



Facility Name & ID Number Symphony of Lincoln

# 0051789 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,125	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			4,732	4,732	8
9	SNF/PED					9
10	ICF	13,657	5,843	6,671	26,171	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,657	5,843	11,403	30,903	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.20%

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

N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES  NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES  NO

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

Date started 01/01/2012

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

YES  Date 12/31/2011 NO

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

YES  NO  If YES, enter number of beds certified 99 and days of care provided 4,299

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name &amp; ID Number

Symphony of Lincoln

# 0051789

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

**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
	<b>A. General Services</b>										
1	Dietary	183,076	19,423	13,417	215,916		215,916		215,916		1
2	Food Purchase		180,586		180,586		180,586		180,586		2
3	Housekeeping	147,581	30,442		178,023		178,023		178,023		3
4	Laundry	33,239	9,262	4,480	46,981		46,981		46,981		4
5	Heat and Other Utilities			216,027	216,027		216,027	303	216,330		5
6	Maintenance	72,090	94	142,067	214,251		214,251	3,501	217,752		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	435,986	239,807	375,991	1,051,784		1,051,784	3,804	1,055,588		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			92,400	92,400		92,400		92,400		9
10	Nursing and Medical Records	2,117,111	208,022		2,325,133		2,325,133	36,776	2,361,909		10
10a	Therapy	274,488			274,488		274,488		274,488		10a
11	Activities	67,774		10,396	78,170		78,170		78,170		11
12	Social Services	32,550		11,626	44,176		44,176		44,176		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Mgmt alloc of benef</b>							7,425	7,425		15
16	<b>TOTAL Health Care and Programs</b>	2,491,923	208,022	114,422	2,814,367		2,814,367	44,201	2,858,568		16
	<b>C. General Administration</b>										
17	Administrative	70,693		369,408	440,101		440,101	(369,347)	70,754		17
18	Directors Fees										18
19	Professional Services			191,192	191,192		191,192	(11,343)	179,849		19
20	Dues, Fees, Subscriptions & Promotions			(8,423)	(8,423)		(8,423)	29,414	20,991		20
21	Clerical & General Office Expenses	218,732	25,456	44,393	288,581		288,581	141,661	430,242		21
22	Employee Benefits & Payroll Taxes			630,177	630,177		630,177		630,177		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,335	1,335		1,335	5,309	6,644		24
25	Other Admin. Staff Transportation			20,240	20,240		20,240	355	20,595		25
26	Insurance-Prop.Liab.Malpractice			287,302	287,302		287,302	6,387	293,689		26
27	Other (specify):* <b>Mgmt alloc of benef</b>							26,137	26,137		27
28	<b>TOTAL General Administration</b>	289,425	25,456	1,535,624	1,850,505		1,850,505	(171,427)	1,679,078		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,217,334	473,285	2,026,037	5,716,656		5,716,656	(123,422)	5,593,234		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.

Facility Name &amp; ID Number

Symphony of Lincoln

#0051789

Report Period Beginning:

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Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			58,765	58,765		58,765	2,671	61,436			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			135,772	135,772		135,772	(6,166)	129,606			32
33	Real Estate Taxes			70,574	70,574		70,574	381	70,955			33
34	Rent-Facility & Grounds			498,983	498,983		498,983	(35,176)	463,807			34
35	Rent-Equipment & Vehicles			233,439	233,439		233,439	3,422	236,861			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			997,533	997,533		997,533	(34,868)	962,665			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			7,327	7,327		7,327		7,327			38
39	Ancillary Service Centers		196,464	823,253	1,019,717		1,019,717		1,019,717			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			230,241	230,241		230,241		230,241			42
43	Other (specify):* <b>Non-Allowable Co</b>	16,725		254,747	271,472		271,472	(271,472)				43
44	<b>TOTAL Special Cost Centers</b>	16,725	196,464	1,315,568	1,528,757		1,528,757	(271,472)	1,257,285			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,234,059	669,749	4,339,138	8,242,946		8,242,946	(429,762)	7,813,184			45

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

Facility Name & ID Number Symphony of Lincoln

# 0051789

Report Period Beginning: 01/01/2015

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**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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(24,995)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,253)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,640)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(21,019)	43		18
19	Entertainment				19
20	Contributions	(7,650)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(123,136)	43		24
25	Fund Raising, Advertising and Promotional	(12,866)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(532)	43		28
29	Other-Attach Schedule See Page 5A	(90,470)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (288,561)</b>		<b>\$</b>	<b>30</b>

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	2	
		Amount	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)	(141,201)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (141,201)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (429,762)</b>		<b>37</b>

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

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Nonallowable marketing events	\$ (34,256)	43	1
2	Laboratory Costs	(19,610)	43	2
3	X-Ray Costs	(9,043)	43	3
4	IL Council LTC	27,233	20	4
5	Legal Expense	(38,069)	19	5
6	Admission Salaries	(16,725)	43	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				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	<b>Total</b>		(90,470)	49

**VII. RELATED PARTIES**

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V	N/A						3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ * 0	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Symphony Financial Services, LLC	100.00%	\$ 217	\$ 217
16	V	6 Maintenance		Symphony Financial Services, LLC	100.00%	1,561	1,561
17	V	10 Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	21,878	21,878
18	V	15 Other		Symphony Financial Services, LLC	100.00%	4,017	4,017
19	V	17 Administrative	309,205	Symphony Financial Services, LLC	100.00%		(309,205)
20	V	19 Professional Services-Other		Symphony Financial Services, LLC	100.00%	23,592	23,592
21	V	20 Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	504	504
22	V	21 Clerical & General Office Exp-Salaries		Symphony Financial Services, LLC	100.00%	104,403	104,403
23	V	24 Travel & Seminar		Symphony Financial Services, LLC	100.00%	4,363	4,363
24	V	26 Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	6,387	6,387
25	V	27 Other		Symphony Financial Services, LLC	100.00%	18,524	18,524
26	V	30 Depreciation		Symphony Financial Services, LLC	100.00%	2,015	2,015
27	V	34 Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(35,496)	(35,496)
28	V	35 Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	2,202	2,202
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 309,205			\$ 154,167	\$ * (155,038)

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

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Ending:

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## 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	100.00%	\$ 86	\$	86	15
16	V	6 Maintenance Salaries		Maestro Consulting Services	100.00%	1,398		1,398	16
17	V	6 Maintenance Expenses		Maestro Consulting Services	100.00%	542		542	17
18	V	7 Employee Benefits - Maintenance		Maestro Consulting Services	100.00%	320		320	18
19	V	10 Clinical Salaries		Maestro Consulting Services	100.00%	14,898		14,898	19
20	V	15 Employee Benefits - Clinical		Maestro Consulting Services	100.00%	3,408		3,408	20
21	V	17 Administrative Salaries	60,203	Maestro Consulting Services	100.00%	61		(60,142)	21
22	V	19 Professional Fees		Maestro Consulting Services	100.00%	3,134		3,134	22
23	V	20 Dues, Fees, Subscriptions, Etc.		Maestro Consulting Services	100.00%	1,677		1,677	23
24	V	21 Clerical & General Salaries		Maestro Consulting Services	100.00%	33,223		33,223	24
25	V	21 Clerical & General Expenses		Maestro Consulting Services	100.00%	4,035		4,035	25
26	V	24 Seminars & Education		Maestro Consulting Services	100.00%	946		946	26
27	V	25 Transportation		Maestro Consulting Services	100.00%	355		355	27
28	V	27 Employee Benefits - Administrative		Maestro Consulting Services	100.00%	7,613		7,613	28
29	V	30 Depreciation		Maestro Consulting Services	100.00%	659		659	29
30	V	32 Interest Expense		Maestro Consulting Services	100.00%	87		87	30
31	V	33 Real Estate Tax		Maestro Consulting Services	100.00%	381		381	31
32	V	35 Equipment Rental		Maestro Consulting Services	100.00%	873		873	32
33	V	35 Auto Lease		Maestro Consulting Services	100.00%	347		347	33
34	V	30 Depreciation		Maestro Consulting Services	100.00%	(3)		(3)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 60,203			\$ 74,040	\$ *	13,837	39

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

Facility Name &amp; ID Number

Symphony of Lincoln

# 0051789

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony Decatur		Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid Aurora		Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of Crestwood		Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of Joliet		Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Crest Belvidere					5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony Lincoln					6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co Decatur					7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood Belvidere					8
9	Joseph Hartman	3.00	Symphony of Evanston Healthcare	Evanston				9
10	David J. Hartman	20.00	Symphony of Dyer	Indiana				10
11	Jay Flatt	3.00	Symphony of Crown Point	Indiana	NuCare Services	Lincolnwood	Bookkeeping Mgmt	11
12	Gerry Jenich	10.00			7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00			Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Bronzeville Park	Chicago	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Claremont Rehab. & Living	Buffalo Grove	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Claremont - Hanover Park	Hanover Park	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Claridge Imperial, LTD.	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Jackson Corp	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Monroe Pavillion	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at 87th Street	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Renaissance at Midway	Chicago				22
23			Renaissance at South Shore	Chicago				23
24			Renaissance at Park South	Chicago	* No expense paid by home to the related			24
25			Aria Post Acute Care	Hillside	entity, therefore no page 6 or 8.			25
26			Seven Oaks	Glendale, Wiscosin	** No expense of this related business			26
27			Renaissance East	Mesa, Arizona	allocated to homes			27
28			Renaissance West	Mesa, Arizona				28
29			Renaissance Village IL	Mesa, Arizona				29
30			Renaissance Village AL	Mesa, Arizona				30

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## 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	No owners receive compensation from this facility.								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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Ending: 2/31/2015

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

Name of Related Organization Symphony Financial Services, LLC  
 Street Address 7257 N. Lincoln Ave  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number (847) 933-2600  
 Fax Number ( )

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

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	5	Utilities	Occupied Bed Days	372,277	11	\$ 3,116	\$ 25,941	\$ 217	1
2	6	Maintenance	Occupied Bed Days	372,277	11	22,405	25,941	1,561	2
3	10	Nursing & Med. Records Salary	Occupied Bed Days	372,277	11	313,972	313,972	21,878	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	372,277	11	57,644	25,941	4,017	4
5	19	Professional Service Legal	Occupied Bed Days	372,277	11	5,442	25,941	379	5
6	19	Professional Service Other	Occupied Bed Days	372,277	11	333,134	25,941	23,213	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	372,277	11	7,234	25,941	504	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	372,277	11	1,244,063	1,244,063	86,689	8
9	21	Clerical & Gen ofc expenses	Occupied Bed Days	372,277	11	254,217	25,941	17,714	9
10	24	Travel & Seminar	Occupied Bed Days	372,277	11	62,607	25,941	4,363	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	372,277	11	91,654	25,941	6,387	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	372,277	11	265,831	25,941	18,524	12
13	30	Depreciation	Occupied Bed Days	372,277	11	28,917	25,941	2,015	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	372,277	11	(509,407)	25,941	(35,496)	14
15	35	Rent - Equipment	Occupied Bed Days	372,277	11	14,362	25,941	1,001	15
16	35	Rent - Vehicles	Occupied Bed Days	372,277	11	17,234	25,941	1,201	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,212,425	\$ 1,558,035		\$ 154,167	25

Facility Name & ID Number Symphony of Lincoln

# 0051789 Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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

Name of Related Organization Maestro Consulting Services  
 Street Address 7257 N. Lincoln Ave,  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number ( 847) 933-2600  
 Fax Number ( )

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

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	5	Utilities	Bed Days Available	307,257	28	\$ 3,424	\$ 7,686	\$ 86	1	
2	6	Maintenance Salaries	Bed Days Available	307,257	28	55,893	7,686	1,398	2	
3	6	Maintenance Expenses	Bed Days Available	307,257	28	21,648	7,686	542	3	
4	7	Employee Benefits - Maintenance	Bed Days Available	307,257	28	12,799	7,686	320	4	
5	10	Clinical Salaries	Bed Days Available	307,257	28	595,582	595,582	7,686	14,898	5
6	15	Employee Benefits - Clinical	Bed Days Available	307,257	28	136,244	7,686	3,408	6	
7	17	Administrative Salaries	Bed Days Available	307,257	28	2,420	2,420	7,686	61	7
8	19	Professional Fees	Bed Days Available	307,257	28	125,288	7,686	3,134	8	
9	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	307,257	28	67,058	7,686	1,677	9	
10	21	Clerical & General Salaries	Bed Days Available	307,257	28	1,328,131	1,328,131	7,686	33,223	10
11	21	Clerical & General Expenses	Bed Days Available	307,257	28	161,289	7,686	4,035	11	
12	24	Seminars & Education	Bed Days Available	307,257	28	37,815	7,686	946	12	
13	25	Transportation	Bed Days Available	307,257	28	14,185	7,686	355	13	
14	27	Employee Benefits - Administrative	Bed Days Available	307,257	28	304,341	7,686	7,613	14	
15	30	Depreciation	Bed Days Available	307,257	28	26,334	7,686	659	15	
16	32	Interest Expense	Bed Days Available	307,257	28	3,464	7,686	87	16	
17	33	Real Estate Tax	Bed Days Available	307,257	28	15,239	7,686	381	17	
18	35	Equipment Rental	Bed Days Available	307,257	28	34,911	7,686	873	18	
19	35	Auto Lease	Bed Days Available	307,257	28	13,885	7,686	347	19	
20	30	Depreciation	Direct					(3)	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,959,950	\$ 1,982,026	\$ 74,040	25	

Facility Name &amp; ID Number

Symphony of Lincoln

# 0051789

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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	Name of Lender	2		3	4	5	6		8	9	10						
		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
	<b>Working Capital</b>																
6	The Private Bank		X	Capital Improvements	Interest Only	12/30/2011	2,000,000	15,945	12/30/17	0.0550	654						
7	The Private Bank		X	Line of Credit	Interest Only	12/30/2011	17,520,000	3,295,724	12/29/16	0.0550	135,118						
8																	
9	<b>TOTAL Facility Related</b>						\$	19,520,000	\$	3,311,669		\$	135,772				
	<b>B. Non-Facility Related*</b>																
10																	
11											87						
12											(6,253)						
13																	
14	<b>TOTAL Non-Facility Related</b>						\$		\$			\$	(6,166)				
15	<b>TOTALS (line 9+line14)</b>						\$	19,520,000	\$	3,311,669		\$	129,606				

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>													
1. Real Estate Tax accrual used on 2014 report.			\$	<b>74,400</b>	1										
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2014		\$	<b>70,674</b>	2										
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(3,726)</b>	3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>74,300</b>	4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5										
		Allocated from Mgmt Co.		381											
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>70,955</b>	7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<u>42,738</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____ 14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____ 15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14	15	LESS REFUND FROM LINE 6 \$ _____ 15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
<b>FOR BHF USE ONLY</b>															
13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13														
14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14														
15	LESS REFUND FROM LINE 6 \$ _____ 15														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16														
	2011	<u>42,870</u>	9												
	2012	<u>69,751</u>	10												
	2013	<u>70,799</u>	11												
	2014	<u>70,674</u>	12												
<b>2015 Tax Accrual = \$70,674 * 1.05 = \$74,207.70; use \$74,300</b>															

**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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0051789

CONTACT PERSON REGARDING THIS REPORT Elizabeth Koshy

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-029-019-00</u>	<u>Nursing Home</u>	\$ <u>43,867.28</u>	\$ <u>43,867.28</u>
2. <u>08-029-019-50</u>	<u>Nursing Home</u>	\$ <u>26,807.02</u>	\$ <u>26,807.02</u>
3. <u>10-27-319-028-0000</u>	<u>Land &amp; Property Mgmt. Co.</u>	\$ <u>91,415.94</u>	\$ <u>381.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>162,090.24</u></u>	\$ <u><u>71,055.30</u></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?                 YES        X   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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 33,852 B. General Construction Type: Exterior Masonry Frame Steel/Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Alloc Fr Maestro 7257</u>		<u>2004</u>	<u>\$ 667</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 667</b>	3

Facility Name &amp; ID Number Symphony of Lincoln

# 0051789

Report Period Beginning:

01/01/2015 Ending:

12/31/2015

**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					\$	\$		\$	\$	\$
5										
6										
7										
8		Allocated from Maestro 7257	2004		6,005		39	154	154	2,080
		Improvement Type**								
9		Wiring for EMR 24 Port Pan, Wire Mold, Cable Ties	2012		6,545	328	20	328		894
10		Exterior Sign	2013		21,718	1,086	20	1,086		2,896
11		General Contractor - Hallway, Lobby, Therapy, Vestibule	2013		67,885	3,394	20	3,394		6,994
12		Dining Room, Willow Lane, Redwood Lane & Nurse's Station								
13										
14		Remodeling - Painting, Wall covering, Wallpaper	2013		85,662	8,566	10	8,566		17,846
15		- Hallway, Dining Room, Willow Lane Resident Rooms & Offices								
16										
17		Remodeling - Flooring	2013		67,014	3,351	20	3,351		6,905
18		- Hallway, Lobby, Dining Room & Willow Lane Resident Rooms								
19										
20		Remodeling - Structural, Iron work, Bond beam	2013		33,520	1,676	20	1,676		3,453
21		-Lobby, Entrance and Vestibule								
22										
23		Remodeling - Electrical	2013		25,461	1,273	20	1,273		2,623
24		-Respirator Receptacles, Lobby, Entrance & Willow Lane								
25										
26		Remodeling - Custom millwork - Lobby, Dining Room.	2013		21,400	1,070	20	1,070		2,205
27		Hallway, Nurse's Station and Willow Lane Wing								
28										
29		Remodeling - Drywall - Hallway, Lobby & Willow Lane	2013		74,126	3,706	20	3,706		7,637
30		Resident Rooms								
31										
32		Remodeling - Ceiling Panel - front/back nurse's station	2013		21,400	1,070	20	1,070		2,205
33		Dining Room, Activity Room & Entryway								
34										
35		Remodeling - Roof Fire proofing, Fire sprinklers	2013		14,297	715	20	715		1,474
36		-Lobby, Main Entrance & Roof								

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Symphony of Lincoln

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Remodeling - Nursing station counters & cabinetry	2013	\$ 6,900	\$ 345	20	\$ 345	\$	\$ 711	37
38	- Redwood Lane and Lobby								38
39									39
40									40
41	Facility Remodeling	2014	37,742	1,887	20	1,887		3,460	41
42	-Ceramic flooring, front entrance								42
43	-Electrical:Repair broken pipe on patio, wiremold in								43
44	hallway, activity room, change wiring in ceiling and								44
45	emergency light panel to put front door on emer panel,								45
46	electrical in vestibule, elec for flag light								46
47	-Faucet & drain at nurse station								47
48	-Glass installation, front entrance								48
49	-Stucco application on front entrance								49
50	-General contracting fee								50
51									51
52	Allocated from Maestro Consulting Services	2003	293		39	3	3	175	52
53	Allocated from Maestro Consulting Services	2004	5,949		39	58	58	3,490	53
54	Allocated from Maestro Consulting Services	2005	353		39	3	3	188	54
55	Allocated from Maestro Consulting Services	2006	478		39	5	5	220	55
56	Allocated from Maestro Consulting Services	2008	504		39	5	5	179	56
57	Allocated from Maestro Consulting Services	2009	8,115		20	79	79	2,614	57
58	Allocated from Maestro Consulting Services	2010	1,247		20	12	12	281	58
59	Allocated from Maestro Consulting Services	2011	67		20	1	1	16	59
60	Allocated from Maestro Consulting Services	2012	75		20	1	1	13	60
61	Allocated from Maestro Consulting Services	2014	938		20	9	9	68	61
62	Allocated from Maestro Consulting Services	2015	264		20			2	62
63									63
64	Allocated from Maestro 7257	2004	119		10			69	64
65	Allocated from Maestro 7257	2005	547		10	4	4	362	65
66	Allocated from Maestro 7257	2015	95		15	2	2	2	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 508,719	\$ 28,467		\$ 28,801	\$ 334	\$ 69,063	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 156,742	\$ 27,848	\$ 27,848	\$		\$ 68,482	71
72	Current Year Purchases	29,403	2,450	2,450			2,450	72
73	Fully Depreciated Assets							73
74	See Sch 13A	55,537		2,335	2,335		30,269	74
75	TOTALS	\$ 241,682	\$ 30,298	\$ 32,633	\$ 2,335		\$ 101,201	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Maestro Consulting Services			\$ 222	\$	\$ 2	\$ 2		\$ 222	76
77										77
78										78
79										79
80	TOTALS			\$ 222	\$	\$ 2	\$ 2		\$ 222	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)	\$ 751,290	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,765	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,436	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,671	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 170,486	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

Facility Name:  
IDPH License ID Number:  
Fiscal Year End:

Symphony of Lincoln  
0051789  
12/31/2015

Schedule 13A

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

<b>Category of Equipment</b>	<b>Cost</b>		<b>Current Book Depreciation</b>
Allocated from Symphony Financial Services, LLC		12,327	
Allocated from Maestro Consulting Services		43,210	
<b>TOTAL</b>		55,537	-

<b>Straight Line</b>		<b>Component</b>	<b>Accumulated</b>
<b>Depreciation</b>	<b>Adjustments</b>	<b>Life</b>	<b>Depreciation</b>
2,015	2,015	5-7	4,946
320	320	5-10	25,323
	-		
2,335	2,335		30,269

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Diana Master Landlord, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1973</u>	<u>126</u>	<u>12/31/2011</u>	\$ <u>498,229</u>	<u>10</u>	<u>10</u>	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				<u>(35,176)</u>			6
7	TOTAL		<u>126</u>		\$ <u>463,053</u>			7

10. Effective dates of current rental agreement:

Beginning 12/31/2011

Ending 12/31/2021

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

Fiscal Year Ending                      Annual Rent

12. /2016                      \$ 260,100

13. /2017                      \$ 265,302

14. /2018                      \$ 270,608

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 10.

754

7,545

9. Option to Buy:  YES  NO Terms: N/A\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 226,036 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Administrative</u>	<u>Toyota Corolla</u>	\$ <u>359.40</u>	\$ <u>4,848</u>	17
18	<u>Facility</u>	<u>2015 Ford T350HD</u>	<u>919.49</u>	<u>5,977</u>	18
19					19
20					20
21	TOTAL		\$ <u>1,278.89</u>	\$ <u>10,826</u>	21

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

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

Facility Name: Symphony of Lincoln  
IDPH License ID Number: 0051789  
Fiscal Year End: 12/31/2015

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
MATTRESS/BED	92,800
BIPAP AUTO, HEATED HUMIDIFIRE	965
OXYGEN	85,737
SECURITY CONTAINER	2,085
DISHMACHINE	1,053
CULLIGAN WATER	195
PLANT RENTAL AND SERVICE	344
COMPUTER LEASE	959
COOLER INFINITY	1,076
COPIER	23,174
DIGITAL MUSIC	831
MAILING SYSTEM	723
Concentrator	467
Equipment Fees	2,376
Patient Lift Elec/Scale	9,827
Home Office Allocation	3,423
<b>Total - Line 16</b>	<b>226,036</b>

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/2015 Ending: 12/31/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides.                  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	39(3)	hrs	\$	4,236	\$	305,020	\$	4,236	\$	305,020	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,208		86,999		1,208		86,999	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39(3)	hrs		5,759		414,682		5,759		414,682	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation		hrs									8	
9	Pharmacy	39(2)	# of prescripts					127,002			127,002	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): <u>Oxygen</u>	39(2)						69,462			69,462	12	
13	Other (specify): <u>See Schedule 16A</u>	39(3)					16,552				16,552	13	
14	TOTAL			\$	11,203	\$	823,253	\$	196,464	11,203	\$	1,019,717	14

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

Facility Name: Symphony of Lincoln  
IDPH License ID Number: 0051789  
Fiscal Year End: 12/31/2015

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

<b>Description</b>	<b>Units</b>	<b>Amount</b>
OTHER SERVICES - MEDICARE		2,118
I.V. THERAPY-MEDICARE		9,613
I.V. THERAPY-MANAGED CARE		2,470
PROGRAM CONSULTATN		2,351
<b>Total - Line 12</b>	<b>-</b>	<b>16,552</b>

Facility Name & ID Number Symphony of Lincoln# 0051789Report Period Beginning: 01/01/2015

Ending:

12/31/2015

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (2,041)	\$ (2,041)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>150,956</u> )	5,224,358	5,224,358	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	914	914	6
7	Other Prepaid Expenses	87,827	87,827	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	70,472	70,472	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,381,530	\$ 5,381,530	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		667	13
14	Buildings, at Historical Cost		6,005	14
15	Leasehold Improvements, at Historical Cost	483,670	502,714	15
16	Equipment, at Historical Cost	186,145	241,904	16
17	Accumulated Depreciation (book methods)	(130,989)	(170,486)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Lease Costs</u> )	4,527	4,527	22
23	Other(specify): <u>Deposits</u>	99,283	99,283	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 642,636	\$ 684,614	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,024,166	\$ 6,066,144	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,394,554	\$ 1,394,554	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,735	111,735	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,300	74,300	32
33	Accrued Interest Payable	409	409	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	1,428,744	1,428,744	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,009,742	\$ 3,009,742	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,311,669	3,311,669	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,311,669	\$ 3,311,669	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,321,411	\$ 6,321,411	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (297,245)	\$ (255,267)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,024,166	\$ 6,066,144	48

\*(See instructions.)

**Facility Name:** Symphony of Lincoln  
**IDPH License ID Number:** 0051789  
**Fiscal Year End:** 12/31/2015

**Schedule 17A**

**XV. Balance Sheet**

**Line 9 Current Assets Other (specify):**

Description	Operating	After Consolidation
Trust Fund	54,602	54,602
Reserve for Capex	15,909	15,909
Employee Loans/Wage Assignment	(39)	(39)
<b>Total - Line 9</b>	<b>70,472</b>	<b>70,472</b>

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

Description	Operating	After Consolidation
Exchange Formation	427,969	427,969
Security Deposit Payable	30,566	30,566
Operating Expenses	221,257	221,257
Management Fees - Symphony	185,798	185,798
Clm. Wrkns Comp/ Deduct	122,403	122,403
Accumulated Amortization Deferred	(44,645)	(44,645)
State Unemployment Tax	7,747	7,747
Federal Unemployment Tax	459	459
Sales Tax	242	242
Payroll Taxes Other	14,088	14,088
Accrued Employee Benefits	125,573	125,573
Due to IDPA - Bed Tax	26,270	26,270
Due to/From Kensington	7,555	7,555
Exchange	102,365	102,365

Due to NuCare	4,935	4,935
Due to Symphony Financial	172,806	172,806
Wage Assign & Garnishments	1,772	1,772
Patient Personal Funds	21,584	21,584
<b>Total - Line 36</b>	<b><u>1,428,744</u></b>	<b><u>1,428,744</u></b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (270,124)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	(755)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (270,879)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(26,366)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (26,366)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (297,245)	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Symphony of Lincoln# 0051789Report Period Beginning: 01/01/2015Ending: 12/31/2015

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,762,908	1
2	Discounts and Allowances for all Levels	(1,364,233)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,398,675</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,588,555	6
7	Oxygen	2,186	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,590,741</b>	8
<b>C. Other Operating Revenue</b>			
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	153,274	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,619	19
20	Radiology and X-Ray	4,457	20
21	Other Medical Services	25,509	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 213,859</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	6,253	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 6,253</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Medicare and Managed Care Rentals</b>	7,052	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 7,052</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,216,580</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,051,784	31
32	Health Care	2,814,367	32
33	General Administration	1,850,505	33
<b>B. Capital Expense</b>			
34	Ownership	997,533	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,298,516	35
36	Provider Participation Fee	230,241	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,242,946</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(26,366)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (26,366)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,951,753	44
45	Private Pay - Net Inpatient Revenue	1,109,422	45
46	Medicare - Net Inpatient Revenue	956,815	46
47	Other-(specify) <u>Hospice &amp; ALF</u>	199,969	47
48	Other-(specify) <u>Managed Care &amp; Veteran</u>	180,716	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 6,398,675</b>	49

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

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

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

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

^ - Tax return prepared on cash basis

Facility Name & ID Number Symphony of Lincoln

# 0051789

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

**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	1,906	2,081	\$ 85,759	\$ 41.21	1
2	Assistant Director of Nursing	36	57	1,936	33.96	2
3	Registered Nurses	8,638	9,394	254,773	27.12	3
4	Licensed Practical Nurses	31,605	33,959	833,532	24.55	4
5	CNAs & Orderlies	66,063	69,832	909,628	13.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	22,444	23,441	274,488	11.71	8
9	Activity Director	5,153	5,539	67,774	12.24	9
10	Activity Assistants					10
11	Social Service Workers	2,006	2,146	32,550	15.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,476	17,570	183,076	10.42	15
16	Dishwashers					16
17	Maintenance Workers	2,921	3,199	72,090	22.54	17
18	Housekeepers	13,711	14,561	147,581	10.14	18
19	Laundry	3,349	3,805	33,239	8.74	19
20	Administrator	1,358	1,408	70,693	50.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,823	12,475	218,732	17.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,822	2,096	31,483	15.02	31
32	Other Health C:					32
33	Other(specify) <u>Admissions</u>	627	722	16,725	23.16	33
34	TOTAL (lines 1 - 33)	189,938	202,285	\$ 3,234,059 *	\$ 15.99	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 13,417	1(3)	35
36	Medical Director	Monthly	92,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,589	11(3)	44
45	Social Service Consultant	Monthly	3,226	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 114,632		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
David Turner	Administrator	0	\$ 70,693	Workers' Compensation Insurance	\$ 124,023	IDPH License Fee	\$ 2,200	
				Unemployment Compensation Insurance	76,417	Advertising: Employee Recruitment	722	
				FICA Taxes	247,439	Health Care Worker Background Check		
				Employee Health Insurance	142,299	(Indicate # of checks performed <u>212</u> )	2,540	
				Employee Meals		Patient Background Checks <u>127</u>	1,529	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	4,680	
				Employee Retirement	22,194	Miscellaneous Dues & Subscriptions	7,139	
				Employee Benefits - Other	10,062			
				Employees' Physical Exams	7,743			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,693	TOTAL (agree to Schedule V, line 22, col.8)		\$ 20,991		
B. Administrative - Other							Allocated from Mgmt. Co.	
Description			Amount				Less: Public Relations Expense ( )	
Management Fees (Eliminated in Col. 7)			\$ 369,408				Non-allowable advertising ( )	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 369,408				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Schedule 21A			\$ 191,192	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	1,335
							Allocated from Mgmt. Co.	5,309
							Entertainment Expense ( )	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 191,192	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 6,644	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Facility Name:** Symphony of Lincoln  
**IDPH License ID Number:** 0051789  
**Fiscal Year End:** 12/31/2015

**Schedule 21A**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
Ability Network	Payer Transactions	1,516
Achieve Accreditation	Accreditation Mntnc.	11,134
Bank of America	Web Hosting	12
Chase Ink	Comcast Services	5,215
Comcast	Internet	2,082
Creative Technology	Email Protection	9,455
E-Health Data Solutions	Carewatch	5,112
Evault	Protect-one-server2k	16,507
Health Data Systems	Micro-Fische Software Maintenance	3,896
Hipp Law Office	Legal Fees	38,068
HK Payroll Services	Work Tax Credit	5,750
IIT/Sourcotech	Monthly Suport Fee	1,380
Infinite Technology	Connect & Test Data Cable	434
Kipp Computer Solutions	Computer Upgrade	100
Medical Business Office	Collection Activity	5,543
Microsoft Corp	Reimb Nurcare Portion	404
Much Shelist	Legal Fees	457
NCI Business Systems	Service and Supply - Network Fee	140
Notto Technology	Cable Connection	132
OTHER	Legal Fees	655
Other	Adjustments & Accruals - Vendor Not Specified	22,627
Personnel Planners	Quarterly U.I. Claims Mgt Fees	1,335
Point B Communication	Yrly Web Hosting	240
RSM US LLP	Accounting Fees	20,640
Stone, McGuire & Siegel	Legal Fees	15,857
Symphony Financial	Consultants	2,811

Telemedicine Solutions	Wound Rounds Care	11,889
Wescom Solutions	Data Processing	7,171
Zirmed	Eligibility Verification	630
	<b>Total (agree to Schedule V, line 19, column 3)</b>	<u><u>191,192</u></u>
Allocated from Management Company Legal Fees		379
Allocated from Management Company Professional Services		26,347
Less: Non-Allowable Legal Fees		(38,069)
	<b>Total (agree to Schedule V, line 19, column 8)</b>	<u><u>179,849</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												N/A
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Symphony of Lincoln# 0051789Report Period Beginning: 01/01/2015Ending: 12/31/2015**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-20 Yr
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 230,241  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 5  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.