383	10
11	Replace 4 Doors With 20-Minute Fire Doors, Custom Match And Stai	2014	2,700		20	135	135	405	11
12	Construct Outside Patio Roof, Detach Structure From Building, Build	2014	2,545		20	127	127	382	12
13	Install Alarm Bell On South Passenger Elevator; Code Data Plates, An	2014	7,176		20	359	359	1,077	13
14	Caulking Windows	2014	22,500		20	1,125	1,125	3,375	14
15	Labor & Materials To Resurface 250 Doors, Remove Doors From Hin	2014	22,500		20	1,125	1,125	3,375	15
16	Roof Installation	2014	49,000		20	2,450	2,450	7,350	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)		\$ 610,839	\$		\$ 31,719	\$ 31,719	\$ 235,627	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 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from Maestro 7257 N. Lincoln Ave	2004	67,164	1,722	35	1,919	197	25,186	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Maestro 7257 N. Lincoln Ave	2015	1,059	101	20	71	(30)	94	9
10 Allocated from Maestro 7257 N. Lincoln Ave	2005	6,123	43	20	219	176	4,270	10
11 Allocated from Maestro 7257 N. Lincoln Ave	2004	1,335		20	67	67	834	11
12								12
13 Allocated from Maestro Consulting Services	2003	546		20	27	27	358	13
14 Allocated from Maestro Consulting Services	2004	11,092		20	602	602	7,058	14
15 Allocated from Maestro Consulting Services	2005	658		20	33	33	390	15
16 Allocated from Maestro Consulting Services	2006	892		20	45	45	462	16
17 Allocated from Maestro Consulting Services	2008	940		20	47	47	388	17
18 Allocated from Maestro Consulting Services	2009	15,132		20	710	710	5,757	18
19 Allocated from Maestro Consulting Services	2010	2,325		20	116	116	757	19
20 Allocated from Maestro Consulting Services	2011	126		20	6	6	37	20
21 Allocated from Maestro Consulting Services	2012	140		20	7	7	33	21
22 Allocated from Maestro Consulting Services	2014	1,749		20	87	87	228	22
23 Allocated from Maestro Consulting Services	2015	492		20	25	25	33	23
24 Allocated from Maestro Consulting Services	2016	2,155	83	20	83		83	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)		\$ 111,928	\$ 1,949		\$ 4,064	\$ 2,115	\$ 45,968	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$111,928	\$1,949		\$4,064	\$2,115	\$45,968	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
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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)		\$111,928	\$1,949		\$4,064	\$2,115	\$45,968	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	\$647,973	\$	\$43,375	\$43,375	10	\$515,337	71
72	Current Year Purchases	4,609	225	453	228	10	490	72
73	Fully Depreciated Assets	1,490,325		159	159	10	1,515,652	73
74								74
75	TOTALS	\$2,142,907	\$225	\$43,986	\$43,761		\$2,031,480	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		1992 FORD VAN	1990	\$2,282	\$	\$	\$	5	\$	76
77		Allocated from Maestro Consulti	2016	413				5	413	77
78										78
79										79
80	TOTALS			\$2,695	\$	\$	\$		\$413	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)	\$8,699,410	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$2,825	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$275,065	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$272,240	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,928,204	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	RESURFACE PK LOT/SIDEWALK -	\$20,903	\$1,184	\$19,204	86
87	Clinic Project- new cabinetry, counter top	4,400	220	1,540	87
88	Dr. Stalling's Office - Front reception new	3,700	185	1,110	88
89	Xray Rm: demolish 4 door opening. furni	16,700	835	5,010	89
90	Dr. Rms-Floor, Wall, Countertop, Sink, Wi	8,500	425	2,125	90
91	TOTALS	\$54,203	\$2,849	\$28,989	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$7,577	92
93			93
94			94
95		\$7,577	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
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:		234		\$2,772,321			3
4	Additions				(2,772,321)			4
5	Allocated from Maestro Consulting Services				7,056			5
6								6
7	TOTAL		234		\$7,056			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: \$34,421Description: 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	Allocated from Maestro Consulting Services		\$	\$3,799	17
18					18
19					19
20					20
21	TOTAL		\$-	\$3,799	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent

12. /2017\$

13. /2018\$

14. /2019\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 623,895	\$		\$ 623,895	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			229,300			229,300	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			599,062			599,062	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				264,513		264,513	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					247,613	120,482		368,095	13
14	TOTAL			\$		\$ 1,699,870	\$ 384,995		\$ 2,084,865	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	\$ 6,063	\$	1
2	Cash-Patient Deposits	67,088		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,550,249		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,963		6
7	Other Prepaid Expenses	30,629		7
8	Accounts Receivable (owners or related parties)	1,206,971		8
9	Other(specify): <u>See Attached Schedule</u>	115,845		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,979,808	\$	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	17,000		15
16	Equipment, at Historical Cost	17,999		16
17	Accumulated Depreciation (book methods)	(3,587)		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>	457,577		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 488,989	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,468,797	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,942,466	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,088		28
29	Short-Term Notes Payable	3,508,144		29
30	Accrued Salaries Payable	155,813		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,943		31
32	Accrued Real Estate Taxes(Sch.IX-B)	418,950		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>	713,201		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,835,605	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	169,746		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 169,746	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,005,351	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 463,446	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,468,797	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 185,478	1
2	Restatements (describe):		2
3	Equity Adjustment	8,054	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 193,532	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	269,914	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)	\$ 269,914	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)	\$ 463,446	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	\$16,682,324	1
2	Discounts and Allowances for all Levels	(397,833)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$16,284,491	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,233,296	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$1,233,296	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	24,022	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,137	19
20	Radiology and X-Ray	303	20
21	Other Medical Services	71,341	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$96,803	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,475	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$3,475	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	474	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$474	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$17,618,539	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,084,033	31
32	Health Care	5,245,418	32
33	General Administration	3,729,021	33
	B. Capital Expense		
34	Ownership	3,388,511	34
	C. Ancillary Expense		
35	Special Cost Centers	2,312,627	35
36	Provider Participation Fee	589,015	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$17,348,625	40
41	Income before Income Taxes (line 30 minus line 40)**	269,914	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$269,914	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$10,657,619	44
45	Private Pay - Net Inpatient Revenue	(92,906)	45
46	Medicare - Net Inpatient Revenue	2,907,539	46
47	Other-(specify) Managed Care	2,455,148	47
48	Other-(specify) Hospice/Veterans	357,091	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$16,284,491	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	2,215	2,402	\$ 109,689	\$ 45.67	1
2	Assistant Director of Nursing	1,794	1,844	78,026	42.31	2
3	Registered Nurses	25,180	27,879	862,026	30.92	3
4	Licensed Practical Nurses	60,442	65,224	1,691,916	25.94	4
5	CNAs & Orderlies	100,571	111,070	1,460,572	13.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,424	2,675	42,233	15.79	8
9	Activity Director	1,743	2,092	39,651	18.95	9
10	Activity Assistants	7,953	8,888	97,587	10.98	10
11	Social Service Workers	7,728	8,126	203,141	25.00	11
12	Dietician					12
13	Food Service Supervisor	1,963	2,189	57,799	26.40	13
14	Head Cook	5,054	5,715	67,436	11.80	14
15	Cook Helpers/Assistants	16,803	18,755	200,120	10.67	15
16	Dishwashers					16
17	Maintenance Workers	4,010	4,397	76,509	17.40	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,680	2,771	201,858	72.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,196	13,290	247,465	18.62	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	583	657	22,981	34.98	31
32	Other Health Care(specify)					32
33	Other(specify)	5,047	5,251	103,254	19.66	33
34	TOTAL (lines 1 - 33)	258,386	283,225	\$ 5,562,263 *	\$ 19.64	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	\$ 38,214	01-03	35
36	Medical Director	Monthly	42,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	82	4,650	10-03	38
39	Pharmacist Consultant	Monthly	38,451	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	44,359	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,420	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric	Monthly	13,640	12-03	47
48					48
49	TOTAL (lines 35 - 48)	127	\$ 183,734		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Rick Walworth	Administrator	0.00%	\$ 201,858	Workers' Compensation Insurance		\$ 175,745	IDPH License Fee	\$ 1,658	
				Unemployment Compensation Insurance		106,511	Advertising: Employee Recruitment		
				FICA Taxes		395,811	Health Care Worker Background Check	4,359	
				Employee Health Insurance		258,364	(Indicate # of checks performed 436)		
				Employee Meals			Patient Background Checks	366 3,657	
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions	20,667	
				Employee Physical Exams		3,096	License and Permits	3,645	
				Pension Plan		25,319	Allocated from Maestro Consulting	18,092	
				Other Employee Benefits		11,190			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
B. Administrative - Other									
Description			Amount						
Maestro Consulting Services - Bookkeeping Fees			\$ 868,755						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 868,755	TOTAL (agree to Schedule V, line 22, col.8)			\$ 976,036	TOTAL (agree to Sch. V, line 20, col. 8)	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Description		
Vendor/Payee	Type		Amount	Line #			Amount		
Marcum LLP	Accounting		\$ 38,901				\$		
Ability Network	Data Processing		5,540						
Creative Technology Solutions	Data Processing		18,363						
Dart Chart Systems	Mngd Care Reimb. Solutions		264						
Ehealth Data Solutions	Data Processing		1,278						
FYI Solutions	Data Processing		490						
Health Data Solutions	Data Processing		6,289						
PointClickCare	E.H.R Software		5,657						
Prime Care Technologies	Data Processing		50				Seminar Expense 3,682		
Telemedicine Solutions	Data Processing		12,165				Allocated from Maestro Consulting 1,420		
Wescom Solutions	Data Processing		28,711						
See Supplemental Schedule			235,725						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			\$		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number		Symphony of Chicago West		STATE OF ILLINOIS	#	0053686	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 - \$24,073							
(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.			\$ 1,658 Line 10							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			Yes							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			Yes 11/1/2015							
(9)	Are you presently operating under a sublease agreement?			YES X NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			Jackson Square Nursing and Rehab IDPH #0039834							
(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.			\$ 589,015							
(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?			No							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.			No							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?			\$ No Indicate the amount. \$ N/A							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? 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							