

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0053694</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Symphony of Lincoln Park</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1366 W Fullerton Ave</u> <u>Chicago</u> <u>60614</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 248-9300</u> Fax # <u>(773) 935-0036</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ *</td></tr><tr><td rowspan="4">Paid Preparer</td><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ *	Paid Preparer	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____ *																								
Paid Preparer	* Subject to the attached Accountants Consulting Report (Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																								
	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																								
Date of Initial License for Current Owners: <u>1/31/1992</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

Facility Name & ID Number Symphony of Lincoln Park

0053694 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	<u>248</u>	Skilled (SNF)	<u>248</u>	<u>90,768</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>248</u>	TOTALS	<u>248</u>	<u>90,768</u>	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	<u>43,396</u>	<u>3,702</u>	<u>35,225</u>	<u>82,323</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,396</u>	<u>3,702</u>	<u>35,225</u>	<u>82,323</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.70%

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 01/31/92

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

YES

☒

Date 01/31/92

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

248

and days of care provided

12,021

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2016

Fiscal Year: 12/31/2016

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

Facility Name & ID Number Symphony of Lincoln Park # 0053694 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	530,446	114,657	52,756	697,859		697,859	8,571	706,430			1
2	Food Purchase		658,508		658,508		658,508	(296)	658,212			2
3	Housekeeping	342,482	97,405		439,887		439,887	12,078	451,965			3
4	Laundry	90,274	21,219	22,004	133,497		133,497		133,497			4
5	Heat and Other Utilities			416,702	416,702		416,702	(21,957)	394,745			5
6	Maintenance	112,803		223,384	336,187		336,187	40,930	377,117			6
7	Other (specify):*							4,206	4,206			7
8	TOTAL General Services	1,076,005	891,789	714,846	2,682,640		2,682,640	43,532	2,726,172			8
	B. Health Care and Programs											
9	Medical Director			132,500	132,500		132,500		132,500			9
10	Nursing and Medical Records	5,869,706	394,180	61,982	6,325,868		6,325,868	161,822	6,487,690			10
10a	Therapy	48,975		34,381	83,356		83,356		83,356			10a
11	Activities	202,231	21,122	2,420	225,773		225,773		225,773			11
12	Social Services	229,656			229,656		229,656		229,656			12
13	CNA Training											13
14	Program Transportation			50,701	50,701		50,701	(2,965)	47,736			14
15	Other (specify):*							25,122	25,122			15
16	TOTAL Health Care and Programs	6,350,568	415,302	281,984	7,047,854		7,047,854	183,980	7,231,834			16
	C. General Administration											
17	Administrative	133,431		1,170,011	1,303,442		1,303,442	(1,123,913)	179,529			17
18	Directors Fees											18
19	Professional Services			516,979	516,979		516,979	37,184	554,163			19
20	Dues, Fees, Subscriptions & Promotions			96,555	96,555		96,555	(12,636)	83,919			20
21	Clerical & General Office Expenses	416,098	3,295	878,222	1,297,615		1,297,615	(371,818)	925,797			21
22	Employee Benefits & Payroll Taxes			1,636,435	1,636,435		1,636,435		1,636,435			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,485	1,485		1,485	1,565	3,050			24
25	Other Admin. Staff Transportation			1,398	1,398		1,398	3,729	5,127			25
26	Insurance-Prop.Liab.Malpractice			672,830	672,830		672,830	8,126	680,956			26
27	Other (specify):*							58,063	58,063			27
28	TOTAL General Administration	549,529	3,295	4,973,915	5,526,739		5,526,739	(1,399,701)	4,127,038			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,976,102	1,310,386	5,970,745	15,257,233		15,257,233	(1,172,189)	14,085,044			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			21,599	21,599		21,599	543,314	564,913			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			157,758	157,758		157,758	14,938	172,696			32
33	Real Estate Taxes			768,893	768,893		768,893	21,357	790,250			33
34	Rent-Facility & Grounds			2,950,191	2,950,191		2,950,191	(2,942,713)	7,478			34
35	Rent-Equipment & Vehicles			54,150	54,150		54,150	9,985	64,135			35
36	Other (specify):*											36
37	TOTAL Ownership			3,952,591	3,952,591		3,952,591	(2,353,119)	1,599,472			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		787,773	3,503,731	4,291,504		4,291,504	(16,249)	4,275,255			39
40	Barber and Beauty Shops			9,077	9,077		9,077		9,077			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			558,471	558,471		558,471		558,471			42
43	Other (specify):*	90,096		162,395	252,491		252,491	(252,491)	0			43
44	TOTAL Special Cost Centers	90,096	787,773	4,233,674	5,111,543		5,111,543	(268,740)	4,842,803			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	8,066,198	2,098,159	14,157,010	24,321,367		24,321,367	(3,794,047)	20,527,320			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	(28,033)	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	522,931	30		9
10	Interest and Other Investment Income	(910)	32		10
11	Discounts, Allowances, Rebates & Refunds	(25)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(296)	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	(61,573)	21		18
19	Entertainment				19
20	Contributions	(20,625)	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	(429,235)	21		24
25	Fund Raising, Advertising and Promotional	(9,162)	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	(3,519,887)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,546,815)		\$	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)	(247,232)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (247,232)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,794,047)		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

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Sequestration Expense	\$ (285,813)	21	1
2	Other Unclassified Income	(262)	21	2
3	Rental Income	(673)	06	3
4	Guest Relations	(90,096)	43	4
5	Bank Charges	(1,398)	21	5
6	Marketing Consultant	(130,291)	43	6
7	Marketing Services	(32,104)	43	7
8	Theft and Damage Loss	(20)	21	8
9	Additional R&M	3,805	06	9
10	Rent for Sale / Leaseback Arrangement	(2,950,191)	34	10
11	PAC Dues	(8,321)	20	11
12	Non-Allowable Legal	(24,524)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,519,887)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Symphony of Lincoln Park # 0053694 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary							8,571					8,571	1
2	Food Purchase	(296)											(296)	2
3	Housekeeping							12,078					12,078	3
4	Laundry													4
5	Heat and Other Utilities	(28,033)		2,566				3,510					(21,957)	5
6	Maintenance	3,132		28,819				8,979					40,930	6
7	Other (specify):*			4,206									4,206	7
8	TOTAL General Services	(25,197)		35,591				33,138					43,532	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			161,822									161,822	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(2,965)							(2,965)	14
15	Other (specify):*			25,122									25,122	15
16	TOTAL Health Care and Programs			186,945		(2,965)							183,980	16
	C. General Administration													
17	Administrative			(1,123,913)									(1,123,913)	17
18	Directors Fees													18
19	Professional Services	(24,524)		46,751				14,957					37,184	19
20	Fees, Subscriptions & Promotions	(38,108)		19,175				6,297					(12,636)	20
21	Clerical & General Office Expenses	(778,326)		340,575				65,932					(371,818)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,505				60					1,565	24
25	Other Admin. Staff Transportation			3,729									3,729	25
26	Insurance-Prop.Liab.Malpractice			4,361				3,765					8,126	26
27	Other (specify):*			58,063									58,063	27
28	TOTAL General Administration	(840,958)		(649,754)				91,011					(1,399,701)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(866,155)		(427,218)		(2,965)		124,149					(1,172,189)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Symphony of Lincoln Park # 0053694 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	522,931		2,305				18,078					543,314	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(910)						15,848					14,938	32
33	Real Estate Taxes			5,730				15,627					21,357	33
34	Rent-Facility & Grounds	(2,950,191)		7,478									(2,942,713)	34
35	Rent-Equipment & Vehicles			7,259				2,726					9,985	35
36	Other (specify):*													36
37	TOTAL Ownership	(2,428,170)		22,772				52,279					(2,353,119)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(16,249)								(16,249)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(252,491)											(252,491)	43
44	TOTAL Special Cost Centers	(252,491)			(16,249)								(268,740)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,546,815)		(404,446)	(16,249)	(2,965)		176,428					(3,794,047)	45

VII. RELATED PARTIES

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

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

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

YES

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	MAESTRO CONSULTING SERVICES LLC	100.00%	\$ 2,566	\$	2,566 15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	23,494		23,494 16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	5,324		5,324 17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,206		4,206 18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	161,822		161,822 19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	25,122		25,122 20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	46,098		46,098 21
22	V	17	ADMINISTRATIVE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%			
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	46,751		46,751 23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	19,175		19,175 24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	302,863		302,863 25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	37,713		37,713 26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,505		1,505 27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	3,729		3,729 28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,361		4,361 29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	58,063		58,063 30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	2,305		2,305 31
32	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	5,730		5,730 32
33	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	7,478		7,478 33
34	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	3,233		3,233 34
35	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,026		4,026 35
36	V								36
37	V	17	MANAGEMENT FEES	1,170,011	MAESTRO CONSULTING SERVICES LLC	100.00%			(1,170,011) 37
38	V								38
39	Total			\$ 1,170,011			\$ 765,565	\$ *	(404,446) 39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & Medical Supplies	\$ 160,405	Integra Healthcare Equipment LLC		\$ 144,156	\$ (16,249)	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			\$ 160,405			\$ 144,156	\$ * (16,249)	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	\$ 22,482	Lifeline Ambulance LLC		\$ 19,517	\$ (2,965)	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			\$ 22,482			\$ 19,517	\$ * (2,965)	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	\$ 271,628	Maple Leaf Insurance	100.00%	\$ 271,628	\$	15
16	V	26	Liability Insurance	451,529	Maple Leaf Insurance	100.00%	451,529		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			\$ 723,157			\$ 723,157	\$ *	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	1	DIETARY	\$	ITEX / AK CARE COMPANY	100.00%	\$ 8,571	\$ 8,571	15
16	V	3	HOUSEKEEPING		ITEX / AK CARE COMPANY	100.00%	12,078	12,078	16
17	V	5	UTILITIES		ITEX / AK CARE COMPANY	100.00%	3,510	3,510	17
18	V	6	REPAIRS AND MAINT.		ITEX / AK CARE COMPANY	100.00%	8,979	8,979	18
19	V	19	PROFESSIONAL FEES		ITEX / AK CARE COMPANY	100.00%	14,957	14,957	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX / AK CARE COMPANY	100.00%	6,297	6,297	20
21	V	21	CLERICAL AND GENERAL		ITEX / AK CARE COMPANY	100.00%	65,932	65,932	21
22	V	24	EDUCATION AND SEMINARS		ITEX / AK CARE COMPANY	100.00%	60	60	22
23	V	26	INSURANCE		ITEX / AK CARE COMPANY	100.00%	3,765	3,765	23
24	V	30	DEPRECIATION		ITEX / AK CARE COMPANY	100.00%	18,078	18,078	24
25	V	32	INTEREST		ITEX / AK CARE COMPANY	100.00%	15,848	15,848	25
26	V	33	REAL ESTATE TAXES		ITEX / AK CARE COMPANY	100.00%	15,627	15,627	26
27	V	35	EQUIPMENT RENTAL		ITEX / AK CARE COMPANY	100.00%	2,726	2,726	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			\$			\$ 176,428	\$ * 176,428	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.

YESNO

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 Health Care, 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 EQUI	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	ITEX - A.K. CARE	LINCOLNWOOD	MANAGEMENT	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 CHICAGO WEST	CHICAGO				14
15			SYMPHONY OF CRESTWOOD	CRESTWOOD				15
16			SYMPHONY OF CROWN POINT	CROWN POINT, IN				16
17			SYMPHONY OF DECATUR	DECATUR				17
18			SYMPHONY OF DYER	DYER, IN				18
19			SYMPHONY OF EVANSTON	EVANSTON				19
20			SYMPHONY OF GLENDALE	GLENDALE, WI				20
21			SYMPHONY OF HANOVER PARK	HANOVER PARK				21
22			SYMPHONY OF JOLIET	JOLIET				22
23			SYMPHONY OF LINCOLN	LINCOLN				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

Facility Name & ID Number Symphony of Lincoln Park # 0053694 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Lincoln Park # 0053694 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	<u>Symphony</u> of Lincoln Park
--------------------------------------	--

0053694

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

MAESTRO CONSULTING SERVICES LLC

Street Address

7257 N. LINCOLN AVENUE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 933-2600

Fax Number

(847) 933-2601

	1 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	\$	90,768	\$ 2,566	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	475,288	90,768	23,494	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711		90,768	5,324	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090		90,768	4,206	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	3,273,643	90,768	161,822	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220		90,768	25,122	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	932,558	90,768	46,098	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28			90,768		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768		90,768	46,751	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900		90,768	19,175	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	6,126,863	90,768	302,863	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920		90,768	37,713	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439		90,768	1,505	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434		90,768	3,729	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214		90,768	4,361	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614		90,768	58,063	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621		90,768	2,305	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912		90,768	5,730	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288		90,768	7,478	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399		90,768	3,233	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453		90,768	4,026	21
22										22
23										23
24										24
25	TOTALS					\$ 15,487,256	\$ 10,808,353		\$ 765,564	25

Facility Name & ID Number Symphony of Lincoln Park # 0053694 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			\$	\$		\$ 144,156	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					\$	\$		\$ 144,156	25

Facility Name & ID Number Symphony of Lincoln Park # 0053694 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	14	Transportation	Direct Allocation			\$	\$		\$ 19,517	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					\$	\$		\$ 19,517	25

Facility Name & ID Number Symphony of Lincoln Park # 0053694 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			\$	\$		\$ 271,628	1
2	26	Liability Insurance	Direct Allocation						451,529	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					\$	\$		\$ 723,157	25

Ending: 12/31/16

(847) 679-1820

Facility Name & ID Number Symphony of Lincoln Park # 0053694 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 Lincoln Park # 0053694 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 Lincoln Park # 0053694 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 Lincoln Park # 0053694 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$			\$		1					
2														2					
3														3					
4														4					
5					-									5					
	Working Capital																		
6	RCA		X	Note Payable				292,722						6					
7	Private Bank		X	Line of Credit								157,758		7					
8					-									8					
9	TOTAL Facility Related						\$	292,722				\$	157,758	9					
	B. Non-Facility Related*																		
10	Interest Income		X									(910)		10					
11	Allocated from Itex		X									15,848		11					
12														12					
13					-									13					
14	TOTAL Non-Facility Related						\$					\$	14,938	14					
15	TOTALS (line 9+line14)						\$	292,722				\$	172,696	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 (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.	\$	635,802	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.)			\$	679,502	2
3. Under or (over) accrual (line 2 minus line 1).			\$	43,700	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	746,550	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	790,250	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	496,415	8		
	2012	549,719	9		
	2013	557,158	10		
	2014	568,381	11		
	2015	658,145	12		
2016 Accrual = \$658,145 x 1.1343 = \$746,550					
Allocated from Maestro Consulting Services - \$5,730					
Allocated from Itex - \$15,627					
*The beginning accrual on line 1 was adjusted, since the ending accrual on the 2015 cost report only represented 2 months.					

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.

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 Lincoln Park

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0053694

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

91,703

B. General Construction Type:

Exterior

Brick

Frame

Reinforced Concrete

Number of Stories

6

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).

Claridge IVY, Ltd; Retirement apartment rentals; 119 units

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

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1998	\$ 40,000	1
2	Allocated from 7257 N. Lincoln Ave.		2004	7,909	2
3	TOTALS			\$ 47,909	3

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	248		1998	1984	\$ 14,437,336	\$	40	\$ 360,933	\$ 360,933	\$ 6,684,480	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1992		60,378		20			60,378	9
10	Various		1993		59,308		20			59,308	10
11	Various		1994		10,638		20			10,373	11
12	Various		1995		43,191		20			43,191	12
13	Various		1996		43,699		20	1,114	1,114	43,699	13
14	Various		1997		62,177		20	3,057	3,057	60,648	14
15	Various		1998		86,071		20	4,304	4,304	79,624	15
16	Various		1999		130,173		20	6,509	6,509	113,907	16
17	Various		2000		176,095		20	8,666	8,666	142,989	17
18	Various		2001		40,770		20	2,039	2,039	30,742	18
19	Various		2002		41,086		20	2,055	2,055	30,557	19
20	Various		2003		96,832		20	4,848	4,848	65,379	20
21	Various		2004		126,481		20	6,275	6,275	79,280	21
22	Various		2005		290,744		20	14,536	14,536	164,207	22
23	Various		2006		427,610		20	21,381	21,381	221,640	23
24	Various		2007		238,023		20	11,904	11,904	110,905	24
25	Various		2008		128,721		20	6,436	6,436	54,033	25
26	Various		2009		205,324		20	10,266	10,266	76,997	26
27	Various		2010		174,646		20	8,731	8,731	56,759	27
28	Various		2011		306,184		20	15,309	15,309	68,891	28
29	Various		2012		61,808		20	3,090	3,090	13,908	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Symphony of Lincoln Park

0053694

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	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		28,336			1,417	1,417	3,542	67
68		828,800	19,378		22,479	3,101	547,336	68
69			21,599			(21,599)		69
70		\$ 18,104,431	\$ 40,977		\$ 515,350	\$ 474,373	\$ 8,822,773	70

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

Facility Name & ID Number Symphony of Lincoln Park

0053694

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		\$ 18,104,431	\$ 40,977		\$ 515,350	\$ 474,373	\$ 8,822,773	1
2	Fire Sprinkler-Install Backflow Preventor, Replace Leak	2013	6,031		20	302	302	1,057	2
3	Painting And Decorating 6Th Floor	2013	5,181		20	260	260	910	3
4	Fabricate Awning And Aluminum Sheet Metal Cover Awnings	2013	4,100		20	206	206	721	4
5	Materials And Labor To Pull/ Install Cable, Wifi	2013	8,000		20	400	400	1,400	5
6	Labao And Materials For Wall Mounted Kiosks In Hallways	2013	4,625		20	232	232	812	6
7	Plant 8 Trees On Southport Ave. And Remove Old Trunks	2013	3,800		20	190	190	665	7
8	Asphalt Sealcoating And Re-Strip Pavement	2013	4,700		20	236	236	826	8
9	Car 5,4,2 Secure Elevator On Top Hatch, Brake Shoes, Generator	2013	15,155		20	758	758	2,653	9
10	Carpet One Roll, Adhesive	2013	3,714		20	186	186	651	10
11	Thermal Ceramic Blanket Around Exhaust-Entire Exhuast Walls	2014	2,525		20	126	126	316	11
12	Data Plates On All Controlers, Elevators	2014	9,974		20	499	499	1,246	12
13	Fire Alarm System Repair	2014	4,121		20	206	206	515	13
14	Replace Marley Oem Cross Flow Nozzles, Fan Shafts, New Oil Lin	2014	3,455		20	173	173	432	14
15	Concrete Work And Pipe Repair	2015	6,250		20	313	313	625	15
16	Elevator Modernization Per Aia Documents	2015	238,600		20	11,930	11,930	23,860	16
17	Plat Survey, Document Research	2015	6,481		20	324	324	648	17
18	Install Lights And Outlets For Elevators	2015	4,400		20	220	220	440	18
19	Install Lights And Outlets For Elevators	2015	3,800		20	190	190	380	19
20	Room Remodel-Soffit,Wall Plastrers,Crown Moulding,Floor,Wall	2015	8,600		20	430	430	860	20
21	Semiprivate Resident Room-Floor,Wallpaper,Light Fixtures,Wind	2015	8,469		20	423	423	847	21
22	21 Fire Sprinklers - Shower Rooms Flrs 2-6, 1St Floor Data Room	2016	6,180		20	309	309	309	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)		\$ 18,462,593	\$ 40,977		\$ 533,262	\$ 492,285	\$ 8,862,945	34

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward	\$ 18,462,593	\$ 40,977		\$ 533,262	\$ 492,285	\$ 8,862,945	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)	\$ 18,462,593	\$ 40,977		\$ 533,262	\$ 492,285	\$ 8,862,945	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		\$ 18,462,593	\$ 40,977		\$ 533,262	\$ 492,285	\$ 8,862,945	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)		\$ 18,462,593	\$ 40,977		\$ 533,262	\$ 492,285	\$ 8,862,945	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		\$18,462,593	\$40,977		\$533,262	\$492,285	\$8,862,945	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)		\$18,462,593	\$40,977		\$533,262	\$492,285	\$8,862,945	34

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

Facility Name & ID Number Symphony of Lincoln Park

0053694

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Paint hallway, lobby, 1st floor, 20 gal. paint, 8 rolls tape	2013	2,579		20	129	129	322	9
10	Paint office, reception office, activity room, beauty shop	2013	1,582		20	79	79	197	10
11	Dining room carpet, remove old and install new	2013	6,900		20	345	345	863	11
12	Dining room carpet, remove old and install new	2013	7,620		20	381	381	953	12
13	Sealcoat & re-stripe pavement - parking lot	2013	4,500		20	225	225	562	13
14	Elevator car 5 - install new breaks & adjust shoes	2013	5,155		20	258	258	645	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)		\$ 28,336	\$		\$ 1,417	\$ 1,417	\$ 3,542	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$28,336	\$		\$1,417	\$1,417	\$3,542	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)		\$28,336	\$		\$1,417	\$1,417	\$3,542	34

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

Facility Name & ID Number Symphony of Lincoln Park

0053694

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Ave. - Maestro	2004	71,182	1,825	35	2,034	209	26,693	3
4	Allocated from Itex - A.K. Care	1993	536,125	13,747	35	15,318	1,571	361,245	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 7257 N. Lincoln Ave. - Maestro	2015	1,122	107	20	75	(32)	100	9
10	Allocated from 7257 N. Lincoln Ave. - Maestro	2005	6,489	46	20	233	187	4,526	10
11	Allocated from 7257 N. Lincoln Ave. - Maestro	2004	1,415		20	71	71	884	11
12									12
13	Allocated from Maestro Consulting Services	2003	579		20	29	29	380	13
14	Allocated from Maestro Consulting Services	2004	11,755		20	638	638	7,480	14
15	Allocated from Maestro Consulting Services	2005	697		20	35	35	413	15
16	Allocated from Maestro Consulting Services	2006	945		20	47	47	490	16
17	Allocated from Maestro Consulting Services	2008	996		20	50	50	411	17
18	Allocated from Maestro Consulting Services	2009	16,037		20	752	752	6,102	18
19	Allocated from Maestro Consulting Services	2010	2,464		20	123	123	802	19
20	Allocated from Maestro Consulting Services	2011	133		20	7	7	39	20
21	Allocated from Maestro Consulting Services	2012	148		20	7	7	35	21
22	Allocated from Maestro Consulting Services	2014	1,854		20	93	93	242	22
23	Allocated from Maestro Consulting Services	2015	521		20	26	26	35	23
24	Allocated from Maestro Consulting Services	2016	2,284	88	20	88		88	24
25									25
26	Allocated from Itex - A.K. Care	1993	67,460	397	20		(397)	67,460	26
27	Allocated from Itex - A.K. Care	1994	36,234	943	20		(943)	36,231	27
28	Allocated from Itex - A.K. Care	1995	6,175	16	20	2	(14)	6,175	28
29	Allocated from Itex - A.K. Care	1996	350		20			350	29
30	Allocated from Itex - A.K. Care	1997	10,417	267	20	521	254	10,156	30
31	Allocated from Itex - A.K. Care	1999	1,157	30	20	58	28	1,041	31
32	Allocated from Itex - A.K. Care	2005	5,065		20	253	253	2,881	32
33	Allocated from Itex - A.K. Care	2007	6,271	146	20	313	167	2,903	33
34	TOTAL (lines 1 thru 33)		\$ 787,875	\$ 17,612		\$ 20,773	\$ 3,161	\$ 537,162	34

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

Facility Name & ID Number Symphony of Lincoln Park

0053694

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	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		\$ 787,875	\$ 17,612		\$ 20,773	\$ 3,161	\$ 537,162	1
2 Allocated from Itex - A.K. Care	2008	23,901	613	20	790	177	6,776	2
3 Allocated from Itex - A.K. Care	2009	1,302	34	20	130	96	977	3
4 Allocated from Itex - A.K. Care	2010	2,782		20	139	139	887	4
5 Allocated from Itex - A.K. Care	2014	11,611	1,115	20	581	(534)	1,468	5
6 Allocated from Itex - A.K. Care	2016	1,329	4	20	66	62	66	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)		\$ 828,800	\$ 19,378		\$ 22,479	\$ 3,101	\$ 547,336	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	\$118,026	\$104	\$12,121	\$12,017	10	\$44,713	71
72	Current Year Purchases	89,347	902	8,926	8,024	10	8,965	72
73	Fully Depreciated Assets	3,631,866		186	186	10	3,658,030	73
74								74
75	TOTALS	\$3,839,239	\$1,006	\$21,233	\$20,227		\$3,711,708	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		1994, 1998 Ford vans	1994	\$51,199	\$	\$	\$	5	\$51,199
77		2003 & 2007 Ford van	2003	58,606				5	49,856
78		2012 Ford bus	2012	52,095		10,419	10,419	5	46,886
79		Allocated from Maestro Consulti	2016	438				5	438
80	TOTALS			\$162,338	\$	\$10,419	\$10,419		\$148,379

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)				\$22,512,078
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$41,983
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$564,914
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$522,931
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$12,723,032

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Renovation	\$1,431,096
93		
94		
95		\$1,431,096

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Main Street (sale/leaseback arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$2,950,191			3
4	Additions				(2,950,191)			4
5	Allocated from Maestro Consulting				7,478			5
6								6
7	TOTAL				\$7,478			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$52,183Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Infiniti G37	\$661	\$7,926	17
18	Allocated from Maestro Consulting Services			4,026	18
19					19
20					20
21	TOTAL		\$661	\$11,952	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent
12. /2017\$
13. /2018\$
14. /2019\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 1,336,324	\$		\$ 1,336,324	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			451,081			451,081	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,331,732			1,331,732	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				630,397		630,397	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					384,594	157,376		541,970	13
14	TOTAL			\$		\$ 3,503,731	\$ 787,773		\$ 4,291,504	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$	1
2	Cash-Patient Deposits	33,848		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,964,022		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,220		6
7	Other Prepaid Expenses	182,091		7
8	Accounts Receivable (owners or related parties)	1,115,128		8
9	Other(specify): <u>See Attached Schedule</u>	797,720		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 11,191,029	\$	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	537,772		15
16	Equipment, at Historical Cost	108,384		16
17	Accumulated Depreciation (book methods)	(21,721)		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>	781,677		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,406,112	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,597,141	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,039,987	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,848		28
29	Short-Term Notes Payable	292,722		29
30	Accrued Salaries Payable	326,850		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,208		31
32	Accrued Real Estate Taxes(Sch.IX-B)	746,550		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>	1,749,357		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,237,522	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,237,522	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (640,381)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,597,141	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (76,031)	1
2	Restatements (describe):		2
3	Other Professional Fees	(35,000)	3
4	Rent	127,641	4
5	Amorization, Other Professional Fees, Misc.	2,031	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,641	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(659,022)	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)	\$ (659,022)	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)	\$ (640,381)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony of Lincoln Park

0053694

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	\$ 22,147,328	1
2	Discounts and Allowances for all Levels	(616,945)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 21,530,383	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,098,455	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,098,455	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	673	16
17	Sale of Drugs	16,998	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	699	19
20	Radiology and X-Ray	188	20
21	Other Medical Services	1,016	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,574	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	910	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 910	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,023	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,023	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,662,345	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,682,640	31
32	Health Care	7,047,854	32
33	General Administration	5,526,739	33
	B. Capital Expense		
34	Ownership	3,952,591	34
	C. Ancillary Expense		
35	Special Cost Centers	4,553,072	35
36	Provider Participation Fee	558,471	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 24,321,367	40
41	Income before Income Taxes (line 30 minus line 40)**	(659,022)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (659,022)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,826,505	44
45	Private Pay - Net Inpatient Revenue	821,453	45
46	Medicare - Net Inpatient Revenue	6,421,577	46
47	Other-(specify) <u>Managed Care</u>	3,746,414	47
48	Other-(specify) <u>Hospice</u>	714,434	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 21,530,383	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	2,835	3,104	\$ 156,063	\$ 50.28	1
2	Assistant Director of Nursing	761	871	39,379	45.20	2
3	Registered Nurses	62,572	66,591	2,091,632	31.41	3
4	Licensed Practical Nurses	58,344	61,638	1,573,013	25.52	4
5	CNAs & Orderlies	145,424	159,489	1,910,684	11.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,857	2,019	48,975	24.26	8
9	Activity Director	2,256	2,350	41,498	17.66	9
10	Activity Assistants	12,789	14,612	160,733	11.00	10
11	Social Service Workers	9,292	10,046	229,656	22.86	11
12	Dietician					12
13	Food Service Supervisor	3,804	4,176	90,040	21.56	13
14	Head Cook	7,111	7,585	105,206	13.87	14
15	Cook Helpers/Assistants	26,876	29,902	335,200	11.21	15
16	Dishwashers					16
17	Maintenance Workers	6,197	6,755	112,803	16.70	17
18	Housekeepers	27,331	30,281	342,482	11.31	18
19	Laundry	7,470	8,421	90,274	10.72	19
20	Administrator	1,818	1,990	111,674	56.12	20
21	Assistant Administrator	517	590	21,757	36.86	21
22	Other Administrative					22
23	Office Manager	1,884	2,077	73,913	35.58	23
24	Clerical	15,918	17,721	342,185	19.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,257	2,571	36,890	14.35	31
32	Other Health Care(specify)					32
33	Other(specify)	5,723	6,160	152,142	24.70	33
34	TOTAL (lines 1 - 33)	403,035	438,951	\$ 8,066,199 *	\$ 18.38	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	\$ 52,756	01-03	35
36	Medical Director	Monthly	132,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	5,133	10-03	38
39	Pharmacist Consultant	Monthly	41,917	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	34,381	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,420	11-03	44
45	Social Service Consultant				45
46	Other(specify) Psychiatric	Monthly	2,932	10-03	46
47	Cardiologist	Monthly	12,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 284,039		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number <u>Symphony of Lincoln Park</u>	STATE OF ILLINOIS # <u>0053694</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
XX. GENERAL INFORMATION:			
(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u>	(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? <u>Yes</u>		
(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. <u>ICLTC - \$25,214</u>	(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? <u>No</u> 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.		
(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u>	(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____		
(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u>	(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 1</u> d. Have vehicle usage logs been maintained? <u>Yes</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u>		
(5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? <u>Yes</u> <u>10 Years</u>	(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>N/A</u>		
(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>2,620</u> Line <u>10</u>	(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u>		
(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.	(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. <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees		
(8) Are you presently operating under a sale and leaseback arrangement? <u>Yes</u> If YES, give effective date of lease. <u>11/01/2015</u>			
(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO			
(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>X</u> NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>The Imperial Grove Pavilion # 37754</u>			
(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>558,471</u> 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? <u>No</u> If YES, attach an explanation of the allocation.			