

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0051789 Facility Name: Symphony of Lincoln Address: 2202 N Kickapoo St Lincoln 62656 Number City Zip Code County: Logan Telephone Number: (217) 735-1538 Fax # (217) 732-4848 HFS ID Number: Date of Initial License for Current Owners: 01/01/2012 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: Amanda Springborn Telephone Number: (314) 925-3838

Email Address:

Facility Name & ID Number Symphony of Lincoln

0051789 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>36,966</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>25</u>	Intermediate (ICF)	<u>25</u>	<u>9,150</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>126</u>	TOTALS	<u>126</u>	<u>46,116</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>343</u>		<u>4,182</u>	<u>4,525</u>	8
9	SNF/PED					9
10	ICF	<u>16,033</u>	<u>6,840</u>	<u>2,972</u>	<u>25,845</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,376</u>	<u>6,840</u>	<u>7,154</u>	<u>30,370</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.86%

D. How many bed-hold days during this year were paid by the Department? N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/31/2011 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 101 and days of care provided 4,182

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ 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 Lincoln # 0051789 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	184,169	16,880	12,233	213,282		213,282		213,282			1
2	Food Purchase		167,319		167,319		167,319		167,319			2
3	Housekeeping	201,672	29,690		231,362		231,362		231,362			3
4	Laundry	36,788	14,555	5,170	56,513		56,513		56,513			4
5	Heat and Other Utilities			222,005	222,005		222,005	1,304	223,309			5
6	Maintenance	35,686	1,051	153,297	190,034		190,034	14,642	204,676			6
7	Other (specify):* Mgmt alloc of benef							2,137	2,137			7
8	TOTAL General Services	458,315	229,495	392,705	1,080,515		1,080,515	18,083	1,098,598			8
	B. Health Care and Programs											
9	Medical Director			93,600	93,600		93,600		93,600			9
10	Nursing and Medical Records	2,143,931	199,071	21,854	2,364,856		2,364,856	82,216	2,447,072			10
10a	Therapy	219,095			219,095		219,095		219,095			10a
11	Activities	153,430		8,862	162,292		162,292		162,292			11
12	Social Services	32,768		2,808	35,576		35,576		35,576			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt alloc of benef							12,764	12,764			15
16	TOTAL Health Care and Programs	2,549,224	199,071	127,124	2,875,419		2,875,419	94,980	2,970,399			16
	C. General Administration											
17	Administrative	100,996		392,498	493,494		493,494	(369,077)	124,417			17
18	Directors Fees											18
19	Professional Services			202,355	202,355		202,355	(2,377)	199,978			19
20	Dues, Fees, Subscriptions & Promotions			11,980	11,980		11,980	9,742	21,722			20
21	Clerical & General Office Expenses	218,805	22,156	59,915	300,876		300,876	191,992	492,868			21
22	Employee Benefits & Payroll Taxes			596,928	596,928		596,928		596,928			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,489	2,489		2,489	803	3,292			24
25	Other Admin. Staff Transportation			11,236	11,236		11,236	1,791	13,027			25
26	Insurance-Prop.Liab.Malpractice			219,025	219,025		219,025	2,215	221,240			26
27	Other (specify):* Mgmt alloc of benef							29,500	29,500			27
28	TOTAL General Administration	319,801	22,156	1,496,426	1,838,383		1,838,383	(135,411)	1,702,972			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,327,340	450,722	2,016,255	5,794,317		5,794,317	(22,348)	5,771,969			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			65,802	65,802		65,802	2,860	68,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			125,554	125,554		125,554	1,884	127,438			32
33	Real Estate Taxes			77,481	77,481		77,481	2,911	80,392			33
34	Rent-Facility & Grounds			578,755	578,755		578,755	3,930	582,685			34
35	Rent-Equipment & Vehicles			183,049	183,049		183,049	3,689	186,738			35
36	Other (specify):*											36
37	TOTAL Ownership			1,030,641	1,030,641		1,030,641	15,274	1,045,915			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,460	8,460		8,460		8,460			38
39	Ancillary Service Centers		176,813	758,497	935,310		935,310		935,310			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,002	228,002		228,002		228,002			42
43	Other (specify):* Non-Allowable Cos	59,596		1,771,017	1,830,613		1,830,613	(1,830,613)				43
44	TOTAL Special Cost Centers	59,596	176,813	2,765,976	3,002,385		3,002,385	(1,830,613)	1,171,772			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,386,936	627,535	5,812,872	9,827,343		9,827,343	(1,837,687)	7,989,656			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	(26,370)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4)	30		9
10	Interest and Other Investment Income	(281)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,526)	43		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	(1,238)	43		18
19	Entertainment				19
20	Contributions	(13,730)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,591,504)	43		24
25	Fund Raising, Advertising and Promotional	(12,325)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(208,311)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,856,289)		\$	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)	18,602		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,602		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,837,687)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (89,996)	43	1
2	Laboratory Costs	(21,744)	43	2
3	X-Ray Costs	(11,584)	43	3
4	Legal Expense	(182)	19	4
5	Admission Salaries	(44,092)	43	5
6	Marketing Travel	(103)	25	6
7	Non Allowable collection fees	(25,106)	19	7
8	Community Relations	(15,504)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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22				22
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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	(208,311)		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	N/A							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			\$			\$	\$ * 0	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	19	Professional Services-Other	\$ 842	Symphony Financial Services, LLC	100%	\$	(842)	15
16	V	21	Clerical & General Office Expenses		Symphony Financial Services, LLC	100%	18,958	18,958	16
17	V	24	Travel & Seminar		Symphony Financial Services, LLC	100%	39	39	17
18	V	30	Depreciation		Symphony Financial Services, LLC	100%	1,693	1,693	18
19	V	32	Interest		Symphony Financial Services, LLC	100%	2,165	2,165	19
20	V	34	Rent - Facility & Grounds		Symphony Financial Services, LLC	100%	130	130	20
21	V	35	Rent - Equipment & Vehicles		Symphony Financial Services, LLC	100%	1	1	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			\$ 842			\$ 22,986	\$ * 22,144	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	5	<u>Utilities</u>	\$	<u>Maestro Consulting Services</u>	100%	\$ 1,304	\$ 1,304	15
16	V	6	<u>Maintenance Salaries</u>		<u>Maestro Consulting Services</u>	100%	11,937	11,937	16
17	V	6	<u>Maintenance Expenses</u>		<u>Maestro Consulting Services</u>	100%	2,705	2,705	17
18	V	7	<u>Employee Benefits - Maintenance</u>		<u>Maestro Consulting Services</u>	100%	2,137	2,137	18
19	V	10	<u>Clinical Salaries</u>		<u>Maestro Consulting Services</u>	100%	82,216	82,216	19
20	V	15	<u>Employee Benefits - Clinical</u>		<u>Maestro Consulting Services</u>	100%	12,764	12,764	20
21	V	17	<u>Administrative Salaries</u>	392,498	<u>Maestro Consulting Services</u>	100%	23,421	(369,077)	21
22	V	19	<u>Professional Fees</u>		<u>Maestro Consulting Services</u>	100%	23,753	23,753	22
23	V	20	<u>Dues, Fees, Subscriptions, Etc.</u>		<u>Maestro Consulting Services</u>	100%	9,742	9,742	23
24	V	21	<u>Clerical & General Salaries</u>		<u>Maestro Consulting Services</u>	100%	153,874	153,874	24
25	V	21	<u>Clerical & General Expenses</u>		<u>Maestro Consulting Services</u>	100%	19,160	19,160	25
26	V	24	<u>Seminars & Education</u>		<u>Maestro Consulting Services</u>	100%	764	764	26
27	V	25	<u>Transportation</u>		<u>Maestro Consulting Services</u>	100%	1,894	1,894	27
28	V	26	<u>Insurance</u>		<u>Maestro Consulting Services</u>	100%	2,215	2,215	28
29	V	27	<u>Employee Benefits - Administrative</u>		<u>Maestro Consulting Services</u>	100%	29,500	29,500	29
30	V	30	<u>Depreciation</u>		<u>Maestro Consulting Services</u>	100%	1,171	1,171	30
31	V	33	<u>Real Estate Tax</u>		<u>Maestro Consulting Services</u>	100%	2,911	2,911	31
32	V	34	<u>Building Rental</u>		<u>Maestro Consulting Services</u>	100%	3,800	3,800	32
33	V	35	<u>Equipment Rental</u>		<u>Maestro Consulting Services</u>	100%	1,642	1,642	33
34	V	35	<u>Auto Lease</u>		<u>Maestro Consulting Services</u>	100%	2,046	2,046	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 392,498			\$ 388,956	\$ * (3,542)	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	10	Nursing and Medical Records	\$ 461	Integra Healthcare Equipment, LLC		\$ 461	\$	15
16	V	35	Rent-Equipment & Vehicles	40,669	Integra Healthcare Equipment, LLC		40,669		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			\$ 41,130			\$ 41,130	\$ * 0	39

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

Facility Name & ID Number

Symphony of Lincoln

0051789

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cres	Belvidere	Maestro Consulting Se	Lincolnwood	Mgmt. Co.	5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				8
9	Joseph Hartman	3.00	Symphony Evanston Healthcare	Evanston				9
10	David J. Hartman	20.00	Symphony of Dyer	Indiana				10
11	Jay Flatt	3.00	Symphony of Crown Point	Indiana	Nucare Services	Lincolnwood	Bookkeeping Mgmt	11
12	Gerry Jenich	10.00	Symphony of Chesterton	Indiana	7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svcs, LLC	10.00			Diamond Insurance	Northbrook	Work Comp Ins.	13
14					Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Monroe Pavillion	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Sycamore Village	Swansea	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Symphony of Aria	Hillside	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Symphony at 87th Street	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Symphony at Midway	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Symphony at Tillers	Oswego	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Symphony at Bronzeville	Chicago	Lifemed Pharmacy	Bensenville	Pharmacy	22
23			Symphony of Buffalo Grove	Buffalo Grove	ConcertoHealth	Chicago	Clinical Services	23
24			Symphony of Chicago West	Chicago				24
25			Symphony of Glendale	Glendale, Wiscosin	* No expense paid by home to the related			25
26			Symphony of Hanover Park	Hanover Park	entity, therefore no page 6 or 8.			26
27			Symphony of Lincoln Park	Chicago	** No expense of this related business			27
28			Symphony of Morgan Park	Chicago	allocated to homes			28
29			Symphony of South Shore	Chicago				29
30			Symphony Residences of Lincoln Park	Chicago				30

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	No owners receive compensation from this facility.			0.00					\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											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 Lincoln # 0051789 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 Symphony Financial Services, LLC
Street Address 7257 N. Lincoln Ave
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 933-2600
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	19	Professional Services-Other	Occupied Bed Days	502,430	12	\$ (13,929)	\$	30,370	\$ (842)	1
2	21	Clerical & General Office Expense	Occupied Bed Days	502,430	12	313,631		30,370	18,958	2
3	24	Travel & Seminar	Occupied Bed Days	502,430	12	638		30,370	39	3
4	30	Depreciation	Occupied Bed Days	502,430	12	28,003		30,370	1,693	4
5	32	Interest	Occupied Bed Days	502,430	12	35,825		30,370	2,165	5
6	34	Rent - Facility & Grounds	Occupied Bed Days	502,430	12	2,143		30,370	130	6
7	35	Rent - Equipment & Vehicles	Occupied Bed Days	502,430	12	14		30,370	1	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					\$ 366,325	\$		\$ 22,144	25

Facility Name & ID Number Symphony of Lincoln# 0051789

Report Period Beginning:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Maestro Consulting Services

Street Address

7257 N. Lincoln Ave,

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 933-2600

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, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	5	Utilities	Bed Days Available	28	\$ 51,919	\$	46,116	\$ 1,304	1
2	6	Maintenance Salaries	Bed Days Available	28	475,288		46,116	11,937	2
3	6	Maintenance Expenses	Bed Days Available	28	107,711		46,116	2,705	3
4	7	Employee Benefits - Maintenance	Bed Days Available	28	85,090		46,116	2,137	4
5	10	Clinical Salaries	Bed Days Available	28	3,273,643		46,116	82,216	5
6	15	Employee Benefits - Clinical	Bed Days Available	28	508,220		46,116	12,764	6
7	17	Administrative Salaries	Bed Days Available	28	932,558		46,116	23,421	7
8	19	Professional Fees	Bed Days Available	28	945,768		46,116	23,753	8
9	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	28	387,900		46,116	9,742	9
10	21	Clerical & General Salaries	Bed Days Available	28	6,126,863		46,116	153,874	10
11	21	Clerical & General Expenses	Bed Days Available	28	762,920		46,116	19,160	11
12	24	Seminars & Education	Bed Days Available	28	30,439		46,116	764	12
13	25	Transportation	Bed Days Available	28	75,434		46,116	1,894	13
14	26	Insurance	Bed Days Available	28	88,214		46,116	2,215	14
15	27	Employee Benefits - Administrative	Bed Days Available	28	1,174,614		46,116	29,500	15
16	30	Depreciation	Bed Days Available	28	46,621		46,116	1,171	16
17	33	Real Estate Tax	Bed Days Available	28	115,912		46,116	2,911	17
18	34	Building Rental	Bed Days Available	28	151,288		46,116	3,800	18
19	35	Equipment Rental	Bed Days Available	28	65,399		46,116	1,642	19
20	35	Auto Lease	Bed Days Available	28	81,453		46,116	2,046	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 15,487,254	\$		\$ 388,956	25

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	10	Nursing and Medical Records	Direct Allocation			\$	\$		\$ 461	1
2	35	Rent-Equipment & Vehicles	Direct Allocation						40,669	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					\$	\$		\$ 41,130	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	The Private Bank		X	Capital Improvements	Interest Only	12/30/2011	2,000,000	12,587	12/30/2017	0.0525	406	6	
7	The Private Bank		X	Line of Credit	Interest Only	12/30/2011	17,520,000	3,882,720	4/22/2017	0.0450	125,148	7	
8												8	
9	TOTAL Facility Related						\$ 19,520,000	\$ 3,895,307			\$ 125,554	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Interest Income Of Interest Income				(281)	12	
13								Allocated from Mgmt Co.			2,165	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 1,884	14	
15	TOTALS (line 9+line14)						\$ 19,520,000	\$ 3,895,307			\$ 127,438	15	

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

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

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

B. Real Estate Taxes

NOTES:

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

FACILITY NAME Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0051789

CONTACT PERSON REGARDING THIS REPORT David Davis

TELEPHONE (847) 745-6205 FAX #: (847) 673-2284

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

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

A. Square Feet: 33,852

B. General Construction Type: Exterior Masonry Frame Steel/Wood Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Alloc Fr Maestro 7257	-	2004	\$ 4,018	1
2					2
3	TOTALS			\$ 4,018	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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8	Allocated from Maestro 7257		2004		36,165		39	927	927	13,562	8
	Improvement Type**										
9	Wiring for EMR 24 Port Pan, Wire Mold, Cable Ties			2012	6,545	327	20	327		1,309	9
10	Exterior Sign			2013	21,718	1,086	20	1,086		4,253	10
11	General Contractor - Hallway, Lobby, Therapy, Vestibule			2013	67,885	3,395	20	3,395		10,466	11
12	Dining Room, Willow Lane, Redwood Lane & Nurse's Station										12
13											13
14	Remodeling - Painting, Wall covering, Wallpaper			2013	85,662	8,565	10	8,565		26,412	14
15	- Hallway, Dining Room, Willow Lane Resident Rooms & Offices										15
16											16
17	Remodeling - Flooring			2013	67,014	3,350	20	3,350		10,331	17
18	- Hallway, Lobby, Dining Room & Willow Lane Resident Rooms										18
19											19
20	Remodeling - Structural, Iron work, Bond beam			2013	33,520	1,676	20	1,676		5,168	20
21	-Lobby, Entrance and Vestibule										21
22											22
23	Remodeling - Electrical			2013	25,461	1,273	20	1,273		3,925	23
24	-Respirator Receptacles, Lobby, Entrance & Willow Lane										24
25											25
26	Remodeling - Custom millwork - Lobby, Dining Room,			2013	21,400	1,070	20	1,070		3,299	26
27	Hallway, Nurse's Station and Willow Lane Wing										27
28											28
29	Remodeling - Drywall - Hallway, Lobby & Willow Lane			2013	74,126	3,707	20	3,707		11,428	29
30	Resident Rooms										30
31											31
32	Remodeling - Ceiling Panel - front/back nurse's station			2013	21,400	1,070	20	1,070		3,299	32
33	Dining Room, Activity Room & Entryway										33
34											34
35	Remodeling - Roof Fire proofing, Fire sprinklers			2013	14,297	715	20	715		2,205	35
36	-Lobby, Main Entrance & Roof										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Symphony of Lincoln

0051789

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Remodeling - Nursing station counters & cabinetry	2013	\$ 6,900	\$ 345	20	\$ 345	\$	\$ 1,064	37
38	- Redwood Lane and Lobby								38
39									39
40									40
41	Facility Remodeling	2014	37,742	1,886	20	1,886		5,346	41
42	-Ceramic flooring, front entrance								42
43	-Electrical:Repair broken pipe on patio, wiremold in								43
44	hallway, activity room, change wiring in ceiling and								44
45	emergency light panel to put front door on emer panel,								45
46	electrical in vestibule, elec for flag light								46
47	-Faucet & drain at nurse station								47
48	-Glass installation, front entrance								48
49	-Stucco application on front entrance								49
50	-General contracting fee								50
51									51
52	Allocated from Maestro Consulting Services	2003	294		39			193	52
53	Allocated from Maestro Consulting Services	2004	5,972		39			3,800	53
54	Allocated from Maestro Consulting Services	2005	354		39			210	54
55	Allocated from Maestro Consulting Services	2006	480		39			249	55
56	Allocated from Maestro Consulting Services	2008	506		39			209	56
57	Allocated from Maestro Consulting Services	2009	8,148		20			3,100	57
58	Allocated from Maestro Consulting Services	2010	1,252		20			407	58
59	Allocated from Maestro Consulting Services	2011	68		20			20	59
60	Allocated from Maestro Consulting Services	2012	75		20			18	60
61	Allocated from Maestro Consulting Services	2014	942		20			123	61
62	Allocated from Maestro Consulting Services	2015	265		20			18	62
63	Allocated from Maestro Consulting Services	2016	1,161		20	45	45	45	63
64									64
65	Allocated from Maestro 7257	2004	719		10			449	65
66	Allocated from Maestro 7257	2005	3,297		10	23	23	2,299	66
67	Allocated from Maestro 7257	2015	570		15	54	54	51	67
68									68
69	Tie to book depreciation			4			(4)		69
70	TOTAL (lines 4 thru 69)		\$ 543,938	\$ 28,469		\$ 29,514	\$ 1,045	\$ 113,258	70

**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	\$186,143	\$33,723	\$33,724	\$1	5-7	\$104,672	71
72	Current Year Purchases	27,256	3,610	3,610	-	5	3,610	72
73	Fully Depreciated Assets				-			73
74	See Sch 13A	54,827		1,814	1,814		49,498	74
75	TOTALS	\$268,226	\$37,333	\$39,148	\$1,815		\$157,780	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Allocated from Maestro Consulting Services			\$222	\$	\$	\$-		\$222
77					-	-	-		
78					-	-	-		
79					-	-	-		
80	TOTALS			\$222	\$-	\$-	\$-		\$222

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$816,404	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$65,802	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$68,662	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$2,860	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$271,260	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	N/A	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
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.

Facility Name: Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/2016

Schedule 13A

XI. Ownership Costs
Line 74 - Equipment Costs - Excluding Transportation

Category of				Current Book	Straight Line		Component	Accumulated
Equipment	Cost			Depreciation	Depreciation	Adjustments	Life	Depreciation
Allocated from Symphony Financial Services, LLC		10,355			1,693	1,693	5-7	5,848
Allocated from Maestro Consulting Services		44,472			121	121	5-10	43,650
						-		
TOTAL		54,827		-	1,814	1,814		49,498

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Diana Master Landlord, LLC
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:	1973	126	12/31/2011	\$ 578,001	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				3,930			6
7	TOTAL		126		\$ 581,931			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
- 754
7,545
10

9. Option to Buy:
- ☐ YES☒ NO
- Terms: N/A
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 177,211
- Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	Toyota Corolla	\$ 359.40	\$ 845	17
18	Facility	2015 Ford T350HD	919.49	6,636	18
19					19
20	Allocated from Mgmt. Co.			2,046	20
21	TOTAL		\$ 1,278.89	\$ 9,527	21

10. Effective dates of current rental agreement:

Beginning 12/31/2011
Ending 12/31/2021

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	\$ 265,302
13.	/2018	\$ 270,608
14.	/2019	\$ 276,020

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

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

Facility Name: Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/2016

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
CPAP/Ventilator T-Bird	59,451
Mattress/Bed	35,089
Broda Chair	510
BiPAP Auto, Heated Humidifier	3,373
Oxygen	8,128
Security Container	1,950
Dishmachine	1,084
Culligan Water	195
Computer Lease	959
Cooler Infinity	1,183
Copier	31,989
Concentrator	24,115
Equipment Fees	1,980
Patient Lift Elec/Scale	752
Wheelchair	528
Pipe-In Music Service	1,208
Ultralife	2,838
Impact Networking	(206)
Gas Equipment	175
Chicago Street Rentals	45
Maestro	222
Home Office Allocation	1,643
Total - Line 16	177,211

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			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(3)	hrs	\$	3,705	\$ 266,767	\$	3,705	\$ 266,767	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,124	80,941		1,124	80,941	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,449	392,298		5,449	392,298	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				107,070		107,070	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					69,743		69,743	12
13	Other (specify): <u>See Schedule 16A</u>	39(3)				18,491			18,491	13
14	TOTAL			\$	10,278	\$ 758,497	\$ 176,813	10,278	\$ 935,310	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name: Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/2016

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

Description	Units	Amount
OTHER SERVICES - MEDICARE		600
I.V. THERAPY-MEDICARE		13,184
I.V. THERAPY-MANAGED CARE		4,707
Total - Line 12	-	18,491

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$ 2,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,325,888)	4,365,163	4,365,163	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,178	68,178	6
7	Other Prepaid Expenses	37,155	37,155	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	44,598	44,598	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,517,094	\$ 4,517,094	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,018	13
14	Buildings, at Historical Cost		36,165	14
15	Leasehold Improvements, at Historical Cost	483,670	507,773	15
16	Equipment, at Historical Cost	213,400	268,448	16
17	Accumulated Depreciation (book methods)	(196,791)	(271,260)	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 (spec Lease Costs	3,773	3,773	22
23	Other(specify): See Schedule 17A	100,824	100,824	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 604,876	\$ 649,741	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,121,970	\$ 5,166,835	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,849,105	\$ 1,849,105	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,724	124,724	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,120	78,120	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,948,159	1,948,159	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,000,108	\$ 4,000,108	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,895,307	3,895,307	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,895,307	\$ 3,895,307	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,895,415	\$ 7,895,415	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,773,445)	\$ (2,728,580)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,121,970	\$ 5,166,835	48

*(See instructions.)

Facility Name: Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	After	
	Operating	Consolidation
Trust Fund	6,288	6,288
Reserve for Capex	24,394	24,394
A/R Maple Leaf Health Insurance Cap	13,916	13,916
Total - Line 9	44,598	44,598

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	After	
	Operating	Consolidation
Security Deposit	42,279	42,279
Real Estate Escrow Deposit	(10,643)	(10,643)
Due To/From Affiliated Companies	69,188	69,188
Total - Line 23	100,824	100,824

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
OPERATING EXPENSES	92,817	92,817
MANAGEMENT FEES - SYMPHONY	402,296	402,296
CLM.WRKNS COMP. DEDUCT./SETTLEMENT	122,580	122,580
STATE UNEMPLOYMENT TAX	7,697	7,697
FEDERAL UNEMPLOYMENT TAX	510	510
SALES TAX	882	882
PAYROLL TAXES OTHER	13,687	13,687
ACCRUED EMPLOYEE BENEFITS	143,777	143,777
DUE TO IDPA - BED TAX	24,626	24,626
DUE TO NUCARE	4,935	4,935
WAGE ASSIGN & GARNISHMENTS	1,685	1,685
PATIENT PERSONAL FUNDS	18,967	18,967
FICA & W/H FED	42	42
DUE TO SYMPHONY FINANCIAL	(1)	(1)
EXCHANGE FORMATION LEASEHOLD	427,970	427,970
EXCHANGE	111,254	111,254
DUE TO/FROM MAESTRO - EXPENSES	62,776	62,776
DUE T/F AFFILIATED COMPANY - HEALTHCARE INSURANCE	256,410	256,410
DUE T/F AFFILIATED COMPANY - RENT	207,218	207,218
DEFERRED RENT LIABILITY	114,075	114,075
ACCUMULATED AMORTIZATION DEFERRED RENT	(66,044)	(66,044)
Total - Line 36	1,948,159	1,948,159

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (297,245)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(521,496)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (818,741)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,954,704)	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)	\$ (1,954,704)	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)	\$ (2,773,445)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony of Lincoln

0051789

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	\$ 7,543,459	1
2	Discounts and Allowances for all Levels	(1,346,388)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,197,071	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,475,613	6
7	Oxygen	2,663	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,478,276	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	146,701	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,604	19
20	Radiology and X-Ray	5,826	20
21	Other Medical Services	5,293	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 189,424	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	281	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 281	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	7,587	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,587	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,872,639	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,080,515	31
32	Health Care	2,875,419	32
33	General Administration	1,838,383	33
	B. Capital Expense		
34	Ownership	1,030,641	34
	C. Ancillary Expense		
35	Special Cost Centers	2,774,383	35
36	Provider Participation Fee	228,002	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,827,343	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,954,704)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,954,704)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,890,517	44
45	Private Pay - Net Inpatient Revenue	1,039,130	45
46	Medicare - Net Inpatient Revenue	872,438	46
47	Other-(specify) Hospice & ALF	201,327	47
48	Other-(specify) Managed Care & Veteran	193,659	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,197,071	49

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

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

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

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

^ - Tax return prepared on cash basis

Facility Name: Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/2016

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Rentals - Medicare	4,677
Rentals - Managed Care	3,178
Barber & Beautician	(272)
Other Unclassied Income	4
Total - Line 28	7,587

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	2,027	2,180	\$ 91,947	\$ 42.18	1
2	Assistant Director of Nursing	300	371	9,452	25.48	2
3	Registered Nurses	9,689	10,361	307,674	29.70	3
4	Licensed Practical Nurses	28,802	31,166	793,291	25.45	4
5	CNAs & Orderlies	64,940	69,201	923,152	13.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,103	12,930	219,095	16.94	8
9	Activity Director	1,921	1,971	31,799	16.13	9
10	Activity Assistants	12,564	13,380	121,631	9.09	10
11	Social Service Workers	2,063	2,173	32,768	15.08	11
12	Dietician					12
13	Food Service Supervisor	5,948	6,445	132,386	20.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,427	5,746	51,783	9.01	15
16	Dishwashers					16
17	Maintenance Workers	1,808	1,926	35,686	18.53	17
18	Housekeepers	20,016	21,329	201,672	9.46	18
19	Laundry	3,886	4,173	36,788	8.82	19
20	Administrator	2,023	2,262	100,996	44.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	844	912	15,504	17.00	23
24	Clerical	12,413	13,408	262,897	19.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,028	1,204	18,415	15.29	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,802	201,138	\$ 3,386,936 *	\$ 16.84	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 12,233	1(3)	35
36	Medical Director	Monthly	93,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	5,118	10(3)	38
39	Pharmacist Consultant	Monthly	15,921	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,121	11(3)	44
45	Social Service Consultant	Monthly	2,808	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 132,801		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

STATE OF ILLINOIS

Facility Name & ID NumberSymphony of Lincoln# 0051789Report Period Beginning:01/01/2016Ending:12/31/2016Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Turner	Administrator	0	\$ 100,996
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,996

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Col. 7)	\$ 392,498
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C		\$ 202,355
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 202,355

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 125,448
Unemployment Compensation Insurance	77,308
FICA Taxes	241,215
Employee Health Insurance	138,962
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	4,727
Employee Benefits - Other	6,339
Employees' Physical Exams	2,929
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ -
Advertising: Employee Recruitment	921
Health Care Worker Background Check (Indicate # of checks performed 197)	2,364
Patient Background Checks 222	2,660
Miscellaneous Licenses & Fees	3,075
Miscellaneous Dues & Subscriptions	2,960
Allocated from Mgmt. Co.	9,742
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	2,489
Allocated from Mgmt. Co.	803
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,292

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name: Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Ability Network	Payer Transactions	5,050
Allscripts LLC	Referral Management Core Integration	3,088
Barracuda Networks, Inc	Cuda Sign Premium Cloud	230
Carbonite Inc	Cloud Backup Service	15,275
Cardmember Service	Inbox Local/Usage Inbound Local/Usage Outboun	379
CDW Government	Monthly Subscription	501
Comcast	Internet	32,722
Corporation Service	Professional Fees	480
Creative Technology	Email Protection	10,130
Curaspan Health Group	Referral Center Network	2,500
Dart Chart Map and Track Systems, LLC	Hmo Contract Specification Sets	145
eFax Corporateq	Inbox Local/Usage Inbound Local/Usage Outboun	417
E-Health Data Solutions	Carewatch	2,130
EMMI Solutions	Internet	83
Empower Retirement	Professional Fees	48
Evault	Protect-one-server2k	1,380
Formation Healthcare Group, LLC	Monthly Subscription	547
Frontier	Communications Services	600
FYI Systems, Inc	Alteryx Designer Desktop	268
HDSI	Data Retrieval	750
Health Data Systems	Micro-Fische Software Maintenance	4,545
Health Dimensions Group	Professional Fees	457
Hipp Law Office	Legal Fees	182
HK Payroll Services	Work Tax Credit	2,930
IIT/Sourcetech	Monthly Suport Fee	1,380
Intermedia Marketing Solutions	Sales/Surveys, Partial Surveys	333
Kipp Computer Solutions	Computer Upgrade	100
Maestro Consulting	Consulting	55,555
Market Matrix	Surveys	3,810
Medical Business Office	Collection Activity	25,106
Microsoft Corp	Computer Software	2,760
Moeo	SPAN iOS + Android App V2	160
Moobile	New Dev Iteration	129
Notto Technology	Cable Connection	403
Other	Adjustments & Accruals - Vendor Not Specified	(21,988)
Pension Financial Services, Inc	Professional Fees	319
Personnel Planners	Quarterly U.I. Claims Mgt Fees	1,243
Point B Communication	Yrly Web Hosting	240
PointClickCare Technology	Clinical/Bookeeping/Data Processing	3,421
Prime Care Technologies	Prime Care	50
Qualfon	Sales/Surveys, Partial Surveys	190
RSM US LLP	Accounting Fees	5,741
State of Illinois	Tax Refund (Wescom)	(204)
Stone, McGuire & Siegel	Legal Fees	16,493
Telemedicine Solutions	Wound Rounds Care	10,974
Ventiv Technology, Inc	RiskConsole	1,459
Wescom Solutions	Data Processing	9,651
Zirmed	Eligibility Verification	193
Total (agree to Schedule V, line 19, column 3)		202,355
Allocated from Management Company Professional Services		22,911
Less: Non-Allowable Legal Fees		(182)
Less: Professional Collections Fees		(25,106)
Total (agree to Schedule V, line 19, column 8)		199,978

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? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-20 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 228,002
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit 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? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 5
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees