

		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>0053744</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																
Facility Name: <u>Symphony of Park South</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>10935 S Halsted St</u> <u>Chicago</u> <u>60028</u>																																																																																		
Number City Zip Code																																																																																		
County: <u>Cook</u>																																																																																		
Telephone Number: <u>(773) 928-2000</u> Fax # <u>(773) 928-9670</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></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><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 colspan="2"></td><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>11/1/2015</u></td><td colspan="2" rowspan="5"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____		Paid Preparer	(Signed) _____ *	* 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>11/1/2015</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		Type of Ownership:		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></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 _____							In the event there are further questions about this report, please contact:		Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>		Email Address: _____	
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Facility Name & ID Number Symphony of Park South

0053744 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	294	294	107,604	1
2	Skilled (SNF)			2
3	Skilled Pediatric (SNF/PED)			3
4	Intermediate (ICF)			4
5	Intermediate/DD			5
6	Sheltered Care (SC)			6
7	ICF/DD 16 or Less			7
294	TOTALS	294	107,604	7

B. Census-For the entire report period.

	1	2345				
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			26,761	26,761	8
9	SNF/PED					9
10	ICF	35,536	2,431	23,831	61,798	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,536	2,431	50,592	88,559	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.30%

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 05/01/1976

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

YES

☐

Date

NO

☒

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

YES

☒

NO

☐

If YES, enter number

of beds certified

294

and days of care provided

7,807

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/16

Fiscal Year: 12/31/16

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

Facility Name & ID Number Symphony of Park South # 0053744 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	403,717	66,987	19,019	489,723		489,723		489,723			1
2	Food Purchase		478,744		478,744	(39,016)	439,728	(131)	439,597			2
3	Housekeeping	255,163	54,940		310,103		310,103		310,103			3
4	Laundry	127,563	12,591	74,678	214,832		214,832		214,832			4
5	Heat and Other Utilities			279,523	279,523		279,523	(20,889)	258,634			5
6	Maintenance	85,854		238,199	324,053		324,053	26,161	350,214			6
7	Other (specify):*							4,986	4,986			7
8	TOTAL General Services	872,297	613,262	611,419	2,096,978	(39,016)	2,057,962	10,127	2,068,089			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	5,533,334	391,954	79,121	6,004,409		6,004,409	183,566	6,187,975			10
10a	Therapy			14,615	14,615		14,615		14,615			10a
11	Activities	100,641	17,370	2,613	120,624		120,624		120,624			11
12	Social Services	270,104			270,104		270,104		270,104			12
13	CNA Training											13
14	Program Transportation			39,380	39,380		39,380	(4,794)	34,586			14
15	Other (specify):*							29,782	29,782			15
16	TOTAL Health Care and Programs	5,904,079	409,324	159,729	6,473,132		6,473,132	208,554	6,681,686			16
	C. General Administration											
17	Administrative	158,666		918,474	1,077,140		1,077,140	(863,825)	213,315			17
18	Directors Fees											18
19	Professional Services			441,257	441,257		441,257	34,402	475,659			19
20	Dues, Fees, Subscriptions & Promotions			89,505	89,505		89,505	(2,081)	87,424			20
21	Clerical & General Office Expenses	258,082	1,445	740,463	999,990		999,990	(229,391)	770,599			21
22	Employee Benefits & Payroll Taxes			1,431,407	1,431,407	39,016	1,470,423		1,470,423			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,961	6,961		6,961	1,784	8,745			24
25	Other Admin. Staff Transportation			251	251		251	4,420	4,671			25
26	Insurance-Prop.Liab.Malpractice			750,431	750,431		750,431	5,169	755,600			26
27	Other (specify):*							68,833	68,833			27
28	TOTAL General Administration	416,748	1,445	4,378,749	4,796,942	39,016	4,835,958	(980,689)	3,855,269			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,193,124	1,024,031	5,149,897	13,367,052		13,367,052	(762,008)	12,605,044			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			4,622	4,622		4,622	288,686	293,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			168,040	168,040		168,040	(4,179)	163,861			32
33	Real Estate Taxes			684,231	684,231		684,231	4,305	688,536			33
34	Rent-Facility & Grounds			2,066,028	2,066,028		2,066,028	(2,057,161)	8,867			34
35	Rent-Equipment & Vehicles			59,513	59,513		59,513	8,606	68,119			35
36	Other (specify):*											36
37	TOTAL Ownership			2,982,434	2,982,434		2,982,434	(1,759,744)	1,222,690			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		366,225	1,609,990	1,976,215		1,976,215	(14,032)	1,962,183			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			650,678	650,678		650,678		650,678			42
43	Other (specify):*	49,202		174,444	223,646		223,646	(223,646)	(0)			43
44	TOTAL Special Cost Centers	49,202	366,225	2,435,112	2,850,539		2,850,539	(237,678)	2,612,861			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,242,326	1,390,256	10,567,443	19,200,025		19,200,025	(2,759,430)	16,440,595			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	(23,932)	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	285,954	30		9
10	Interest and Other Investment Income	(4,179)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(131)	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	(5,601)	21		18
19	Entertainment				19
20	Contributions	(13,950)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(410,119)	21		24
25	Fund Raising, Advertising and Promotional	(718)	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	(2,557,019)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,729,695)		\$	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)	(29,735)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (29,735)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,759,430)		37

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

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

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

Report Period Beginning:

Ending:

ID#

0053744

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare 2% Sequester	\$ (212,090)	21	1
2	Pharmacy-Veteran	(4,201)	10	2
3	X-Ray-Veteran	(100)	10	3
4	Laboratory-Veteran	(2,967)	10	4
5	Rentals-Veteran	(518)	10	5
6	Other Outside Serv-Veteran	(55)	10	6
7	Community Relations	(8,410)	43	7
8	Marketing	(1,700)	43	8
9	Guest Relations	(40,792)	43	9
10	Bank Charges	(1,166)	21	10
11	Marketing Consultant	(131,403)	43	11
12	Marketing Services	(41,341)	43	12
13	Patient Needs Account	(431)	10	13
14	Rent for sale/leaseback	(2,066,027)	34	14
15	Recovery	(4,162)	21	15
16	Non-Allowable legal	(21,021)	19	16
17	PAC Dues	(10,144)	20	17
18	Capitalized R&M	(8,003)	06	18
19	Non Facility Related RE Taxes	(2,488)	33	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
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36				36
37				37
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,557,019)		49

ID#0053744

Report Period Beginning:01/01/16

Ending:12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
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67				18
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80				31
81				32
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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 Park South # 0053744 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(131)											(131)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(23,932)		3,043									(20,889)	5
6	Maintenance	(8,003)		34,164									26,161	6
7	Other (specify):*			4,986									4,986	7
8	TOTAL General Services	(32,066)		42,193									10,127	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(8,272)		191,838									183,566	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation						(4,794)						(4,794)	14
15	Other (specify):*			29,782									29,782	15
16	TOTAL Health Care and Programs	(8,272)		221,620			(4,794)						208,554	16
	C. General Administration													
17	Administrative			(863,825)									(863,825)	17
18	Directors Fees													18
19	Professional Services	(21,021)		55,423									34,402	19
20	Fees, Subscriptions & Promotions	(24,812)		22,731									(2,081)	20
21	Clerical & General Office Expenses	(633,138)		403,747									(229,391)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,784									1,784	24
25	Other Admin. Staff Transportation			4,420									4,420	25
26	Insurance-Prop.Liab.Malpractice			5,169									5,169	26
27	Other (specify):*			68,833									68,833	27
28	TOTAL General Administration	(678,971)		(301,718)									(980,689)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(719,309)		(37,905)			(4,794)						(762,008)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Symphony of Park South # 0053744 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	285,954		2,732									288,686	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,179)											(4,179)	32
33	Real Estate Taxes	(2,488)		6,793									4,305	33
34	Rent-Facility & Grounds	(2,066,027)		8,866									(2,057,161)	34
35	Rent-Equipment & Vehicles			8,606									8,606	35
36	Other (specify):*													36
37	TOTAL Ownership	(1,786,740)		26,996									(1,759,744)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(14,032)							(14,032)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(223,646)											(223,646)	43
44	TOTAL Special Cost Centers	(223,646)				(14,032)							(237,678)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,729,695)		(10,909)		(14,032)	(4,794)						(2,759,430)	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. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	<u>UTILITIES</u>	\$	<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	\$ 3,043	\$ 3,043	15
16	V	6	<u>MAINTENANCE SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	27,852	27,852	16
17	V	6	<u>MAINTENANCE EXPENSES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	6,312	6,312	17
18	V	7	<u>EMPLOYEE BENEFITS - MAINTENANCE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	4,986	4,986	18
19	V	10	<u>CLINICAL SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	191,838	191,838	19
20	V	15	<u>EMPLOYEE BENEFITS - CLINICAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	29,782	29,782	20
21	V	17	<u>ADMINISTRATIVE SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	54,649	54,649	21
22	V	17	<u>ADMINISTRATIVE EXPENSES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%			22
23	V	19	<u>PROFESSIONAL FEES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	55,423	55,423	23
24	V	20	<u>DUES, FEES, SUBSCRIPTIONS, ETC.</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	22,731	22,731	24
25	V	21	<u>CLERICAL & GENERAL SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	359,039	359,039	25
26	V	21	<u>CLERICAL & GENERAL EXPENSES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	44,708	44,708	26
27	V	24	<u>SEMINARS AND EDUCATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	1,784	1,784	27
28	V	25	<u>TRANSPORTATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	4,420	4,420	28
29	V	26	<u>INSURANCE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	5,169	5,169	29
30	V	27	<u>EMPLOYEE BENEFITS - ADMINISTRATIVE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	68,833	68,833	30
31	V	30	<u>DEPRECIATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	2,732	2,732	31
32	V	33	<u>REAL ESTATE TAX</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	6,793	6,793	32
33	V	34	<u>BUILDING RENTAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	8,866	8,866	33
34	V	35	<u>EQUIPMENT RENTAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	3,832	3,832	34
35	V	35	<u>AUTO LEASE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	4,773	4,773	35
36	V								36
37	V	17	<u>Management Fees</u>	918,474				(918,474)	37
38	V								38
39	Total			\$ 918,474			\$ 907,565	\$ * (10,909)	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	\$ 285,578	Maple Leaf		\$ 285,578	\$	15
16	V	26	Liability Insurance	482,481	Maple Leaf		482,481		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			\$ 768,059			\$ 768,059	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME and Medical Supplies	\$ 138,519	Integra Healthcare Equipment LLC		\$ 124,487	\$ (14,032)	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			\$ 138,519			\$ 124,487	\$ * (14,032)	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	\$ 36,344	Lifeline Ambulance		\$ 31,550	\$ (4,794)	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			\$ 36,344			\$ 31,550	\$ * (4,794)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Symcare Healthcare, LLC	99.99%	CALIFORNIA GARDENS	CHICAGO	MAESTRO CONSULTING SERV	LINCOLNWOOD	MANAGEMENT	1
2	Symcare HMG, LLC	0.01%	MAPLECREST CARE CENTRE	BELVIDERE	7257 N. LINCOLN AVENUE	LINCOLNWOOD	BUILDING RENTAL	2
3			MCKINLEY COURT	DECATUR	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY/WORK COMP IN	3
4			MONROE PAVILION	CHICAGO	INTEGRA HEALTHCARE 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				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 LINCOLN PARK	CHICAGO				24
25			SYMPHONY OF ORCHARD VALLEY	AURORA				25
26			SYMPHONY OF SOUTH SHORE	CHICAGO				26
27			SYMPHONY RESIDENCES OF LINCOLN PARK	CHICAGO				27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Symphony of Park South # 0053744 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

Ending: 12/31/16

(847) 933-2601

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,836,222	28	\$ 51,919	\$	107,604	\$ 3,043	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	475,288	107,604	27,852	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711		107,604	6,312	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090		107,604	4,986	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	3,273,643	107,604	191,838	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220		107,604	29,782	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	932,558	107,604	54,649	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28			107,604		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768		107,604	55,423	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900		107,604	22,731	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	6,126,863	107,604	359,039	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920		107,604	44,708	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439		107,604	1,784	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434		107,604	4,420	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214		107,604	5,169	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614		107,604	68,833	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621		107,604	2,732	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912		107,604	6,793	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288		107,604	8,866	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399		107,604	3,832	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453		107,604	4,773	21
22										22
23										23
24										24
25	TOTALS					\$ 15,487,256	\$ 10,808,353		\$ 907,565	25

Facility Name & ID Number Symphony of Park South # 0053744 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 69720 West Bay Rd
City / State / Zip Code Grand Cayman Ky. 11102
Phone Number ()
Fax Number ()

	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	22	Workers comp	Direct Allocation			\$	\$		\$ 285,578	1
2	26	Liability insurance	Direct Allocation						482,481	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					\$	\$		\$ 768,059	25

Facility Name & ID Number Symphony of Park South # 0053744 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	39	DME and Medical Equipment	Direct Allocation		\$	\$		\$ 124,487	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				\$	\$		\$ 124,487	25

Facility Name & ID Number Symphony of Park South # 0053744 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	14	Transportation	Direct Allocation		\$	\$		\$ 31,550	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				\$	\$		\$ 31,550	25

Facility Name & ID Number Symphony of Park South # 0053744 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 Park South # 0053744 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 Park South # 0053744 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 Park South # 0053744 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 Park South # 0053744 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Intercompany Loan		X				\$	4,152,342			\$	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Private Bank		X	Line of credit							168,040	6
7												7
8					-							8
9	TOTAL Facility Related						\$	4,152,342			\$ 168,040	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,179)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						\$				\$ (4,179)	14
15	TOTALS (line 9+line14)						\$	4,152,342			\$ 163,861	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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Symphony of Park South

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0053744

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>25-16-316-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>62,717.64</u>	\$ <u>62,717.64</u>
2. <u>25-16-316-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>60,261.68</u>	\$ <u>60,261.68</u>
3. <u>25-16-332-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>206,625.74</u>	\$ <u>206,625.74</u>
4. <u>25-16-332-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>303,672.80</u>	\$ <u>303,672.80</u>
5. <u>25-16-321-001-0000</u>	<u>Empty Lot</u>	\$ <u>978.87</u>	\$ <u></u>
6. <u>25-16-321-002-0000</u>	<u>Empty Lot</u>	\$ <u>502.54</u>	\$ <u></u>
7. <u>25-16-321-003-0000</u>	<u>Empty Lot</u>	\$ <u>502.54</u>	\$ <u></u>
8. <u>25-16-321-004-0000</u>	<u>Empty Lot</u>	\$ <u>502.54</u>	\$ <u></u>
9. <u>See Attached</u>	<u>Allocated from Maestro</u>	\$ <u>95,270.31</u>	\$ <u>5,582.91</u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>731,034.66</u>	\$ <u>638,860.77</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates

RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Symphony of Park South</u>	COUNTY	<u>Cook</u>
---------------	-------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0053744

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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

C. Tax Bills

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

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

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 855,000	1
2	Allocated from 7257 Lincoln-Maestro			9,376	2
3	TOTALS			\$ 864,376	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	294			1976	\$ 7,334,294	\$	39	\$	\$	\$ 7,334,294	4
5				1994	554,636		39	27,732	27,732	440,982	5
6				1994	3,020		39	151	151	2,392	6
7				1994	106,949		39	5,347	5,347	86,170	7
8											8
	Improvement Type**										
9	Various			1978	750		20			750	9
10	Various			1979	12,807		20			12,807	10
11	Various			1980	35,915		20			35,915	11
12	Various			1981	13,910		20			13,910	12
13	Various			1982	8,814		20			8,814	13
14	Various			1983	12,936		20			12,936	14
15	Various			1984	20,560		20			20,560	15
16	Various			1985	18,883		20			18,883	16
17	Various			1986	2,456		20			2,456	17
18	Various			1987	4,000		20	127	127	3,734	18
19	Various			1988	82,596		20	2,622	2,622	73,984	19
20	Various			1989	1,225		20	39	39	1,066	20
21	Various			1990	91,597		20	1,128	1,128	75,840	21
22	Various			1993	53,620		20			53,610	22
23	Various			1995	137,949		20	16	16	137,956	23
24	Various			1996	519,100		20	5,542	5,542	519,100	24
25	Various			1997	76,548		20	3,740	3,740	75,001	25
26	Various			1998	77,488		20	3,646	3,646	71,502	26
27	Various			1999	278,572		20	13,863	13,863	247,939	27
28	Various			2000	48,393		20	2,246	2,246	37,487	28
29	Various			2001	97,460		20	4,812	4,812	74,896	29
30	Various			2002	25,280		20			25,280	30
31	Various			2003	461,684		20	9,012	9,012	427,212	31
32	Various			2004	62,146		20			62,146	32
33	Various			2005	94,134		20			94,134	33
34	Various			2006	114,124		20	2,463	2,463	114,124	34
35	Various			2007	377,501		20	24,081	24,081	261,552	35
36	Various			2008	823,017		20	41,004	41,004	365,349	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 Park South

0053744

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	
37	Various	2009	\$ 267,116	\$	20	\$ 18,163	\$ 18,163	\$ 150,949	37
38	Various	2010	211,043		20	13,397	13,397	88,417	38
39	Various	2011	129,999		20	7,177	7,177	46,058	39
40	Various	2012	30,043		20	3,057	3,057	13,277	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		50,886			326	326	47,033	67
68	Related Party Allocations (Pages 12H & 12I)		140,623	2,449		5,107	2,658	57,758	68
69	Financial Statement Depreciation			4,622			(4,622)		69
70	TOTAL (lines 4 thru 69)		\$ 12,382,075	\$ 7,071		\$ 194,796	\$ 187,725	\$ 11,116,274	70

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

Facility Name & ID Number Symphony of Park South

0053744

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		\$ 12,382,075	\$ 7,071		\$ 194,796	\$ 187,725	\$ 11,116,274	1
2	Fire Alarm System Device Installation	2013	3,215		20	161	161	643	2
3	Elevator Doors	2013	10,061		20	503	503	1,970	3
4	Wifi Cable Wiring	2013	5,500		20	1,100	1,100	4,217	4
5	Receptacles For Kiosks	2013	3,045		20	609	609	2,233	5
6	Light Fixtures	2013	4,160		20	832	832	2,704	6
7	Door Operator Package For Car #3	2013	10,062		20	503	503	1,593	7
8	Back Flow Repairs	2013	2,725		20	136	136	443	8
9	Supply, Terminate & Perform Functional Testing Of Remote E-St	2013	3,455		20	173	173	605	9
10	2 Make-Up Air Units	2014	30,200		20	1,510	1,510	4,153	10
11	Hand Rails	2014	5,200		20	260	260	672	11
12	Fire Alarm System	2014	6,832		20	342	342	882	12
13	Elevator - Hydraulic Valve	2014	5,132		20	257	257	642	13
14	Sink & Piping	2014	9,950		20	498	498	1,244	14
15	Pvc Piping	2014	2,980		20	149	149	373	15
16	Dialysis Room Wall	2014	4,900		20	245	245	592	16
17	Dialysis Room Electrical Work	2014	6,090		20	305	305	736	17
18	Compressor For A/C	2014	2,888		20	578	578	1,540	18
19	1 Rooftop Ac Unit	2014	3,508		20	175	175	395	19
20	Fire Alarm Work	2014	14,681		20	734	734	1,590	20
21	Fire Alarm Work	2014	2,729		20	136	136	284	21
22	Phone Port Repair	2014	3,836		20	192	192	384	22
23	Install Electrical Panel In Generator Room	2015	5,280		20	264	264	528	23
24	Topographical Plan - Parking Lot	2015	4,160		20	208	208	416	24
25	Topographical Plan - Parking Lot	2015	3,259		20	163	163	326	25
26	Hot Water Heater	2015	10,388		20	519	519	1,039	26
27	Replace Injection Pump & Thermostat Seal	2015	8,303		20	415	415	830	27
28	Door Operator East Elevation Courtyard	2016	3,316		20	166	166	166	28
29	Electrical Panel-Circuits From Electrical Room To Therapy Room	2016	6,300		20	315	315	315	29
30	Condensing Unit	2016	6,650		20	333	333	333	30
31	Heat Exchanger	2016	2,500		20	125	125	125	31
32	Fr Door Operator	2016	2,940		20	147	147	147	32
33	Injector Pump For Air System	2016	2,564		20	128	128	128	33
34	TOTAL (lines 1 thru 33)		\$ 12,578,882	\$ 7,071		\$ 206,976	\$ 199,905	\$ 11,148,519	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		\$12,578,882	\$7,071		\$206,976	\$199,905	\$11,148,519	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,578,882	\$7,071		\$206,976	\$199,905	\$11,148,519	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		\$12,578,882	\$7,071		\$206,976	\$199,905	\$11,148,519	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)		\$12,578,882	\$7,071		\$206,976	\$199,905	\$11,148,519	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 12,578,882	\$ 7,071		\$ 206,976	\$ 199,905	\$ 11,148,519	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)		\$ 12,578,882	\$ 7,071		\$ 206,976	\$ 199,905	\$ 11,148,519	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Building Company		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Landscaping	1994	25,996		20			25,996	9
10 Sprinkler System	1994	8,900		20			8,900	10
11 Sign- Awning	1994	9,474		20			9,474	11
12 Repair Hot Water System Causing Flood	2008	3,256		20	163	163	1,345	12
13 Installation of 240 Volt Line for Hall Heater; Removed & Replace	2008	3,260		20	163	163	1,318	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)		\$ 50,886	\$		\$ 326	\$ 326	\$ 47,033	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 50,886	\$		\$ 326	\$ 326	\$ 47,033	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
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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)		\$ 50,886	\$		\$ 326	\$ 326	\$ 47,033	34

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

Facility Name & ID Number Symphony of Park South

0053744

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-Maestro	2004	84,385	2,164	35	2,411	247	31,644	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 7257 N. Lincoln-Maestro	2015	1,330	126	20	89	(37)	118	9
10	Allocated from 7257 N. Lincoln-Maestro	2005	7,693	54	20	276	222	5,365	10
11	Allocated from 7257 N. Lincoln-Maestro	2004	1,677		20	84	84	1,048	11
12									12
13	Allocated from Maestro Consulting Services	2003	686		20	34	34	450	13
14	Allocated from Maestro Consulting Services	2004	13,936		20	756	756	8,868	14
15	Allocated from Maestro Consulting Services	2005	826		20	41	41	490	15
16	Allocated from Maestro Consulting Services	2006	1,120		20	56	56	581	16
17	Allocated from Maestro Consulting Services	2008	1,181		20	59	59	488	17
18	Allocated from Maestro Consulting Services	2009	19,011		20	892	892	7,234	18
19	Allocated from Maestro Consulting Services	2010	2,921		20	146	146	951	19
20	Allocated from Maestro Consulting Services	2011	158		20	8	8	47	20
21	Allocated from Maestro Consulting Services	2012	176		20	9	9	42	21
22	Allocated from Maestro Consulting Services	2014	2,197		20	110	110	286	22
23	Allocated from Maestro Consulting Services	2015	618		20	31	31	41	23
24	Allocated from Maestro Consulting Services	2016	2,708	105	20	105		105	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)		\$ 140,623	\$ 2,449		\$ 5,107	\$ 2,658	\$ 57,758	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$140,623	\$2,449		\$5,107	\$2,658	\$57,758	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$140,623	\$2,449		\$5,107	\$2,658	\$57,758	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,023,295	\$	\$82,783	\$82,783	10	\$855,784	71
72	Current Year Purchases	33,625	283	3,351	3,068	10	3,398	72
73	Fully Depreciated Assets	2,824,735		199	199	10	2,856,557	73
74								74
75	TOTALS	\$3,881,654	\$283	\$86,333	\$86,050		\$3,715,739	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Maestro consultin	2016	\$519	\$	\$	\$	5	\$519	76
77										77
78										78
79										79
80	TOTALS			\$519	\$	\$	\$		\$519	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$17,325,431	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$7,354	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$293,308	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$285,954	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$14,864,777	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land - 2012	\$44,811	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$44,811	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Main Street (Sale/Leaseback Arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$2,066,028			3
4	Additions				(2,066,028)			4
5								5
6	Allocated from Maestro				8,866			6
7	TOTAL				\$8,866			7

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?

☐ YES

☐ NO
16. Rental Amount for movable equipment: \$63,345Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Maestro		\$	\$4,773	17
18					18
19					19
20					20
21	TOTAL		\$-	\$4,773	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 563,709	\$		\$ 563,709	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			205,601			205,601	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			538,304			538,304	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				267,364		267,364	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					302,376	98,861		401,237	13
14	TOTAL			\$		\$ 1,609,990	\$ 366,225		\$ 1,976,215	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,726	\$	1
2	Cash-Patient Deposits	49,010		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,694,923		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,504		6
7	Other Prepaid Expenses	237		7
8	Accounts Receivable (owners or related parties)	1,013,860		8
9	Other(specify): <u>See Attached Schedule</u>	255,323		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,022,583	\$	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	6,300		15
16	Equipment, at Historical Cost	43,548		16
17	Accumulated Depreciation (book methods)	(4,664)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 45,184	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,067,767	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,732,802	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,010		28
29	Short-Term Notes Payable	4,152,342		29
30	Accrued Salaries Payable	126,410		30
31	Accrued Taxes Payable (excluding real estate taxes)	93,144		31
32	Accrued Real Estate Taxes(Sch.IX-B)	695,835		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>	731,127		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,580,670	\$	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)	\$ 9,580,670	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (512,903)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,067,767	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 136,070	1
2	Restatements (describe):		2
3	Adjustment for Equity restatement	(34,705)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 101,365	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(614,268)	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)	\$ (614,268)	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)	\$ (512,903)	24 *

* This must agree with page 17, line 47.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,102,442	1
2	Discounts and Allowances for all Levels	(218,063)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,884,379	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	692,829	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 692,829	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	501	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	223	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,646	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,370	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,179	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,585,757	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,096,978	31
32	Health Care	6,473,132	32
33	General Administration	4,796,942	33
	B. Capital Expense		
34	Ownership	2,982,434	34
	C. Ancillary Expense		
35	Special Cost Centers	2,199,861	35
36	Provider Participation Fee	650,678	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,200,025	40
41	Income before Income Taxes (line 30 minus line 40)**	(614,268)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (614,268)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 10,170,593	44
45	Private Pay - Net Inpatient Revenue	684,268	45
46	Medicare - Net Inpatient Revenue	4,343,254	46
47	Other-(specify) Managed Care	1,547,917	47
48	Other-(specify) Veterans/Hospice	1,138,347	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 17,884,379	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,949	2,177	\$ 123,295	\$ 56.64	1
2	Assistant Director of Nursing	1,926	2,012	86,305	42.90	2
3	Registered Nurses	39,305	42,686	1,366,798	32.02	3
4	Licensed Practical Nurses	71,403	76,687	2,082,827	27.16	4
5	CNAs & Orderlies	152,505	163,746	1,806,113	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,314	1,453	34,983	24.08	9
10	Activity Assistants	5,564	5,937	65,658	11.06	10
11	Social Service Workers	8,747	9,537	213,064	22.34	11
12	Dietician					12
13	Food Service Supervisor	2,201	2,507	51,471	20.53	13
14	Head Cook	3,473	3,734	67,170	17.99	14
15	Cook Helpers/Assistants	24,115	26,519	285,076	10.75	15
16	Dishwashers					16
17	Maintenance Workers	3,917	4,233	85,854	20.28	17
18	Housekeepers	20,060	22,324	255,163	11.43	18
19	Laundry	11,254	12,457	127,563	10.24	19
20	Administrator	1,753	2,304	158,666	68.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,834	14,764	258,082	17.48	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	2,298	2,533	36,627	14.46	31
32	Other Health Care(specify)					32
33	Other(specify)	5,713	6,243	137,611	22.04	33
34	TOTAL (lines 1 - 33)	371,331	401,853	\$ 7,242,326 *	\$ 18.02	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	405	\$ 19,019	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	7,501	10-03	38
39	Pharmacist Consultant	Monthly	40,620	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	292	14,615	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,613	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	Psychiatric Consultant	\$140 per eval	31,000	10-03	48
49	TOTAL (lines 35 - 48)	745	\$ 139,368		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.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$30,740
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,664 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? Yes
If YES, give effective date of lease. 11/1/15
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Renaissance Park South #0049098
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 650,678
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 39,016 Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees