

		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: 0053751

Facility Name: Symphony of South Shore

Address: 2425 East 71st St Chicago 60649
Number City Zip Code

County: Cook

Telephone Number: (773) 721-5000 Fax # (773) 721-6850

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2015

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

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

Facility Name & ID Number Symphony of South Shore

0053751 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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>248</u>	Skilled (SNF)	<u>248</u>	<u>90,768</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>248</u>	TOTALS	<u>248</u>	<u>90,768</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>13,904</u>	<u>13,904</u>	8
9	SNF/PED					9
10	ICF	<u>37,594</u>	<u>3,994</u>	<u>25,851</u>	<u>67,439</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,594</u>	<u>3,994</u>	<u>39,755</u>	<u>81,343</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.62%

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 10/23/1998

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/23/1998 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 248 and days of care provided 13,904

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Symphony of South Shore # 0053751 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	465,986	53,286	20,371	539,643		539,643		539,643			1
2	Food Purchase		506,732		506,732	(28,548)	478,184	(248)	477,936			2
3	Housekeeping	240,500	58,795		299,295		299,295		299,295			3
4	Laundry	172,724	13,227	25,989	211,940		211,940		211,940			4
5	Heat and Other Utilities			311,842	311,842		311,842	(7,318)	304,524			5
6	Maintenance	111,584		299,427	411,011		411,011	24,854	435,865			6
7	Other (specify):*							4,206	4,206			7
8	TOTAL General Services	990,794	632,040	657,629	2,280,463	(28,548)	2,251,915	21,494	2,273,409			8
	B. Health Care and Programs											
9	Medical Director			135,190	135,190		135,190		135,190			9
10	Nursing and Medical Records	5,968,592	397,978	44,603	6,411,173		6,411,173	159,869	6,571,042			10
10a	Therapy	21,855		38,859	60,714		60,714		60,714			10a
11	Activities	159,532	9,293	1,980	170,805		170,805		170,805			11
12	Social Services	286,571			286,571		286,571		286,571			12
13	CNA Training											13
14	Program Transportation			27,265	27,265		27,265	(4,266)	22,999			14
15	Other (specify):*							25,122	25,122			15
16	TOTAL Health Care and Programs	6,436,550	407,271	247,897	7,091,718		7,091,718	180,726	7,272,444			16
	C. General Administration											
17	Administrative	183,071		1,103,806	1,286,877		1,286,877	(1,057,708)	229,169			17
18	Directors Fees											18
19	Professional Services			417,987	417,987		417,987	21,735	439,722			19
20	Dues, Fees, Subscriptions & Promotions			73,055	73,055		73,055	(4,762)	68,293			20
21	Clerical & General Office Expenses	285,343	49,636	928,684	1,263,663		1,263,663	(481,308)	782,355			21
22	Employee Benefits & Payroll Taxes			1,461,028	1,461,028	28,548	1,489,576		1,489,576			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,631	4,631		4,631	1,505	6,136			24
25	Other Admin. Staff Transportation			3,689	3,689		3,689	3,729	7,418			25
26	Insurance-Prop.Liab.Malpractice			917,675	917,675		917,675	4,361	922,036			26
27	Other (specify):*							58,063	58,063			27
28	TOTAL General Administration	468,414	49,636	4,910,555	5,428,605	28,548	5,457,153	(1,454,386)	4,002,767			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,895,758	1,088,947	5,816,081	14,800,786		14,800,786	(1,252,166)	13,548,620			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			11,951	11,951		11,951	252,435	264,386			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			157,260	157,260		157,260	(5,522)	151,738			32
33	Real Estate Taxes			566,421	566,421		566,421	5,730	572,151			33
34	Rent-Facility & Grounds			2,609,927	2,609,927		2,609,927	(2,602,449)	7,478			34
35	Rent-Equipment & Vehicles			67,394	67,394		67,394	7,259	74,653			35
36	Other (specify):*											36
37	TOTAL Ownership			3,412,953	3,412,953		3,412,953	(2,342,547)	1,070,406			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		617,373	2,468,845	3,086,218		3,086,218	(22,219)	3,063,999			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			544,075	544,075		544,075		544,075			42
43	Other (specify):*	61,567		174,501	236,068		236,068	(236,068)	0			43
44	TOTAL Special Cost Centers	61,567	617,373	3,187,421	3,866,361		3,866,361	(258,287)	3,608,074			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,957,325	1,706,320	12,416,455	22,080,100		22,080,100	(3,852,999)	18,227,101			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	(9,884)	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	250,130	30		9
10	Interest and Other Investment Income	(5,522)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(248)	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	(11,893)	21		18
19	Entertainment				19
20	Contributions	(14,950)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(526,926)	21		24
25	Fund Raising, Advertising and Promotional	(2,316)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,166,664)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,488,273)		\$	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)	(364,726)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (364,726)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,852,999)		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#

0053751

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Community Relations	\$ 1,240	43	1
2	Guest Relations	(62,807)	43	2
3	Marketing Consultant	(95,168)	43	3
4	Marketing Services	(79,333)	43	4
5	Bank Charges	(988)	21	5
6	Patient Need	(1,953)	10	6
7	Theft & Damage Loss	(195)	21	7
8	Medicare Sequestration	(281,882)	21	8
9	PAC Dues	(6,671)	20	9
10	Additional R&M	6,007	06	10
11	Main Street Sale/Leaseback Arrangement	(2,609,927)	34	11
12	Non Allowable Legal Fees	(25,016)	19	12
13	Capitalized R&M	(9,972)	06	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,166,664)		49

ID#

0053751

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

Summary B

12/31/16

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

[illegible]

VII. RELATED PARTIES

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

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

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

YES

X NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	MAESTRO CONSULTING SERVICES LLC	100.00%	\$ 2,566	\$ 2,566	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	23,494	23,494	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	5,324	5,324	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,206	4,206	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	161,822	161,822	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	25,122	25,122	20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	46,098	46,098	21
22	V	17	ADMINISTRATIVE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%			22
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	46,751	46,751	23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	19,175	19,175	24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	302,863	302,863	25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	37,713	37,713	26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,505	1,505	27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	3,729	3,729	28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,361	4,361	29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	58,063	58,063	30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	2,305	2,305	31
32	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	5,730	5,730	32
33	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	7,478	7,478	33
34	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	3,233	3,233	34
35	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,026	4,026	35
36	V								36
37	V	17	MANAGEMENT FEES	1,103,806	MAESTRO CONSULTING SERVICES LLC	100.00%		(1,103,806)	37
38	V								38
39	Total			\$ 1,103,806			\$ 765,565	\$ * (338,241)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & Medical Supplies	\$ 219,338	Integra Healthcare Equipment, LLC		\$ 197,119	\$ (22,219)	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			\$ 219,338			\$ 197,119	\$ * (22,219)	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	\$ 32,343	Lifeline Ambulance LLC	100.00%	\$ 28,077	\$ (4,266)	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			\$ 32,343			\$ 28,077	\$ * (4,266)	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	\$ 351,015	Maple Leaf Insurance	100.00%	\$ 351,015	\$	15
16	V	26	Liability Insurance	451,529	Maple Leaf Insurance	100.00%	451,529		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 802,544			\$ 802,544	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Symcare Healthcare LLC	99.99%	CALIFORNIA GARDENS	CHICAGO	MAESTRO CONSULTING SERV	LINCOLNWOOD	MANAGEMENT	1
2	Symcare HMG LLC	0.01%	MAPLECREST CARE CENTRE	BELVIDERE	7257 N. LINCOLN AVENUE	LINCOLNWOOD	BUILDING RENTAL	2
3			MCKINLEY COURT	DECATUR	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY/WORK COMP IN	3
4			MONROE PAVILION	CHICAGO	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	4
5			NORTHWOODS CARE CENTRE	BELVIDERE	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERVICES	5
6			SYCAMORE VILLAGE	SWANSEA	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	6
7			SYMPHONY ARIA	HILLSIDE				7
8			SYMPHONY AT 87TH STREET	CHICAGO				8
9			SYMPHONY AT MIDWAY	CHICAGO				9
10			SYMPHONY AT THE TILLERS	OSWEGO				10
11			SYMPHONY OF BRONZEVILLE	CHICAGO				11
12			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				12
13			SYMPHONY OF CHESTERTON	CHESTERTON, IN				13
14			SYMPHONY OF 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 MORGAN PARK	CHICAGO				25
26			SYMPHONY OF ORCHARD VALLEY	AURORA				26
27			SYMPHONY OF SOUTH SHORE	CHICAGO				27
28			SYMPHONY RESIDENCES OF LINCOLN PARK	CHICAGO				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									\$		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 South Shore # 0053751 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

Ending: 12/31/16

(847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,836,222	28	\$ 51,919	\$	90,768	\$ 2,566	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	475,288	90,768	23,494	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711		90,768	5,324	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090		90,768	4,206	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	3,273,643	90,768	161,822	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220		90,768	25,122	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	932,558	90,768	46,098	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28			90,768		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768		90,768	46,751	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900		90,768	19,175	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	6,126,863	90,768	302,863	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920		90,768	37,713	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439		90,768	1,505	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434		90,768	3,729	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214		90,768	4,361	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614		90,768	58,063	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621		90,768	2,305	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912		90,768	5,730	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288		90,768	7,478	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399		90,768	3,233	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453		90,768	4,026	21
22										22
23										23
24										24
25	TOTALS					\$ 15,487,256	\$ 10,808,353		\$ 765,564	25

Facility Name & ID Number Symphony of South Shore # 0053751 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	39	DME & Medical Supplies	Direct Allocation		\$	\$		\$ 197,119	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				\$	\$		\$ 197,119	25

Facility Name & ID Number Symphony of South Shore # 0053751 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	14	Transportation	Direct Allocation			\$	\$		\$ 28,077	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					\$	\$		\$ 28,077	25

Facility Name & ID Number Symphony of South Shore # 0053751 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	22	Workers Compensation	Direct Allocation			\$	\$		\$ 351,015	1
2	26	Liability Insurance	Direct Allocation						451,529	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 802,544	25

Facility Name & ID Number Symphony of South Shore # 0053751 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 South Shore # 0053751 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 South Shore # 0053751 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 South Shore # 0053751 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 South Shore # 0053751 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	RCA		X	Note Payable				138,173					6
7	The Private Bank		X	Line of Credit								157,260	7
8					-								8
9	TOTAL Facility Related						\$	\$ 138,173			\$ 157,260	9	
	B. Non-Facility Related*												
10	Interest Income		X									(5,522)	10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$	\$			\$ (5,522)	14	
15	TOTALS (line 9+line14)						\$	\$ 138,173			\$ 151,738	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.)

B. Real Estate Taxes

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Symphony of South Shore

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0053751

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>21-30-101-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>45,908.74</u>	\$ <u>45,908.74</u>
2. <u>21-30-101-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>86,332.70</u>	\$ <u>86,332.70</u>
3. <u>21-30-101-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>234,149.90</u>	\$ <u>234,149.90</u>
4. <u>21-30-101-022-0000</u>	<u>Long Term Care Property</u>	\$ <u>66,907.57</u>	\$ <u>66,907.57</u>
5. <u>21-30-101-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>158,217.58</u>	\$ <u>158,217.58</u>
6. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>95,270.31</u>	\$ <u>4,709.40</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>686,786.80</u>	\$ <u>596,225.89</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.

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.

FACILITY NAME Symphony of South Shore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053751

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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.)

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.

A. Square Feet:

80,865

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Allocated from Maestro Consulting/7257 Lincoln			\$ 7,909	1
2					2
3	TOTALS			\$ 7,909	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various		1998		78,106		20	3,905	3,905	70,907	9	
10	Various		1999		88,720		20	4,436	4,436	78,203	10	
11	Various		2000		72,602		20	3,630	3,630	60,501	11	
12	Various		2001		45,629		20	2,281	2,281	35,674	12	
13	Various		2002		11,757		20			11,757	13	
14	Various		2003		16,299		20			16,299	14	
15	Various		2004		62,649		20			62,649	15	
16	Various		2005		10,333		20	315	315	9,235	16	
17	Various		2006		72,736		20	1,871	1,871	64,798	17	
18	Various		2007		176,978		20	17,306	17,306	169,636	18	
19	Various		2008		131,853		20	11,460	11,460	95,117	19	
20	Various		2009		477,567		20	38,058	38,058	328,734	20	
21	Various		2010		138,348		20	8,462	8,462	100,438	21	
22	Various		2011		211,126		20	19,935	19,935	112,353	22	
23	Various		2012		39,292		20	3,326	3,326	15,229	23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	118,621	2,066		4,308	2,242	48,720	68
69	Financial Statement Depreciation		11,951			(11,951)		69
70	TOTAL (lines 4 thru 69)	\$ 1,752,615	\$ 14,017		\$ 119,294	\$ 105,277	\$ 1,280,248	70

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

Facility Name & ID Number Symphony of South Shore

0053751

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		\$ 1,752,615	\$ 14,017		\$ 119,294	\$ 105,277	\$ 1,280,248	1
2	Security System-Replace Dvr,Cameras,Cctv On Parking Lot & Str	2013	4,878		20	976	976	3,577	2
3	Awning	2013	6,380		20	638	638	2,286	3
4	Entrance & Ramp Of Parking Garage	2013	32,575		20	2,172	2,172	7,782	4
5	Wiring For Wi-Fi	2013	7,388		20	1,478	1,478	5,541	5
6	8 Cctvs	2013	4,220		20	844	844	2,954	6
7	Divider Wall, Cabinet-Room 339, Window Sills-All Resident Room	2013	16,680		20	3,336	3,336	10,842	7
8	Install 2 Cctv Outside Facing Parking Lot	2013	3,310		20	331	331	1,076	8
9	Sprinkler System	2013	9,422		20	942	942	3,062	9
10	Hvac Motors & Blowers	2013	4,813		20	963	963	3,770	10
11	1St - 4Th Floors - Flooring, Light Fixtures, Paint, Cabinetry, Wall	2013	616,651		20	30,833	30,833	110,483	11
12	Elevator Repairs & 16 Led Recessed Cans	2013	5,480		20	274	274	845	12
13	Replace Lighting Balast Parking Lot Top & Mounted On Bldg, Re	2013	6,660		20	333	333	1,332	13
14	Boiler Repairs - 4 Ignitors And 2 Boards	2013	6,957		20	348	348	1,362	14
15	Window Replacement For Foom 208 And Window For Attic Stock	2013	2,716		20	136	136	521	15
16	Replaced Roof Outside Oxygen Room	2013	3,920		20	196	196	702	16
17	Labor & Material To Service And Replace Siemens Elevator Lines	2013	2,718		20	136	136	419	17
18	A/C Repair	2013	3,243		20	162	162	595	18
19	Tiling - Therapy Room	2013	3,302		20	165	165	509	19
20	Corner Guards For Entire 1St, 2Nd, 4Th & Part Of 3Rd Floors	2013	3,564		20	178	178	564	20
21	Brackets, Window Sills In Bistro & Dining Room	2014	5,610		20	281	281	842	21
22	Cabinets, Studs, Drywall For Therapy Room	2014	2,970		20	148	148	433	22
23	Electrical Work - Therapy Room	2014	9,800		20	490	490	1,429	23
24	Signs & Banners For Entire 1St Floor	2014	2,554		20	255	255	660	24
25	Treatement In Resident Rooms, Surface Top In Dinnig Room	2014	139,380		20	6,969	6,969	18,003	25
26	5 Wanderguard Complete System	2014	14,754		20	738	738	1,967	26
27	1 Fire Alarm System Device, 1 Replaced Tamper Panel Trouble B	2014	7,755		20	388	388	872	27
28	Electrical Work In Parking Lot, Install New Cameras In The Park	2014	6,020		20	301	301	627	28
29	Install 10 New Security Cameras.	2014	5,170		20	1,034	1,034	2,413	29
30	Pump Repair & Replace Motor For Water Heater	2014	2,818		20	141	141	399	30
31	Repair Pipe In Dietary Area	2014	2,850		20	143	143	297	31
32	Remove & Install New Vinyl Plank & Base	2014	7,750		20	388	388	775	32
33	Commercial Water Heater	2015	7,841		20	392	392	784	33
34	TOTAL (lines 1 thru 33)		\$ 2,712,763	\$ 14,017		\$ 175,400	\$ 161,383	\$ 1,467,972	34

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

Facility Name & ID Number Symphony of South Shore

0053751

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 12B, Carried Forward		\$ 2,712,763	\$ 14,017		\$ 175,400	\$ 161,383	\$ 1,467,972	1
2	Installed New Pump For Boiler	2015	4,490		20	224	224	449	2
3	Install New Recirculating Pump For Boiler	2015	4,068		20	203	203	407	3
4	Repaired Pump Valves	2015	2,794		20	140	140	279	4
5	Parking Lot Work	2015	365,310		20	18,266	18,266	36,531	5
6	Wall Mount Charging Station	2015	3,684		20	184	184	368	6
7	Camera / Indoor Keypads / Electrical In Kitchen	2016	2,560		20	128	128	128	7
8	Kitchen Improvements - New Walls, Flooring	2016	4,670		20	234	234	234	8
9	Plumbing Service / Piping	2016	8,150		20	408	408	408	9
10	Kitchen Improvements - Drywall & Trim	2016	6,500		20	325	325	325	10
11	Install 2 New Hand Washing	2016	12,800		20	640	640	640	11
12	Fan Motors	2016	5,848		20	292	292	292	12
13	Booster System - New Motor, Seals, Gauges	2016	3,266		20	163	163	163	13
14	Restore South Side Of Garage Roof By Patch/New Frame/Pour Co	2016	2,700		20	135	135	135	14
15	Repair Boilers - Vacuum,Piping,Electricals,Controls,Air Intakes/V	2016	4,498		20	225	225	225	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)		\$ 3,144,101	\$ 14,017		\$ 196,967	\$ 182,950	\$ 1,508,556	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 12C, Carried Forward		\$ 3,144,101	\$ 14,017		\$ 196,967	\$ 182,950	\$ 1,508,556	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
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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)		\$ 3,144,101	\$ 14,017		\$ 196,967	\$ 182,950	\$ 1,508,556	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		\$ 3,144,101	\$ 14,017		\$ 196,967	\$ 182,950	\$ 1,508,556	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)		\$ 3,144,101	\$ 14,017		\$ 196,967	\$ 182,950	\$ 1,508,556	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 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		\$	\$		\$	\$	\$	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Symphony of South Shore

0053751

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from Maestro Consulting/7257 Lincoln	2004	71,182	1,825	35	2,034	209	26,693	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Maestro Consulting Services	2003	579		20	29	29	380	9
10 Allocated from Maestro Consulting Services	2004	11,755		20	638	638	7,480	10
11 Allocated from Maestro Consulting Services	2005	697		20	35	35	413	11
12 Allocated from Maestro Consulting Services	2006	945		20	47	47	490	12
13 Allocated from Maestro Consulting Services	2008	996		20	50	50	411	13
14 Allocated from Maestro Consulting Services	2009	16,037		20	752	752	6,102	14
15 Allocated from Maestro Consulting Services	2010	2,464		20	123	123	802	15
16 Allocated from Maestro Consulting Services	2011	133		20	7	7	39	16
17 Allocated from Maestro Consulting Services	2012	148		20	7	7	35	17
18 Allocated from Maestro Consulting Services	2014	1,854		20	93	93	242	18
19 Allocated from Maestro Consulting Services	2015	521		20	26	26	35	19
20 Allocated from Maestro Consulting Services	2016	2,284	88	20	88		88	20
21								21
22 Allocated from Maestro Consulting/7257 Lincoln	2015	1,122	107	20	75	(32)	100	22
23 Allocated from Maestro Consulting/7257 Lincoln	2005	6,489	46	20	233	187	4,526	23
24 Allocated from Maestro Consulting/7257 Lincoln	2004	1,415		20	71	71	884	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)		\$ 118,621	\$ 2,066		\$ 4,308	\$ 2,242	\$ 48,720	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 118,621	\$ 2,066		\$ 4,308	\$ 2,242	\$ 48,720	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 118,621	\$ 2,066		\$ 4,308	\$ 2,242	\$ 48,720	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	\$617,396	\$	\$59,121	\$59,121	10	\$484,552	71
72	Current Year Purchases	82,786	239	8,130	7,891	10	8,169	72
73	Fully Depreciated Assets	779,477		168	168	10	806,320	73
74								74
75	TOTALS	\$1,479,658	\$239	\$67,419	\$67,180		\$1,299,041	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 Consulti	2016	\$438	\$	\$	\$	5	\$438	76
77										77
78										78
79										79
80	TOTALS			\$438	\$	\$	\$		\$438	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,632,107	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$14,256	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$264,386	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$250,130	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,808,035	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$8,195	92
93			93
94			94
95		\$8,195	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

☒ YES

☐ NO

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

**

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 55,177
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2016 Ford T350HD	\$ 919	\$ 15,449	17
18	Allocated from Maestro Consulting			4,026	18
19					19
20					20
21	TOTAL		\$ 919	\$ 19,475	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	\$		\$ 991,769	\$		\$ 991,769	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			261,801			261,801	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			990,539			990,539	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				414,862		414,862	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					224,736	202,511		427,247	13
14	TOTAL			\$		\$ 2,468,845	\$ 617,373		\$ 3,086,218	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	\$ 1,285	\$	1
2	Cash-Patient Deposits	41,806		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,505,488		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,500		6
7	Other Prepaid Expenses	2,180		7
8	Accounts Receivable (owners or related parties)	900,457		8
9	Other(specify): <u>See Attached Schedule</u>	247,964		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,701,680	\$	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	34,680		15
16	Equipment, at Historical Cost	107,148		16
17	Accumulated Depreciation (book methods)	(12,045)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	548,519		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 678,302	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,379,982	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,918,732	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,806		28
29	Short-Term Notes Payable	138,173		29
30	Accrued Salaries Payable	154,498		30
31	Accrued Taxes Payable (excluding real estate taxes)	100,512		31
32	Accrued Real Estate Taxes(Sch.IX-B)	542,745		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>	789,116		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,685,582	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	136,789		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 136,789	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,822,371	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 557,611	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,379,982	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 245,855	1
2	Restatements (describe):		2
3	Equity Restatement	(19,375)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 226,480	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	331,131	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)	\$ 331,131	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)	\$ 557,611	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	\$21,675,252	1
2	Discounts and Allowances for all Levels	(304,857)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$21,370,395	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,022,526	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$1,022,526	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	9,525	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,050	19
20	Radiology and X-Ray		20
21	Other Medical Services	213	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$12,788	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,522	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$5,522	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)	\$22,411,231	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,280,463	31
32	Health Care	7,091,718	32
33	General Administration	5,428,605	33
	B. Capital Expense		
34	Ownership	3,412,953	34
	C. Ancillary Expense		
35	Special Cost Centers	3,322,286	35
36	Provider Participation Fee	544,075	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$22,080,100	40
41	Income before Income Taxes (line 30 minus line 40)**	331,131	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$331,131	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$9,559,576	44
45	Private Pay - Net Inpatient Revenue	794,224	45
46	Medicare - Net Inpatient Revenue	7,849,493	46
47	Other-(specify)Managed Care	2,436,128	47
48	Other-(specify)Hospice	730,974	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$21,370,395	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	1,758	2,105	\$ 115,980	\$ 55.10	1
2	Assistant Director of Nursing	2,827	3,562	140,684	39.50	2
3	Registered Nurses	42,421	45,738	1,534,972	33.56	3
4	Licensed Practical Nurses	78,612	82,714	2,322,596	28.08	4
5	CNAs & Orderlies	143,182	154,253	1,804,758	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,598	1,773	21,855	12.33	8
9	Activity Director	2,088	2,214	52,918	23.90	9
10	Activity Assistants	8,246	8,997	106,614	11.85	10
11	Social Service Workers	8,988	10,046	266,415	26.52	11
12	Dietician					12
13	Food Service Supervisor	6,098	6,656	149,755	22.50	13
14	Head Cook	3,432	3,633	64,775	17.83	14
15	Cook Helpers/Assistants	22,455	24,272	251,456	10.36	15
16	Dishwashers					16
17	Maintenance Workers	4,636	4,830	111,584	23.10	17
18	Housekeepers	18,226	19,778	240,500	12.16	18
19	Laundry	13,793	15,033	172,724	11.49	19
20	Administrator	2,088	2,125	182,607	85.93	20
21	Assistant Administrator	10	13	464	35.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,827	14,823	285,343	19.25	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	625	667	16,859	25.28	31
32	Other Health Care(specify)					32
33	Other(specify)	4,732	5,238	114,466	21.85	33
34	TOTAL (lines 1 - 33)	379,642	408,470	\$ 7,957,325 *	\$ 19.48	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	433	\$ 20,371	01-03	35
36	Medical Director	Monthly	135,190	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	62	3,390	10-03	38
39	Pharmacist Consultant	Monthly	41,213	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	777	38,859	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,980	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,308	\$ 241,003		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.

STATE OF ILLINOIS

Facility Name & ID NumberSymphony of South Shore# 0053751Report Period Beginning:01/01/16Ending:12/31/16Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Ebony Scott

Administrator

0.00

\$ 182,607

Laura A. Aranda

Asst. Admin

0.00

464

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 183,071

B. Administrative - Other

Description

Amount

Management Fees - Maestro Consulting

\$ 1,103,806

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 1,103,806

C. Professional Services

Vendor/Payee

Type

Amount

See Attached

Legal Fees

\$ 48,508

Marcum LLP

Accounting Fees

48,014

Achieve Accreditation

Other Professional

8,649

Corporation Service

Due Diligence

1,255

Engineering Resources

Topographical Plan

4,328

Health Dimensions Group

Management Consulting

899

Klein & Hoffman

Water Management

3,513

Language Line Service

Translation

3,056

Maestro Consulting

Consulting Services

106,195

Medical Business Office

Medical Coding

56,555

Personnel Planners

Unemployment Consulting

7,630

See Supplemental Schedule

129,385

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 417,988

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 351,015

Unemployment Compensation Insurance

132,842

FICA Taxes

582,524

Employee Health Insurance

333,388

Employee Meals

28,548

Illinois Municipal Retirement Fund (IMRF)*

Pension Plan

43,270

Employee Physical Exams

5,538

Other Employee Benefits

12,451

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,489,576

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

11,382

(Indicate # of checks performed 1138)

Patient Background Checks

605

Dues and Subscription

20,704

License and Permits

10,982

Allocated from Maestro Consulting

19,175

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 68,293

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

4,631

Allocated from Maestro Consulting

1,505

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 6,136

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number		Symphony of South Shore		STATE OF ILLINOIS	#	0053751	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>ICLTC: \$20,214</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>None</u> Line <u>N/A</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>Yes</u> <u>11/1/2015</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>X</u> NO <u> </u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>Renaissance at South Shore IDPH # 0042085</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>544,075</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?			\$ <u>28,548</u> <u>No</u> Indicate the amount. \$ <u>N/A</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% Ln 1</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>No</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>N/A</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							