

		FOR BHF USE					

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFO THAT IS NECESSARY TO ACCOMPLISH THE STATUT PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCL OF THIS INFORMATION IS MANDATORY. FAILURE T ANY INFORMATION ON OR BEFORE THE DUE DATE RESULT IN CESSATION OF PROGRAM PAYMENTS. T HAS BEEN APPROVED BY THE FORMS MANAGEMEN

<p>I. IDPH License ID Number: <u>0051789</u></p> <p>Facility Name: <u>Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln</u></p> <p>Address: <u>2202 N Kickapoo Street</u> <u>Lincoln</u> <u>62656</u> <small>Number City Zip Code</small></p> <p>County: <u>Logan</u></p> <p>Telephone Number: <u>(217) 735-1538</u> Fax # <u>(217) 732-4848</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>01/01/2012</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/17</u> to <u>12/31/17</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Type or Print Name) <u>Dorothy Kuhl</u> (Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Dorothy Kuhl</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.																												
	<input checked="" type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Dorothy Kuhl</u> (Title) <u>Chief Financial Officer</u>																												
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																												

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln

0051789 Report Period Beginning: 1/1/17 Ending: 12/31/17

III. STATISTICAL DATA

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

N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,120</u>		<u>7,594</u>	<u>9,714</u>	8
9	SNF/PED					9
10	ICF	<u>14,109</u>	<u>4,318</u>	<u>692</u>	<u>19,119</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,229</u>	<u>4,318</u>	<u>8,286</u>	<u>28,833</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.69%

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

N/A (Do not include bed reserve 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 109 and days of care provided 2,898

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphc # 0051789 Report Period Beginning: 1/1/17 Ending: 12/31/17

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	197,144	24,270	16,159	237,573		237,573	-	237,573		1
2	Food Purchase		163,736		163,736		163,736	-	163,736		2
3	Housekeeping	225,714	33,131	-	258,845		258,845	-	258,845		3
4	Laundry	39,074	25,584	1,170	65,828	-	65,828	-	65,828		4
5	Heat and Other Utilities			199,185	199,185		199,185	1,258	200,443		5
6	Maintenance	-	-	119,647	119,647		119,647	11,358	131,005		6
7	Other (specify):* Mgmt alloc of benef	-	-	-	-		-	2,023	2,023		7
8	TOTAL General Services	461,932	246,721	336,161	1,044,814	-	1,044,814	14,639	1,059,453		8
	B. Health Care and Programs										
9	Medical Director	-	-	93,600	93,600		93,600	-	93,600		9
10	Nursing and Medical Records	2,073,203	139,036	19,846	2,232,085		2,232,085	84,986	2,317,071		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	394,940	-	2,640	397,580		397,580	-	397,580		11
12	Social Services	30,396	-	-	30,396		30,396	-	30,396		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):* Mgmt alloc of benef	-	-	-	-		-	13,223	13,223		15
16	TOTAL Health Care and Programs	2,498,539	139,036	116,086	2,753,661	-	2,753,661	98,209	2,851,870		16
	C. General Administration										
17	Administrative	99,296	-	338,904	438,200		438,200	(298,387)	139,813		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			281,969	281,969		281,969	(6,442)	275,527		19
20	Dues, Fees, Subscriptions & Promotions			12,049	12,049		12,049	2,233	14,282		20
21	Clerical & General Office Expenses	120,820	22,339	40,936	184,095		184,095	168,532	352,627		21
22	Employee Benefits & Payroll Taxes			457,790	457,790		457,790	-	457,790		22
23	Inservice Training & Education			-	-		-	-	-		23
24	Travel and Seminar			822	822		822	814	1,636		24
25	Other Admin. Staff Transportation		-	13,194	13,194		13,194	4,840	18,034		25
26	Insurance-Prop.Liab.Malpractice			62,079	62,079		62,079	1,834	63,913		26
27	Other (specify):* Mgmt alloc of benef	-	-	-	-		-	30,261	30,261		27
28	TOTAL General Administration	220,116	22,339	1,207,743	1,450,198	-	1,450,198	(96,315)	1,353,883		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,180,587	408,096	1,659,990	5,248,673	-	5,248,673	16,533	5,265,206		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 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	
	D. Ownership											
30	Depreciation			49,482	49,482		49,482	23,710	73,192			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			75,360	75,360		75,360	9,009	84,369			32
33	Real Estate Taxes			71,786	71,786		71,786	2,220	74,006			33
34	Rent-Facility & Grounds			445,013	445,013		445,013	3,523	448,536			34
35	Rent-Equipment & Vehicles			222,605	222,605		222,605	(8,653)	213,952			35
36	Other (specify):*			-	-		-	-	-			36
37	TOTAL Ownership			864,246	864,246	-	864,246	29,809	894,055			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	15,039	15,039		15,039	-	15,039			38
39	Ancillary Service Centers	-	140,663	623,691	764,354		764,354	-	764,354			39
40	Barber and Beauty Shops	-	-	-	-		-	-	-			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			226,508	226,508		226,508	-	226,508			42
43	Other (specify):* Non-Allowable Cos	128,189	-	709,171	837,360		837,360	(837,360)	-			43
44	TOTAL Special Cost Centers	128,189	140,663	1,574,409	1,843,261	-	1,843,261	(837,360)	1,005,901			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,308,776	548,759	4,098,645	7,956,180	-	7,956,180	(791,018)	7,165,162			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.)

		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	(27,423)	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	18,684	30		9
10	Interest and Other Investment Income	(2,626)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,784)	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	11,347	43		18
19	Entertainment	(766)	43		19
20	Contributions	(850)	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	(578,831)	43		24
25	Fund Raising, Advertising and Promotional	(5,700)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	66	43		28
29	Other-Attach Schedule <u>See Page 5A</u>	(249,035)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (837,918)		\$ 0	30

BHF USE ONLY							
48		49		50		51	

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)	46,900		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 46,900		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (791,018)		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	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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln

ID# 0051789

Report Period Beginning: 1/1/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (71,147)	43	1
2	Laboratory Costs	(23,373)	43	2
3	X-Ray Costs	(9,464)	43	3
4	Lobbying expense	(1,663)	20	4
5	Theft and Loss	(246)	43	5
6	Admission Salaries	(80,121)	43	6
7	Legal Fees	(5,437)	19	7
8	Nonallowable collection fees	(5,244)	19	8
9	Community Relations	(48,068)	43	9
10	Misc Income Offset	(1,685)	21	10
11	To Capitalize Expenses over \$2,500.	(2,587)	6	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	Total	(249,035)		49

Facility Name & ID Number

Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln

0051789

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	N/A	\$			\$	\$	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.

Facility Name & ID Number

Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln

0051789

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	21	Clerical & General Office Expenses	\$	Symphony Financial Services, LLC	100.00%	\$ 17,537	\$	17,537	15
16	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	1,559		1,559	16
17	V	32	Interest		Symphony Financial Services, LLC	100.00%	3,304		3,304	17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$			\$ 22,400	\$ *	22,400	39

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

Facility Name & ID Number

Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln

0051789

Report Period Beginning:

1/1/17

Ending: 12/31/17

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%	\$ 1,258	\$	1,258	15
16	V	6 Maintenance Salaries		Maestro Consulting Services	100.00%	11,156		11,156	16
17	V	6 Maintenance Expenses		Maestro Consulting Services	100.00%	2,789		2,789	17
18	V	7 Employee Benefits - Maintenance		Maestro Consulting Services	100.00%	2,023		2,023	18
19	V	10 Clinical Salaries		Maestro Consulting Services	100.00%	72,469		72,469	19
20	V	10 Contract Nursing		Maestro Consulting Services	100.00%	12,697		12,697	20
21	V	15 Employee Benefits - Clinical		Maestro Consulting Services	100.00%	13,223		13,223	21
22	V	17 Administrative Salaries	338,904	Maestro Consulting Services	100.00%	40,517		(298,387)	22
23	V	19 Professional Fees		Maestro Consulting Services	100.00%	4,239		4,239	23
24	V	20 Dues, Fees, Subscriptions, Etc.		Maestro Consulting Services	100.00%	3,896		3,896	24
25	V	21 Clerical & General Salaries		Maestro Consulting Services	100.00%	130,599		130,599	25
26	V	21 Clerical & General Expenses		Maestro Consulting Services	100.00%	22,081		22,081	26
27	V	24 Seminars & Education		Maestro Consulting Services	100.00%	814		814	27
28	V	25 Transportation		Maestro Consulting Services	100.00%	4,840		4,840	28
29	V	26 Insurance		Maestro Consulting Services	100.00%	1,834		1,834	29
30	V	27 Employee Benefits - Administrative		Maestro Consulting Services	100.00%	30,261		30,261	30
31	V	30 Depreciation		Maestro Consulting Services	100.00%	3,467		3,467	31
32	V	32 Interest Expense		Maestro Consulting Services	100.00%	8,331		8,331	32
33	V	33 Real Estate Tax		Maestro Consulting Services	100.00%	2,220		2,220	33
34	V	34 Building Rental		Maestro Consulting Services	100.00%	3,523		3,523	34
35	V	35 Equipment Rental		Maestro Consulting Services	100.00%	587		587	35
36	V	35 Auto Lease		Maestro Consulting Services	100.00%	1,939		1,939	36
37	V								37
38	V								38
39	Total		\$ 338,904			\$ 374,763	\$ *	35,859	39

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

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln

0051789

Report Period Beginning: 1/1/17

Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 847	Integra Healthcare Equipment, LLC	19.00%	\$ 667	\$ (180)	15
16	V	35	Rent-Equipment & Vehicles	52,556	Integra Healthcare Equipment, LLC	19.00%	41,377	(11,179)	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			\$ 53,403			\$ 42,044	\$ * (11,359)	39

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

Facility Name & ID Number

Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln

0051789

Report Period Beginning:

1/1/17

Ending:

12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare,	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cres	Belvidere	Maestro Consulting Se	Lincolnwood	Mgmt. Co.	5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Cot	Decatur				7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				8
9	Joseph Hartman	3.00	Symphony Evanston Healthcare	Evanston				9
10	David Hartman	20.00	Symphony of Dyer	Indiana				10
11	Mark Hartman-Benoit Holdings	3.00	Symphony of Crown Point	Indiana	Nucare Services	Lincolnwood	Bookkeeping Mgmt	11
12	IBEX Mgmt Svces, LLC	14.00	Symphony of Chesterton	Indiana	7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	Penina Hartman	2.00			Diamond Insurance	Northbrook	Work Comp Ins.	13
14	Drake Louis	4.00			Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Monroe Pavillion	Chicago	JLR Financial Svcs. Co	Lincolnwood	Management Co.	16
17			Sycamore Village	Swansea	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Symphony of Aria	Hillside	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Symphony at 87th Street	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Symphony at Midway	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Symphony at Tillers	Oswego	Integra Respiratory Se	Elmhurst	Respiratory Services	21
22			Symphony at Bronzeville	Chicago	Lifemed Pharmacy	Bensenville	Pharmacy	22
23			Symphony of Buffalo Grove	Buffalo Grove	ConcertoHealth	Chicago	Clinical Services	23
24			Symphony of Chicago West	Chicago				24
25			Symphony of Glendale	Glendale, Wiscosin	* No expense paid by home to the related			25
26			Symphony of Hanover Park	Hanover Park	entity, therefore no page 6 or 8.			26
27			Symphony of Lincoln Park	Chicago	** No expense of this related business			27
28			Symphony of Morgan Park	Chicago	allocated to homes			28
29			Symphony of South Shore	Chicago				29
30			Symphony Residences of Lincoln Park	Chicago				30

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symph # 0051789 Report Period Beginning: 1/1/17 Ending: 12/31/17

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.			0.00					\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln # 0051789 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	21	Clerical & General Office Expens	Occupied Bed Days	499,232	12	\$ 303,646	\$ 28,833	\$ 17,537	1
2	30	Depreciation	Occupied Bed Days	499,232	12	26,988	28,833	1,559	2
3	32	Interest	Occupied Bed Days	499,232	12	57,206	28,833	3,304	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					\$ 387,840	\$	\$ 22,400	25

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln # 0051789 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	1,835,856	28	\$ 50,076	\$ 46,116	\$ 1,258	1
2	6	Maintenance Salaries	Bed Days Available	1,835,856	28	444,128	46,116	11,156	2
3	6	Maintenance Expenses	Bed Days Available	1,835,856	28	111,048	46,116	2,789	3
4	7	Employee Benefits - Maintenance	Bed Days Available	1,835,856	28	80,529	46,116	2,023	4
5	10	Clinical Salaries	Bed Days Available	1,835,856	28	2,884,957	2,884,957	72,469	5
6	10	Contract Nursing	Bed Days Available	1,835,856	28	505,476	46,116	12,697	6
7	15	Employee Benefits - Clinical	Bed Days Available	1,835,856	28	526,402	46,116	13,223	7
8	17	Administrative Salaries	Bed Days Available	1,835,856	28	1,612,976	1,612,976	40,517	8
9	19	Professional Fees	Bed Days Available	1,835,856	28	168,752	46,116	4,239	9
10	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	1,835,856	28	155,112	46,116	3,896	10
11	21	Clerical & General Salaries	Bed Days Available	1,835,856	28	5,199,066	5,199,066	130,599	11
12	21	Clerical & General Expenses	Bed Days Available	1,835,856	28	879,035	46,116	22,081	12
13	24	Seminars & Education	Bed Days Available	1,835,856	28	32,418	46,116	814	13
14	25	Transportation	Bed Days Available	1,835,856	28	192,674	46,116	4,840	14
15	26	Insurance	Bed Days Available	1,835,856	28	73,017	46,116	1,834	15
16	27	Employee Benefits - Administrative	Bed Days Available	1,835,856	28	1,204,673	46,116	30,261	16
17	30	Depreciation	Bed Days Available	1,835,856	28	138,011	46,116	3,467	17
18	32	Interest Expense	Bed Days Available	1,835,856	28	331,638	46,116	8,331	18
19	33	Real Estate Tax	Bed Days Available	1,835,856	28	88,385	46,116	2,220	19
20	34	Building Rental	Bed Days Available	1,835,856	28	140,244	46,116	3,523	20
21	35	Equipment Rental	Bed Days Available	1,835,856	28	23,351	46,116	587	21
22	35	Auto Lease	Bed Days Available	1,835,856	28	77,202	46,116	1,939	22
23									23
24									24
25	TOTALS					\$ 14,919,170	\$ 10,141,127	\$ 374,763	25

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln # 0051789 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	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	10	Nursing and Medical Records	Direct Allocation			\$		\$ 667	1
2	35	Rent-Equipment & Vehicles	Direct Allocation					41,377	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					\$		\$ 42,044	25

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Sympho # 0051789 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	<u>Omnicare</u>		<u>X</u>	<u>Pharmacy Services</u>	<u>\$67,444.34</u>	<u>11/27/2017</u>	<u>\$ 2,170,337</u>	<u>\$ 21,851</u>	<u>10/20/2020</u>	<u>0.0750</u>	<u>\$ 251</u>	1								
2	<u>LifeMed Illinois, LLC</u>	<u>X</u>		<u>Pharmacy Services</u>	<u>\$38,731.00</u>	<u>12/29/2017</u>	<u>6,197,033</u>	<u>121,399</u>	<u>1/1/2024</u>	<u>0.0750</u>		2								
3												3								
4												4								
5												5								
Working Capital																				
6	<u>CIBC Bank, USA</u>		<u>X</u>	<u>Line of Credit (Revolving)</u>	<u>Interest Only</u>	<u>12/30/2011</u>	<u>6,000,000</u>		<u>6/2/2018</u>	<u>0.0525</u>	<u>75,109</u>	6								
7												7								
8												8								
9	TOTAL Facility Related				\$106,175.34		\$ 14,367,370	\$ 143,250			\$ 75,360	9								
B. Non-Facility Related*																				
10												10								
11												11								
12											<u>(2,626)</u>	12								
13											<u>11,635</u>	13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 9,009	14								
15	TOTALS (line 9+line14)						\$ 14,367,370	\$ 143,250			\$ 84,369	15								

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2016 report.			\$	78,120	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.)	2016		\$	74,211	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(3,909)	3
4.	Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	75,695	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Alloc Fr. Mgmt Co.		2,220	
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	74,006	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2012	69,751	8		
		2013	70,799	9		
		2014	70,674	10		
		2015	73,661	11		
		2016	74,211	12		
2017 Tax Accrual = \$74,211 * 1.02 = \$75,695; use \$75,695						
		FOR BHF USE ONLY				
		13	FROM R. E. TAX STATEMENT FOR 2016	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATI	\$		16

NOTES:

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

2016 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 Dorothy Kuhl

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 2016 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 2016.

(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>46,062.12</u>	\$ <u>46,062.12</u>
2. <u>08-029-019-50</u>	<u>Nursing Home</u>	\$ <u>28,148.62</u>	\$ <u>28,148.62</u>
3. <u>10-27-319-028-0000</u>	<u>Land & Property Mgmt. Co.</u>	\$ <u>88,384.90</u>	\$ <u>2,220.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>162,595.64</u>	\$ <u>76,430.74</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln

0051789

Report Period Beginning:

1/1/17

Ending:

12/31/17

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>\$ 4,019</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 4,019	3

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln# 0051789

Report Period Beginning:

1/1/17

Ending:

12/31/17**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8	Allocated from Maestro 7257	2004		36,172		39	927	927	14,598	8
	Improvement Type**									
9	Wiring for EMR 24 Port Pan, Wire Mold, Cable Ties		2012	6,545	327	20	327		1,636	9
10	Exterior Sign		2013	21,718	1,086	20	1,086		5,339	10
11	General Contractor - Hallway, Lobby, Therapy, Vestibule		2013	67,885	3,395	20	3,395		13,861	11
12	Dining Room, Willow Lane, Redwood Lane & Nurse's Station									12
13										13
14	Remodeling - Painting, Wall covering, Wallpaper		2013	85,662	8,565	10	8,565		34,977	14
15	- Hallway, Dining Room, Willow Lane Resident Rooms & Offices									15
16										16
17	Remodeling - Flooring		2013	67,014	3,350	20	3,350		13,681	17
18	- Hallway, Lobby, Dining Room & Willow Lane Resident Rooms									18
19										19
20	Remodeling - Structural, Iron work, Bond beam		2013	33,520	1,676	20	1,676		6,844	20
21	-Lobby, Entrance and Vestibule									21
22										22
23	Remodeling - Electrical		2013	25,461	1,273	20	1,273		5,198	23
24	-Respirator Receptacles, Lobby, Entrance & Willow Lane									24
25										25
26	Remodeling - Custom millwork - Lobby, Dining Room, Hallway, Nurse's Station and Willow Lane Wing		2013	21,400	1,070	20	1,070		4,369	26
27										27
28										28
29	Remodeling - Drywall - Hallway, Lobby & Willow Lane Resident Rooms		2013	74,126	3,707	20	3,707		15,135	29
30										30
31										31
32	Remodeling - Ceiling Panel - front/back nurse's station		2013	21,400	1,070	20	1,070		4,369	32
33	Dining Room, Activity Room & Entryway									33
34										34
35	Remodeling - Roof Fire proofing, Fire sprinklers		2013	14,297	715	20	715		2,920	35
36	-Lobby, Main Entrance & Roof									36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln# 0051789

Report Period Beginning:

1/1/17

Ending:

12/31/17**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	2013	\$ 6,900	\$ 345	20	\$ 345	\$	\$ 1,409	37
38								38
39								39
40								40
41	2014	37,742	1,886	20	1,886		7,232	41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52	2017	3,339	168	5	168		168	52
53								53
54	2017	2,587		10	129	129	129	54
55								55
56								56
57								57
58								58
59			(18,555)			18,555		59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 525,768	\$ 10,078		\$ 29,689	\$ 19,611	\$ 131,865	70

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12A, Carried Forward	\$ 525,768	\$ 10,078		\$ 29,689	\$ 19,611	\$ 131,865
2							
3	Allocated from Maestro Consulting Services	2003	294				208
4	Allocated from Maestro Consulting Services	2004	5975				4,099
5	Allocated from Maestro Consulting Services	2005	354				228
6	Allocated from Maestro Consulting Services	2006	480				273
7	Allocated from Maestro Consulting Services	2008	506				234
8	Allocated from Maestro Consulting Services	2009	8149				3,508
9	Allocated from Maestro Consulting Services	2010	1252				470
10	Allocated from Maestro Consulting Services	2011	68				23
11	Allocated from Maestro Consulting Services	2012	75				22
12	Allocated from Maestro Consulting Services	2014	942				170
13	Allocated from Maestro Consulting Services	2015	265				31
14	Allocated from Maestro Consulting Services	2016	1161		149	149	161
15	Allocated from Maestro Consulting Services	2017	155				8
16							
17	Allocated from Maestro 7257	2004	719				485
18	Allocated from Maestro 7257	2005	3298		23	23	2,418
19	Allocated from Maestro 7257	2015	570		49	49	89
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 550,031	\$ 10,078		\$ 29,910	\$ 19,832	\$ 144,292

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

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of L # 0051789

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	\$ 206,204	\$ 39,184	\$ 39,184	\$ 0	5-7	\$ 140,271	71
72	Current Year Purchases	1,885	220	220	0	5	220	72
73	Fully Depreciated Assets	7,195			0	5-7	7,195	73
74	See Sch 13A	64,724		3,878	3,878	5-10	40,285	74
75	TOTALS	\$ 280,008	\$ 39,404	\$ 43,282	\$ 3,878		\$ 187,971	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 Mgmt. Co.			\$ 223	\$	\$	\$ 0		\$ 223	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 223	\$ 0	\$ 0	\$ 0		\$ 223	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)	\$ 834,281	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,482	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,192	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 23,710	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 332,486	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: Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln
IDPH License ID Nur 0051789
Fiscal Year End: 12/31/17

Schedule 13A

XI. Ownership Costs

Line 74 - Equipment Costs - Excluding Transportation

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
Allocated from Symphony Financial Services, LLC	9,730		1,559	1,559	5-7	7,053
Allocated from Maestro Consulting Services	54,994		2319	2319	5-10	33,232
TOTAL	64,724	-	3,878	3,878		40,285

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>444,258</u>	<u>10</u>	<u>10</u>	3
4	Additions							4
5								5
6	<u>Allocated from Mgmt. Co.</u>				<u>3,523</u>			6
7	TOTAL		<u>126</u>		\$ <u>447,781</u>			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 10.

755
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: \$ 197,153 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>422.59</u>	\$ <u>3,803</u>	17
18	<u>Facility</u>	<u>2015 Ford T350HD</u>	<u>919.49</u>	<u>11,057</u>	18
19					19
20	<u>Allocated from Mgmt. Co.</u>			<u>1,939</u>	20
21	TOTAL		\$ <u>1,342.08</u>	\$ <u>16,799</u>	21

10. Effective dates of current rental agreement:

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

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2018</u>	\$ <u>270,608</u>
13.	<u>/2019</u>	\$ <u>276,020</u>
14.	<u>/2020</u>	\$ <u>281,541</u>

* 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 Maple Ridge, LLC D/B/A Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/17

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
COMPUTER RENTAL	959
KITCHEN EQUIPMENT RENTAL	1,275
NURSING EQUIPMENT RENTAL	148,535
OFFICE EQUIPMENT RENTAL	54,544
POSTAGE METER RENTAL	572
STORAGE RENTAL	600
WATER COOLER RENTAL	1,260
Allocated from Mgmt Co.	(10,592)
Total - Line 16	<u>197,153</u>

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					Units	Cost										
1	Licensed Occupational Therapist	39(3)	hrs	\$	2,779	\$ 200,062	\$	2,779	\$	200,062						1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,335	96,092		1,335		96,092						2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs		3,771	271,513		3,771		271,513						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							124,201					124,201	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>See Sch 16A</u>	39(2)			778	56,024		778		56,024						12
13	Other (specify): <u>Oxygen</u>	39(3)								16,462					16,462	13
14	TOTAL			\$	8,663	\$ 623,691	\$	8,663	\$	140,663	\$	8,663	\$	764,354		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 Maple Ridge, LLC D/B/A Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/17

Schedule 16A

XIV. Special Services (Direct Cost)

Line 12 Other (specify)

Description	Amount
I.V. Therapy Costs	12,506
Inhalation Therapy Costs	43,228
Other Ancillary Costs	290
Total - Line 12	<u>56,024</u>

Facility Name & ID Number **Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln # 0051789**Report Period Beginning: **1/1/17**Ending: **12/31/17****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$ 2,000	1
2	Cash-Patient Deposits	20,425	20,425	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>2,902,771</u>)	4,177,205	4,177,205	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,574	1,574	6
7	Other Prepaid Expenses	85,480	85,480	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,286,684	\$ 4,286,684	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,019	13
14	Buildings, at Historical Cost		36,172	14
15	Leasehold Improvements, at Historical Cost	483,670	513,859	15
16	Equipment, at Historical Cost	222,914	280,231	16
17	Accumulated Depreciation (book methods)	(264,837)	(332,486)	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 (spe <u>Lease Costs</u>)	3,018	3,018	22
23	Other(specify): <u>See Schedule 17A</u>	66,677	66,677	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 511,442	\$ 571,490	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,798,126	\$ 4,858,174	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,905,974	\$ 1,905,974	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,425	20,425	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	302,964	302,964	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,583	17,583	31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,695	75,695	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	6,355,104	6,355,104	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,677,745	\$ 8,677,745	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	143,250	143,250	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 143,250	\$ 143,250	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,820,995	\$ 8,820,995	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,022,869)	\$ (3,962,821)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,798,126	\$ 4,858,174	48

*(See instructions.)

Facility Name: Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln
IDPH License ID Num: 0051789
Fiscal Year End: 12/31/17

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Other Assets - Security Deposits	42,279	42,279
Due To/From - Glendale	12,784	12,784
Due To/From - Decatur	5,807	5,807
Due To/From - McKinley LLC	5,807	5,807
Total - Line 23	66,677	66,677

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Cash	30,513	30,513
CSA I/C Related/Party Due To/From Accts	4,109,512	4,109,512
Due To/From - Symphony Healthcare	60,992	60,992
Due To/From - Maestro	66,553	66,553
Accrued Payables	2,305	2,305
Accounts Payables - Patient Security Depo:	10,000	10,000
Accrued Payables - Health Insurance	3,884	3,884
Accrued Payables - Garnishments	27,248	27,248
Accrued Payables - WC/GL Insurance	211,631	211,631
Accrued Payables - Bed Taxes	1,216	1,216
Accrued Payables - Bed Taxes Add'l	124,148	124,148
Accrued Payables - Management Fees	2,350	2,350
Accrued Payables - Interest	251	251
Accrued Payables - Rent	402,879	402,879
Accrued Payables - Sales Tax	362,179	362,179
Deferred Rent	924,500	924,500
Lease Holds Payable	14,943	14,943
Total - Line 36	6,355,104	6,355,104

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,773,445)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,773,444)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,249,425)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,249,425)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,022,869)	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.

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,446,611	1
2	Discounts and Allowances for all Levels	(1,097,227)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,349,384	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,136,264	6
7	Oxygen	2,500	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,138,764	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	155,176	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,692	19
20	Radiology and X-Ray	6,004	20
21	Other Medical Services	33,874	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 214,746	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,626	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,626	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	(450)	28
28a	Other Income	1,685	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,235	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,706,755	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,044,814	31
32	Health Care	2,753,661	32
33	General Administration	1,450,198	33
B. Capital Expense			
34	Ownership	864,246	34
C. Ancillary Expense			
35	Special Cost Centers	1,616,753	35
36	Provider Participation Fee	226,508	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,956,180	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,249,425)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,249,425)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,582,211	44
45	Private Pay - Net Inpatient Revenue	1,104,530	45
46	Medicare - Net Inpatient Revenue	641,223	46
47	Other-(specify) <u>Hospice & ALF</u>	191,770	47
48	Other-(specify) <u>Managed Care & Veteran</u>	829,650	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,349,384	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 a cash basis.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,065	2,225	\$ 91,001	\$ 40.90	1
2	Assistant Director of Nursing	1,711	1,868	52,977	28.36	2
3	Registered Nurses	5,238	5,652	184,398	32.63	3
4	Licensed Practical Nurses	29,596	31,688	868,377	27.40	4
5	CNAs & Orderlies	49,975	52,655	762,340	14.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	15,971	17,086	394,940	23.11	10
11	Social Service Workers	1,761	1,925	30,396	15.79	11
12	Dietician					12
13	Food Service Supervisor	1,998	2,268	42,689	18.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,108	16,249	154,455	9.51	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	17,605	18,714	225,714	12.06	18
19	Laundry	3,960	4,477	39,074	8.73	19
20	Administrator	2,011	2,194	99,296	45.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,918	8,733	168,888	19.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,671	2,965	45,223	15.25	31
32	Other Health C: MDS	1,861	2,157	68,887	31.94	32
33	Other(specify) Admissions	2,957	3,234	80,121	24.77	33
34	TOTAL (lines 1 - 33)	162,406	174,090	\$ 3,308,776 *	\$ 19.01	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	\$ 16,159	1(3)	35
36	Medical Director	Monthly	93,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	13,739	10(3), (7)	38
39	Pharmacist Consultant	Monthly	9,981	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,640	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 136,119		49

C. CONTRACT NURSES

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

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	\$ 1,912	Workers' Compensation Insurance	\$ 128,537	IDPH License Fee	\$ 1,327	
Jennifer Banks	Administrator	0	97,384	Unemployment Compensation Insurance	48,114	Advertising: Employee Recruitment	678	
				FICA Taxes	241,344	Health Care Worker Background Check		
				Employee Health Insurance	29,517	(Indicate # of checks performed 73)	871	
				Employee Meals		<u>Patient Background Checks</u>	<u>344</u>	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	400	
				Employee Retirement	4,242	Illinois Council on Long Term Care	5,040	
				Employee Benefits - Other	4,532	Miscellaneous Dues & Subscriptions	(400)	
				Employees' Physical Exams	1,504	Lobbying Offset	(1,663)	
						<u>Allocated from Mgmt. Co.</u>	<u>3,896</u>	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 99,296		\$ 14,282	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Management Fees (Eliminated in Col. 7)				N/A			Out-of-State Travel	
\$ 338,904							\$	
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 338,904				\$			822	
							<u>Allocated from Mgmt. Co.</u>	
							<u>814</u>	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 281,969				\$			\$ 1,636	

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln
 IDPH License ID Nur 0051789
 Fiscal Year End: 12/31/17

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Ability Network	Payer Transactions	4,617
American Express	Internet	2,237
Carbonite Inc	Cloud Backup Service	17,156
Comcast	Internet	6,631
Corporation Service	Professional Fees	1,001
Creative Technology	Email Protection	14,915
Dart Chart Map and Track Systems, LLC	Hmo Contract Specification Sets	113
Davis & Campbell L.L.C	Business Counseling Services	41,987
Edwin C. Mills	Legal Fees	4,890
EMMI Solutions	Internet	271
Formation Healthcare Group, LLC	Monthly Subscription	62
Frontier	Communications Services	1,199
Health Data Systems	Micro-Fische Software Maintenance	5,780
Hipp Law Office	Legal Fees	315
HK Payroll Services	Work Tax Credit	1,466
IIT/Sourcetechn	Monthly Support Fee	1,380
LTC Consulting Services	Collection Activity	5,096
Maestro Consulting	Consulting	112,326
Maestro Consulting	Legal Fees	2,745
Maple Ridge	Petty Cash	1,191
Marcum LLP	Public Accounting and Advisory Ser	1,190
Market Matrix	Surveys	252
McCabe, Kirshner P.C...	Legal Fees	608
Medical Business Office	Collection Activity	1,915
MTS Consulting, LLC	Tax Consulting Services	86
National Datacare Corporation	Trust Fund and Medicaid Bill Servic	1,156
Nexuscomm, LLC	Cable Connection	3,697
Notto Technology	Cable Connection	126
Personnel Planners	Quarterly U.I. Claims Mgt Fees	1,030
PointClickCare Technology	Clinical/Bookkeeping/Data Processin	13,042
Prime Care Technologies	Prime Care	20
Real Time Medical Systems LLC	Software Services	2,888
RSM US LLP	Accounting Fees	18,796
Stone, McGuire & Siegel	Legal Fees	1,200
Stone, Podgrund, & Korey	Legal Fees	233
Telemedicine Solutions	Wound Rounds Care	10,352
Total (agree to Schedule V, line 19, column 3)		281,969
Allocated from Management Company	Professional Services	4,239
Less: Non-Allowable Legal Fees		(5,437)
Less: Professional Collection Fees		(5,244)
Total (agree to Schedule V, line 19, column 8)		275,527

Facility Name & ID Number Symphony Maple Ridge, LLC D/B/A Symphony of Lincoln# 0051789

Report Period Beginning:

1/1/17

Ending:

12/31/17**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. IL Council LTC \$5,040
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 226,508
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 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