

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

<p>I. IDPH License ID Number: <u>0051763</u></p> <p>Facility Name: <u>Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY</u></p> <p>Address: <u>2330 W. Galena Blvd</u> <u>Aurora</u> <u>60506</u> Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(630) 896-4686</u> Fax # <u>(630) 896-7868</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>1/1/18</u> to <u>12/31/18</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td> </tr> </table> <p style="text-align: center; margin-top: 10px;">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) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(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																																					
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Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY

0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	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 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>37,505</u>	<u>3,283</u>	<u>16,897</u>	<u>57,685</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>37,505</u>	<u>3,283</u>	<u>16,897</u>	<u>57,685</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.85%

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 203 and days of care provided 3,587

Medicare Intermediary Wisconsin Physician Services (WPS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPH # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	304,252	23,201	23,871	351,324		351,324	-	351,324		1
2	Food Purchase		312,056		312,056		312,056	-	312,056		2
3	Housekeeping	136,854	127,832	-	264,686		264,686	-	264,686		3
4	Laundry	92,830	31,837	5,492	130,159		130,159	-	130,159		4
5	Heat and Other Utilities			286,218	286,218		286,218	2,147	288,365		5
6	Maintenance	95,519	-	174,297	269,816		269,816	126	269,942		6
7	Other (specify):*	-	-	-				-			7
8	TOTAL General Services	629,455	494,926	489,878	1,614,259		1,614,259	2,273	1,616,532		8
	B. Health Care and Programs										
9	Medical Director	-	-	24,000	24,000		24,000	-	24,000		9
10	Nursing and Medical Records	4,179,387	215,713	131,329	4,526,429		4,526,429	144,242	4,670,671		10
10a	Therapy	-	-	-				-			10a
11	Activities	93,724	-	2,914	96,638		96,638	-	96,638		11
12	Social Services	55,088	-	-	55,088		55,088	-	55,088		12
13	CNA Training	-	-	-				-			13
14	Program Transportation	-	-	-				-			14
15	Other (specify):* Mgmt alloc of benef	-	-	-				44,626	44,626		15
16	TOTAL Health Care and Programs	4,328,199	215,713	158,243	4,702,155		4,702,155	188,868	4,891,023		16
	C. General Administration										
17	Administrative	108,132	-	673,186	781,318		781,318	(673,186)	108,132		17
18	Directors Fees			-				-			18
19	Professional Services			475,060	475,060		475,060	85,526	560,586		19
20	Dues, Fees, Subscriptions & Promotions			46,799	46,799		46,799	(11,643)	35,156		20
21	Clerical & General Office Expenses	212,193	18,985	102,587	333,765		333,765	130,973	464,738		21
22	Employee Benefits & Payroll Taxes			1,040,222	1,040,222		1,040,222	-	1,040,222		22
23	Inservice Training & Education			-				-			23
24	Travel and Seminar			3,127	3,127		3,127	1,048	4,175		24
25	Other Admin. Staff Transportation		-	5,963	5,963		5,963	7,970	13,933		25
26	Insurance-Prop.Liab.Malpractice			716,699	716,699		716,699	3,994	720,693		26
27	Other (specify):* Mgmt alloc of benef	-	-	-				22,263	22,263		27
28	TOTAL General Administration	320,325	18,985	3,063,643	3,402,953		3,402,953	(433,055)	2,969,898		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,277,979	729,624	3,711,764	9,719,367		9,719,367	(241,914)	9,477,453		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 & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF ORC #0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			162,620	162,620		162,620	64,095	226,715		30
31	Amortization of Pre-Op. & Org.			-				-			31
32	Interest			63,182	63,182		63,182	(22,168)	41,014		32
33	Real Estate Taxes			148,578	148,578		148,578	4,040	152,618		33
34	Rent-Facility & Grounds			1,785,969	1,785,969		1,785,969	2,935	1,788,904		34
35	Rent-Equipment & Vehicles			79,695	79,695		79,695	12,390	92,085		35
36	Other (specify):*			-				-			36
37	TOTAL Ownership			2,240,044	2,240,044		2,240,044	61,292	2,301,336		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation	-	-	253	253		253	-	253		38
39	Ancillary Service Centers	-	140,927	1,837,566	1,978,493		1,978,493	(315)	1,978,178		39
40	Barber and Beauty Shops	-	-	-				-			40
41	Coffee and Gift Shops	-	-	-				-			41
42	Provider Participation Fee			439,518	439,518		439,518	-	439,518		42
43	Other (specify):* Non-Allowable Cos	106,308	-	515,115	621,423		621,423	(621,423)			43
44	TOTAL Special Cost Centers	106,308	140,927	2,792,452	3,039,687		3,039,687	(621,738)	2,417,949		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,384,287	870,551	8,744,260	14,999,098		14,999,098	(802,360)	14,196,738		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	(24,343)	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	44,782	30		9
10	Interest and Other Investment Income	(24,834)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	5,673	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	(19,439)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(328,614)	43		24
25	Fund Raising, Advertising and Promotional	(107)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See PG5A</u>	(281,207)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (628,089)		\$	30

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)	(174,271)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (174,271)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (802,360)		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

BHF USE ONLY							
48		49		50		51	

Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY

ID# 0051763

Report Period Beginning: 1/1/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (102,047)	43	1
2	Laboratory Costs	(15,723)	43	2
3	X-Ray Costs	(12,609)	43	3
4	Theft and Damage Loss	(3,799)	43	4
5	Real Estate Taxes	0	33	5
6	Marketing Salaries	(111)	43	6
7	Lobbying Expense	(16,840)	20	7
8	Admissions Salary	(75,031)	43	8
9	Director of Customer Experience	(44,577)	43	9
10	Radiology Costs	(221)	43	10
11	Other income	(10)	21	11
12	Capitalized R&M	(6,019)	6	12
13	Trust Overcharges	(426)	43	13
14	Nonallowable legal	(3,794)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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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	(281,207)		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 Schedule V	2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item		Name of Related Organization				
1	V		\$			\$	\$	1
2	V			N/A				2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Services	\$	Symphony Financial Services, LLC	100%	\$ 107	\$ 107	15
16	V	21 Clerical & Gen office exp	\$	Symphony Financial Services, LLC	100%	19,404	19,404	16
17	V	30 Depreciation		Symphony Financial Services, LLC	100%	3,933	3,933	17
18	V	32 Interest		Symphony Financial Services, LLC	100%	2,602	2,602	18
19	V	35 Equipment Rental		Symphony Financial Services, LLC	100%	2,194	2,194	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		\$			\$ 28,240	\$ * 28,240	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 Utilities	\$	Maestro Consulting Services	100%	\$ 2,147	\$ 2,147	15
16	V	6 Maintenance Salaries		Maestro Consulting Services	100%	0		16
17	V	6 Maintenance Expenses		Maestro Consulting Services	100%	6,145	6,145	17
18	V	7 Employee Benefits - Maintenance		Maestro Consulting Services	100%	0		18
19	V	10 Clinical Salaries		Maestro Consulting Services	100%	138,769	138,769	19
20	V	10 Contract Nursing		Maestro Consulting Services	100%	6,890	6,890	20
21	V	15 Employee Benefits - Clinical		Maestro Consulting Services	100%	44,626	44,626	21
22	V	17 Administrative - Other	673,186	Maestro Consulting Services	100%	0	(673,186)	22
23	V	19 Professional Fees		Maestro Consulting Services	100%	89,213	89,213	23
24	V	20 Dues, Fees, Subscriptions, Etc.		Maestro Consulting Services	100%	5,197	5,197	24
25	V	21 Clerical & General Salaries		Maestro Consulting Services	100%	69,228	69,228	25
26	V	21 Clerical & General Expenses		Maestro Consulting Services	100%	42,306	42,306	26
27	V	24 Seminars and Education		Maestro Consulting Services	100%	1,048	1,048	27
28	V	25 Transportation		Maestro Consulting Services	100%	7,970	7,970	28
29	V	26 Insurance		Maestro Consulting Services	100%	3,994	3,994	29
30	V	27 Employee Benefits - Administrative		Maestro Consulting Services	100%	22,263	22,263	30
31	V	30 Depreciation		Maestro Consulting Services	100%	15,380	15,380	31
32	V	32 Interest Expense		Maestro Consulting Services	100%	65	65	32
33	V	33 Real Estate Tax		Maestro Consulting Services	100%	4,040	4,040	33
34	V	34 Building Rental		Maestro Consulting Services	100%	2,935	2,935	34
35	V	35 Equipment Rental		Maestro Consulting Services	100%	7,267	7,267	35
36	V	35 Auto Lease		Maestro Consulting Services	100%	6,464	6,464	36
37	V							37
38	V							38
39	Total		\$ 673,186			\$ 475,947	\$ * (197,239)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing and Medical Records	\$ 9,125	Integra Healthcare Equipment, LLC	0.19	\$ 7,708	\$ (1,417)	15
16	V	35 Rent-Equipment & Vehicles	22,474	Integra Healthcare Equipment, LLC	0.19	18,984	(3,490)	16
17	V	39 Oxygen	2,030	Integra Healthcare Equipment, LLC	0.19	1,715	(315)	17
18	V	43 Penalties-Admin	316	Integra Healthcare Equipment, LLC	0.19	267	(49)	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		\$ 33,945			\$ 28,673	\$ * (5,272)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Worker's Compensation	\$ 165,380	Maple Leaf Insurance	100%	\$ 165,380	\$	15
16	V	26	Liability Insurance	430,912	Maple Leaf Insurance	100%	430,912		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			\$ 596,292			\$ 596,292	\$ *	39

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

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD V/1# 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	28.49	Symphony Countryside, LLC D/B/A Countrysit	Aurora	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	5.23	Symphony Crestwood, LLC D/B/A Symphony c	Crestwood	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	5.23	Symphony Deerbrook, LLC D/B/A Symphony c	Joliet	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	5.23	Symphony Maple Crest, LLC D/B/A Maple Cre	Belvidere	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	5.23	Symphony Northwoods, LLC D/B/A Northwooc	Belvidere	Maestro Consulting S	Lincolnwood	Mgmt. Co.	5
6	Rena Dickman	5.23	Symphony Evanston Healthcare	Evanston				6
7	Robert Hartman	4.65	Symphony of Dyer	Indiana				7
8	Jack Hartman	3.49	Symphony of Crown Point	Indiana				8
9	Joseph Hartman	3.49	Symphony of Chesterton	Indiana				9
10	David J. Hartman	23.26						10
11	Mark Hartman-Bemoit Holdings	3.49			Nucare Services	Lincolnwood	Bookkeeping Mgmt	11
12	Penina Hartman	2.33			7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	Drake Louis	4.65			Diamond Insurance	Northbrook	Work Comp Ins.	13
14					Mapleleaf Insurance	Grand Cayman	Liability/Work Con	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Monroe Pavillion	Chicago	JLR Financial Svcs. C	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 S	Elmhurst	Respiratory Service	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 Countryside, LLC D/B/A SYMP1 # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
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

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF OI # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Occupied Bed Days	480,705	9	\$ 694	\$ 74,095	\$ 107	1
2	21	Clerical & General Office Expenses	Occupied Bed Days	480,705	9	125,888	74,095	19,404	2
3	30	Depreciation	Occupied Bed Days	480,705	9	25,515	74,095	3,933	3
4	32	Interest	Occupied Bed Days	480,705	9	16,882	74,095	2,602	4
5	35	Equipment Rental	Occupied Bed Days	480,705	9	14,234	74,095	2,194	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					\$ 183,213	\$	\$ 28,240	25

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF OI # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	5	Utilities	Bed Days Available	1,668,541	25	\$ 48,352	\$ 74,095	\$ 2,147	1	
2	6	Maintenance Salaries	Bed Days Available	1,668,541	25		74,095		2	
3	6	Maintenance Expenses	Bed Days Available	1,668,541	25	138,375	74,095	6,145	3	
4	7	Employee Benefits - Maintenance	Bed Days Available	1,668,541	25		74,095		4	
5	10	Clinical Salaries	Bed Days Available	1,668,541	25	3,124,933	3,124,933	74,095	138,769	5
6	10	Contract Nursing	Bed Days Available	1,668,541	25	155,149	74,095	6,890	6	
7	15	Employee Benefits - Clinical	Bed Days Available	1,668,541	25	1,004,938	74,095	44,626	7	
8	17	Administrative - Other	Bed Days Available	1,668,541	25		74,095		8	
9	19	Professional Fees	Bed Days Available	1,668,541	25	2,008,992	74,095	89,213	9	
10	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	1,668,541	25	117,020	74,095	5,197	10	
11	21	Clerical & General Salaries	Bed Days Available	1,668,541	25	1,558,938	1,558,938	74,095	69,228	11
12	21	Clerical & General Expenses	Bed Days Available	1,668,541	25	952,676	74,095	42,306	12	
13	24	Seminars and Education	Bed Days Available	1,668,541	25	23,599	74,095	1,048	13	
14	25	Transportation	Bed Days Available	1,668,541	25	179,481	74,095	7,970	14	
15	26	Insurance	Bed Days Available	1,668,541	25	89,939	74,095	3,994	15	
16	27	Employee Benefits - Administrati	Bed Days Available	1,668,541	25	501,334	74,095	22,263	16	
17	30	Depreciation	Bed Days Available	1,668,541	25	346,345	74,095	15,380	17	
18	32	Interest Expense	Bed Days Available	1,668,541	25	1,470	74,095	65	18	
19	33	Real Estate Tax	Bed Days Available	1,668,541	25	90,970	74,095	4,040	19	
20	34	Building Rental	Bed Days Available	1,668,541	25	66,085	74,095	2,935	20	
21	35	Equipment Rental	Bed Days Available	1,668,541	25	163,656	74,095	7,267	21	
22	35	Auto Lease	Bed Days Available	1,668,541	25	145,555	74,095	6,464	22	
23									23	
24									24	
25	TOTALS				\$ 10,717,807	\$ 4,683,871		\$ 475,947	25	

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF OI # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing and Medical Records	Direct Allocation		\$	\$		7,708	1
2	35	Rent-Equipment & Vehicles	Direct Allocation					18,984	2
3	39	Oxygen	Direct Allocation					1,715	3
4	43	Penalties-Admin	Direct Allocation					267	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		28,673	25

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF OI # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Worker's Compensation	Direct Allocation		\$	\$		\$ 165,380	1
2	26	Liability Insurance	Direct Allocation					430,912	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				\$	\$		\$ 596,292	25

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPH # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	LifeMed	X		Pharmacy Services	38731	1/1/2018	\$ 6,197,033	\$ 152,285	1/1/2024	0.075	\$ 8,334	1								
2	Omnicare		X	Pharmacy Services	67444.34	11/27/2017	2,170,337	31,274	10/20/2020	0.075	5,404	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Midcap Financial Trust*		X	Line of Credit (Revolving)	Interest Only	9/18/2018	35,000,000		9/17/2021	LIBOR +4.25'	49,444	6								
7	* Original loan with Symcare Healthcare LLC. Facility pays the interest expense																			
8												8								
9	TOTAL Facility Related				\$106,175.34		\$ 43,367,370	\$ 183,559			\$ 63,182	9								
B. Non-Facility Related*																				
10												10								
11											(24,835)	11								
12											65	12								
13											2,602	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (22,168)	14								
15	TOTALS (line 9+line14)						\$ 43,367,370	\$ 183,559			\$ 41,014	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 2017 report.		\$	122,406	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.)	2017	\$	132,187	2
3. Under or (over) accrual (line 2 minus line 1).		\$	9,781	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	138,797	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
	Alloc Fr. Mgmt Co.		4,040	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	152,618	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	156,396	8	
	2014	59,086	9	
	2015	108,269	10	
	2016	116,961	11	
	2017	132,187	12	
2018 Tax Accrual = \$132,187 X 1.05 = \$138,797 (rounded)				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Symphony Countryside, LLC D/B/A Countryside Care Centri COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0051763

CONTACT PERSON REGARDING THIS REPORT Ari Krupp

TELEPHONE (410) 258-7363 FAX #: N/A

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-19-176-009</u>	<u>Nursing Home</u>	\$ <u>132,186.98</u>	\$ <u>132,186.98</u>
2. <u>10-27-319-028-0000</u>	<u>Land & Property Mgmt. Co.</u>	\$ <u>87,874.67</u>	\$ <u>4,040.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>220,061.65</u></u>	\$ <u><u>136,226.98</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? 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 59536 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Alloc Fr Maestro 7257</u>	<u>-</u>		<u>\$ 7,105</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 7,105	3

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$ -		\$ -	\$	\$	4
5						-		-			5
6						-		-			6
7						-		-			7
8		Allocated from Maestro 7257	2004		63,946	-	39	1,827	1,827	27,634	8
		Improvement Type**									
9		Architectural fees, contractor fees, paint, remove wallpaper, install flooring, demo, carpentry, drywall, install wallpaper	2013		198,047	9,902	20	9,902		59,413	9
10		First Floor				-		-			10
11		Demo/carpentry/drywall, acoustical ceiling, interior electrical	2013		116,913	5,846	20	5,846		35,075	11
12		alarms, painting, wall covering, floor covering, add 3 heads				-		-			12
13		contractor fees - First Floor and Dining Room				-		-			13
14		Interior painting, replace storefront glass, wall and floor coverings - First Floor	2013		22,173	1,110	20	1,110		6,472	14
15		Repiped water line to 3 compartments	2013		2,630	132	20	132		758	15
16		Demo/carpentry/drywall, permit, contractor fees - First Floor	2013		54,915	2,746	20	2,746		16,018	16
17		Interior electrical alarms	2013		16,460	823	20	823		4,801	17
18		Exterior demo/carpentry, interior elec/alarms, plumbing, open office, engineering - First Floor & Dining Room	2013		50,619	2,531	20	2,531		14,553	18
19		Carpet removal - Nurses station tie back in all vct	2013		10,856	543	20	543		3,122	19
20		Roofing	2013		10,000	500	20	500		2,875	20
21		Lounge 500 - New Carpet	2013		3,100	443	7	443		2,509	21
22		Demo/carpentry/drywall, electrical, glass, demo brick & rebuild around windows, engineering, besam swing door, painting, modified, bitumen, ridge vent, aluminum soffit, architecture fees, stucco molding, contractors fees - First Floor, Spa Room, Rear Entry Vestibule, Exterior of Building	2013		303,589	15,179	20	15,179		84,271	22
23		Fencing in patio	2013		2,922	195	15	195		1,055	23
24		Electircal work for office	2013		4,391	219	20	219		1,169	24
25		Demo/carpentry/drywall, window wall tape & mud, saw cut concrete, excavation, rough in & frame roof & rear vestibule, steel posts, besam swing door, contractors fees - Rear Vestibule & Second Floor	2013		49,040	2,452	20	2,452		12,872	25
26						-		-			26
27						-		-			27
28						-		-			28
29						-		-			29
30						-		-			30
31						-		-			31
32						-		-			32
33						-		-			33
34						-		-			34
35						-		-			35
36						-		-			36

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

See Page 12A, Line 70 for total

**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	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	Painting/Carpentry - Entry & Second Floor	2013	\$ 13,180	\$ 1,882	7	\$ 1,882	\$	\$ 9,882	37
38	Demo/Carpentry/Drywall, exterior demo, emergency power, electrical, gen cont fees-Entryway & Second Floor	2013	53,564	2,679	20	2,679		13,617	38
39				-		-			39
40	Painting/Carpentry - Office & Back Entrance	2013	1,980	283	7	283		1,438	40
41	Roof Garden	2013	8,595	573	15	573		2,912	41
42				-		-			42
43	Facility Remodeling	2014	85,002	5,741	5-20	5,741		26,615	43
44	- Custom Hollow Metal Doors & Frames: Entrance			-		-			44
45	- Exterior Demo & Carpentry			-		-			45
46	- General Contracting			-		-			46
47	- Architecture Fees			-		-			47
48	- Install & Wire 2 Light Poles & Replace Ballards			-		-			48
49	- Interior Painting of Door Jambs & 3 Hallways			-		-			49
50	- Supplied & Installed Metal Flashing, Flat Roof, and Cement Roof on 2nd Floor			-		-			50
51				-		-			51
52	- Sealcoating Parking Lot			-		-			52
53	- Bipart Slide Door			-		-			53
54	- Repair and Install Grease Interceptor: Kitchen			-		-			54
55	- Enclose Top of W/Drywall in Closet: Resident Rooms			-		-			55
56	- Remove Vent and Install Piece of Sheet Metal in closets			-		-			56
57	- Tape and Install FRP			-		-			57
58	- Provide Door Coordinators on 8 doors			-		-			58
59				-		-			59
60	Code-Compliant Door Restrictor on 2-Stop Hydraulic Elevator	2015	3,300	165	20	165		633	60
61	New Overhang Roof, Replaced 12 Pieces of Metal Decking	2015	21,248	1,062	20	1,062		3,716	61
62	-Applied Patch to Wall Flashing			-		-			62
63				-		-			63
64	Window Treatments, Design Fee for Dialysis Unit	2015	4,409	220	20	220		697	64
65	Demo, Flooring, Electrical, plumbing, permits	2015	53,972	2,698	20	2,698		8,544	65
66	Signs & Banners Aluminium, Rebranded Facility	2015	20,164	1,008	20	1,008		3,079	66
67				-		-			67
68				-		-			68
69				-		-			69
70	TOTAL (lines 4 thru 69)		\$ 1,175,014	\$ 58,930		\$ 60,757	\$ 1,827	\$ 343,728	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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,175,014	\$ 58,930		\$ 60,757	\$ 1,827	\$ 343,728	1
2	Relocate sink waste, vent H&C water supply in 1 dialysis station	2016	15,315	766	20	766		2,298	2
3				-		-			3
4	Install new stand alone wall mounted cooling system in mechanical room.	2016	20,741	1,037	20	1,037		3,025	4
5				-		-			5
6	Design and IFPH Certification for dialysis unit	2016	12,694	635	20	635		1,640	6
7	Strip and refinish floors 2nd floor dining room	2016	6,434	919	7	919		2,068	7
8	Lounge, corridors, 1st floor patient rooms(9)			-		-			8
9	Therapy Room (2)			-		-			9
10	Roof Repairs-33,750 Square feet	2016	3,015	603	5	603		1,357	10
11				-		-			11
12	Galvanized Steel Insulate Mechanical Room	2017	2,531	182	14	182		348	12
13	Remodify Ductwork - Rooftop	2017	8,100	576	14	576		1,155	13
14	Remodify Ductwork - Rooftop	2017	8,100	576	14	576		1,107	14
15	A/C Heat Pump	2017	6,099	1,225	5	1,225		1,531	15
16	Install power unit ATS 3 phase-Electrical Room 1st floor	2018	5,516	409	14	409		409	16
17	Elevator-Door Edge Lobby	2018	3,250	179	14	179		179	17
18	Repair damaged asphalt in 22 areas in parking lot	2018	8,900	184	14	184		184	18
19	Phone System Upgrade - Full building 1st floor main	2018	45,831	18	7	18		18	19
20				-		-			20
21	Reconcile for Financial statements			-		-			21
22	Allocated from Maestro Consulting Services	2003	520	-		26	26	393	22
23	Allocated from Maestro Consulting Services	2004	10,560	-		527	527	7,773	23
24	Allocated from Maestro Consulting Services	2005	626	-		31	31	434	24
25	Allocated from Maestro Consulting Services	2006	849	-		42	42	525	25
26	Allocated from Maestro Consulting Services	2008	895	-		45	45	459	26
27	Allocated from Maestro Consulting Services	2009	14,407	-		720	720	6,922	27
28	Allocated from Maestro Consulting Services	2010	2,214	-		111	111	942	28
29	Allocated from Maestro Consulting Services	2011	120	-		6	6	47	29
30	Allocated from Maestro Consulting Services	2012	133	-		7	7	45	30
31	Allocated from Maestro Consulting Services	2014	1,665	-		83	83	384	31
32	Allocated from Maestro Consulting Services	2015	468	-		23	23	78	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		\$ 1,353,997	\$ 66,239		\$ 69,687	\$ 3,448	\$ 377,049	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 1,353,997	\$ 66,239		\$ 69,687	\$ 3,448	\$ 377,049		1
2			-		-				2
3	Allocated from Maestro Consulting Services	2016 2,052	-	20	205	205	490		3
4	Allocated from Maestro Consulting Services	2017 274	-	20	14	14	27		4
5	Allocated from Maestro 7257	2004 1,271	-	20	64	64	921		5
6	Allocated from Maestro 7257	2005 5,829	-	10	209	209	4,484		6
7	Allocated from Maestro 7257	2015 1,008	-	10	67	67	224		7
8			-						8
9	Broken cast iron piping and combi oven	2018 6,019	-	20	301	301	301		9
10			-						10
11	Book depreciation tied to financial statements		(44,481)		-	44,481			11
12			-		-				12
13			-		-				13
14			-		-				14
15			-		-				15
16			-		-				16
17			-		-				17
18			-		-				18
19			-		-				19
20			-		-				20
21			-		-				21
22			-		-				22
23			-		-				23
24			-		-				24
25			-		-				25
26			-		-				26
27			-		-				27
28			-		-				28
29			-		-				29
30			-		-				30
31			-		-				31
32			-		-				32
33			-		-				33
34	TOTAL (lines 1 thru 33)	\$ 1,370,450	\$ 21,758		\$ 70,547	\$ 48,789	\$ 383,496		34

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

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	\$ 760,644	\$ 136,846	\$ 136,846	\$ -	5	\$ 710,829	71
72	Current Year Purchases	18,921	2,357	2,357	-	5	2,357	72
73	Fully Depreciated Assets	52,826			-		52,826	73
74	See Sch 13A	208,767		15,306	15,306		92,221	74
75	TOTALS	\$ 1,041,158	\$ 139,203	\$ 154,509	\$ 15,306		\$ 858,233	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	Patient Transportation	2008 Ford Van	2013	\$ 16,587	\$ 1,659	\$ 1,659	\$ -	10	\$ 9,538	76
77					-	-	-			77
78	Alloc. from Maestro Consult.			393	-	-	-		393	78
79					-	-	-			79
80	TOTALS			\$ 16,980	\$ 1,659	\$ 1,659	\$ -		\$ 9,931	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,435,693	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 162,620	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 226,715	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 64,095	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,251,660	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	CIP	\$ 1,456	92
93			93
94			94
95		\$ 1,456	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 Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY
IDPH License ID Number: 0051763
Fiscal Year End: 12/31/18

Schedule 13A

XI. Ownership Costs

Line 74 - Equipment Costs - Excluding Transportation

Category of				Current Book	Straight Line		Component	Accumulated
Equipment	Cost			Depreciation	Depreciation	Adjustments	Life	Depreciation
Allocated from Symphony Financial		25,061			3,933			22,100
Allocated from Maestro Consulting		183,706			11,373			70,121
TOTAL		208,767			15,306	0		92,221

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF ORC# 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Eclipse Kensington 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>1972</u>	<u>203</u>	<u>12/31/2011</u>	\$ <u>1,784,973</u>	<u>10</u>	<u>10</u>	3
4	Additions						4
5							5
6	<u>Alloc. Mgmt. Co. Maestro</u>			<u>2,935</u>			6
7	TOTAL	203		\$ 1,787,908			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. 12/31/2019 \$ 1,185,759

13. 12/31/2020 \$ 1,209,474

14. 12/31/2021 \$ 1,233,664

8. List separately any amortization of lease expense included on page 4, line 34. 996

This amount was calculated by dividing the total amount to be amortized 9959

by the length of the lease 10.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 85,621 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			\$	\$	17
18					18
19					19
20	<u>Alloc. from Mgmt. Co.</u>			<u>6,464</u>	20
21	TOTAL		\$	\$ 6,464	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 Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY
IDPH License ID Number: 0051763
Fiscal Year End: 12/31/18

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Bariatric beds, pressurized mattresses, wheelchair	22,469
Respiratory equipment	770
Vital monitors	2,136
Ice making machine	5,160
Dishwashing machine rental	739
Water dispenser	88
Copier	40,562
Music over the paging system	254
Postage machine	1,644
Aquarium tank and service	5,828
Allocated from Symphony Finan	2,194
Allocated from Integra	(3,490)
Allocated from Maestro	7,267
Total - Line 16	<u>85,621</u>

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18
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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VA# 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff 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	\$	9,468	\$ 681,729	\$	9,468	\$	681,729						1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,597	114,949		1,597		114,949						2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs		13,530	974,159		13,530		974,159						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							138,897					138,897	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Oxygen</u>	39(2)								1,715					1,715	12
13	Other (specify): <u>See Schedule 16A</u>	39(3)								811					58,412	13
14	TOTAL			\$	25,406	\$ 1,829,249	\$	25,406	\$	140,612					\$ 1,969,861	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 Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY
IDPH License ID Number: 0051763
Fiscal Year End: 12/31/18

Schedule 16A

XIV. Special Services (Direct Cost)

Line 13 Other (specify)

Description	Units	Amount
Inhalation Therapy Costs-Medicaid		5,773
Inhalation Therapy Costs-Medicare A		6,738
Inhalation Therapy Costs-Managed Care		7,363
Inhalation Therapy Costs-Private		672
I.V. Therapy Costs-Medicaid		3,800
I.V. Therapy Costs-Medicare A		17,082
I.V. Therapy Costs-Managed Care		16,134
I.V. Therapy Costs-Private		850
Total - Line 13	-	58,412

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF OR# 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,500	\$ 3,500	1
2	Cash-Patient Deposits	33,190	33,190	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>4,337,241</u>)	6,073,912	6,073,912	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,615	5,615	6
7	Other Prepaid Expenses	311,301	311,301	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,427,518	\$ 6,427,518	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		7,105	13
14	Buildings, at Historical Cost		63,946	14
15	Leasehold Improvements, at Historical Cost	1,205,664	1,306,504	15
16	Equipment, at Historical Cost	901,638	1,058,138	16
17	Accumulated Depreciation (book methods)	(1,061,733)	(1,251,660)	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 (sp) <u>Lease Cost</u>	9,959	9,959	22
23	Other(specify): <u>See Schedule 17A</u>	133,523	133,523	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,189,051	\$ 1,327,515	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,616,569	\$ 7,755,033	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 3,993,831	\$ 3,993,831	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	100,705	100,705	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	358,322	358,322	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,405	54,405	31
32	Accrued Real Estate Taxes(Sch.IX-B)	138,797	138,797	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>	2,431,663	2,431,663	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,077,723	\$ 7,077,723	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	183,559	183,559	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)	\$ 183,559	\$ 183,559	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,261,282	\$ 7,261,282	46
47	TOTAL EQUITY(page 18, line 24)	\$ 355,287	\$ 493,751	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,616,569	\$ 7,755,033	48

*(See instructions.)

Facility Name: Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY
 IDPH License ID Number: 0051763
 Fiscal Year End: 12/31/18

Schedule 17A

XV. Balance Sheet

Line 23 Long-Term Assets Other (specify):

Description	After	
	Operating	Consolidation
Fixed Assets - Construction in Process	1,456	1,456
Other Assets - Security Deposits	271,874	271,874
Due To/From - Crestwood LLC	830,000	830,000
Due To/From - Decatur	231,000	231,000
Due To/From - Deerbrook LLC	98,000	98,000
Due To/From - Maple Crest LLC	(22,234)	(22,234)
Due To/From - Maple Ridge LLC	112,600	112,600
Due To/From - McKinley LLC	105,000	105,000
Due To/From - Northwoods LLC	100,000	100,000
Due To/From - Sycamore LLC	105,000	105,000
Due To/From - Tillers	(17,715)	(17,715)
Due To/From - Crown Point LLC	-	-
Due To/From - Dyer LLC	-	-
Due To/From - Symphony Healthcare	(941,946)	(941,946)
Due To/From - Symphony Financial Services	(575,135)	(575,135)
Due To/From - Symcare Healthcare	(165,110)	(165,110)
Due To/From - Symdiana Healthcare	127,000	127,000
Due To/From - Maestro	(126,267)	(126,267)
Total - Line 23	133,523	133,523

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
ACCUMULATED AMORTIZATION DEFERED	-	-
Cash	178,284	178,284
CSA I/C Related/Party Due To/From Accts	(251,090)	(251,090)
Resident Receivable Balance	-	-
Accrued Payables	41,391	41,391
Accrued Payables - Professional Fees	22,669	22,669
Accrued Payables - Health Insurance	122,091	122,091
Accrued Payable - Dental Insurance	(725)	(725)
Accrued Payables - Vision Insurance	(117)	(117)
Accrued Payables - Life Insurance	4,443	4,443
Accrued Payables - Short Term Disability	(6,196)	(6,196)
Accrued Payables - Payroll Union Dues	2,001	2,001
Accrued Payables - 401K Deductions	1,959	1,959
Accrued Payables - 401K Loan Repayments	919	919
Accrued Payables - Garnishments	(11,126)	(11,126)
Accrued Payables - WC/GL Insurance	320,371	320,371
Accrued Payables - Bed Taxes Add'l	26,375	26,375
Accrued Payables - Management Fees	680,871	680,871
Accrued Payables - Interest	354	354
Accrued Payables - Rent	224,825	224,825
Accrued Payables - Sales Tax	444	444
Sales Tax Payable - Manual	118	118
Deferred Rent	418,287	418,287
Lease Holds Payable	655,515	655,515
Total - Line 36	2,431,663	2,431,663

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,128,156	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(625,958)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,502,198	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,146,911)	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)	\$ (1,146,911)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 355,287	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,465,363	1
2	Discounts and Allowances for all Levels	(2,409,675)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,055,688	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,419,643	6
7	Oxygen	9,365	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,429,008	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	201,982	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,759	19
20	Radiology and X-Ray	16,284	20
21	Other Medical Services	83,621	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 342,646	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	24,835	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,835	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	10	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,852,187	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,614,259	31
32	Health Care	4,702,155	32
33	General Administration	3,402,953	33
B. Capital Expense			
34	Ownership	2,240,044	34
C. Ancillary Expense			
35	Special Cost Centers	2,600,169	35
36	Provider Participation Fee	439,518	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,999,098	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,146,911)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,146,911)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,026,720	44
45	Private Pay - Net Inpatient Revenue	727,958	45
46	Medicare - Net Inpatient Revenue	932,329	46
47	Other-(specify) <u>MAIP</u>	315,266	47
48	Other-(specify) <u>Managed Care/Veteran/Hospice</u>	1,053,415	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,055,688	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.

^ Entity is a cash basis taxpayer

Facility Name & ID Number **Symphony Countryside, LLC D/B/A SYMPHONY OF ORC**

0051763

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	1,881	2,004	\$ 106,497	\$ 53.14	1
2	Assistant Director of Nursing	1,645	1,809	73,942	40.87	2
3	Registered Nurses	31,632	35,573	1,096,840	30.83	3
4	Licensed Practical Nurses	28,484	33,191	893,614	26.92	4
5	CNAs & Orderlies	95,504	110,053	1,636,787	14.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,871	6,513	93,724	14.39	10
11	Social Service Workers	2,121	2,197	55,088	25.07	11
12	Dietician					12
13	Food Service Supervisor	1,644	1,691	44,721	26.45	13
14	Head Cook	6,084	7,079	89,533	12.65	14
15	Cook Helpers/Assistants	14,066	16,158	169,998	10.52	15
16	Dishwashers					16
17	Maintenance Workers	3,680	4,366	95,519	21.88	17
18	Housekeepers	11,225	12,339	136,854	11.09	18
19	Laundry	6,652	7,700	92,830	12.06	19
20	Administrator	1,622	1,736	108,132	62.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,895	12,005	212,193	17.68	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	4,369	4,868	81,018	16.64	31
32	Other Health C: See Sch 20A	9,279	10,161	290,689	28.61	32
33	Other(specify) See Sch 20A	3,412	3,651	106,308	29.12	33
34	TOTAL (lines 1 - 33)	240,066	273,094	\$ 5,384,287 *	\$ 19.72	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	\$ 23,871	1(3)	35
36	Medical Director	Monthly	24,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	6,890	10()	38
39	Pharmacist Consultant	Monthly	16,970	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	8,317	39 (3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,914	11(3)	44
45	Social Service Consultant				45
46	Other(specify) Dialysis	Monthly	107,415	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 190,377		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

Facility Name: Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY
IDPH License ID Number: 0051763
Fiscal Year End: 12/31/18

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Alzheimers Program Coordinator	903	956	10,664	\$ 11.15
MDS Coordinator	4,029	4,346	137,462	\$ 31.63
Nurse - Unit Manager	4,347	4,858	142,563	\$ 29.35
Total - Line 32 Other Health Care (specify):	9,279	10,160	290,689	

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions Coordinator	1,837	1,964	61,620	\$ 31.37
Director of Customer Experience & Marketing	1,575	1,687	44,688	\$ 26.49
Total - Line 33 Other (specify):	3,412	3,651	106,308	

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	
<u>Brittany Herwig</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 108,132</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 162,689</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>48,389</u>	<u>Advertising: Employee Recruitment</u>	<u>2,912</u>	
				<u>FICA Taxes</u>	<u>399,992</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>413,001</u>	<u>(Indicate # of checks performed <u>157</u>)</u>	<u>1,883</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks <u>223</u></u>	<u>2,675</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>5,058</u>	
				<u>Employee Retirement</u>	<u>6,558</u>	<u>Healthcare Council of Illinois</u>	<u>33,681</u>	
				<u>Employee Benefits - Other</u>	<u>9,159</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>590</u>	
				<u>Employees' Physical Exams</u>	<u>434</u>	<u>Lobbying Expense</u>	<u>(16,840)</u>	
						<u>Allocated from Maestro</u>	<u>5,197</u>	
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 108,132					
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
					\$ 1,040,222		\$ 35,156	
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
<u>Management Fees (Eliminated in Col. 7)</u>			<u>\$ 673,186</u>	Description	Line #	Amount	Description	Amount
							<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 673,186				<u>Seminar Expense</u>	<u>3,127</u>
(Attach a copy of any management service agreement)								
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount					
<u>ABILITY Network, Inc.</u>	<u>Secure Exchange Managed</u>		<u>\$ 7,881</u>				<u>Allocated from Maestro</u>	<u>1,048</u>
<u>Allscripts LLC</u>	<u>IT System</u>		<u>3,182</u>				<u>Entertainment Expense</u>	<u>()</u>
<u>Alteryx, Inc.</u>	<u>Data analytics</u>		<u>1,017</u>					
<u>American Express</u>	<u>Internet</u>		<u>5,342</u>					
<u>Applicant Tracking System</u>	<u>Recruiting</u>		<u>66</u>					
<u>Cerida Investment Corp</u>	<u>Business Services</u>		<u>432</u>					
<u>Comcast Cable</u>	<u>Internet</u>		<u>31,097</u>					
<u>Creative Technology Solutions</u>	<u>IT Support</u>		<u>23,488</u>					
<u>Dart Chart Systems</u>	<u>Software</u>		<u>6,952</u>					
<u>DataRobot, Inc</u>	<u>Computer Services</u>		<u>1,250</u>					
<u>Digital Marketing SEO</u>	<u>Branding</u>		<u>403</u>					
<u>See Schedule 21C</u>			<u>393,950</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 475,060	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,175
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VALLEY
 IDPH License ID Number: 0051763
 Fiscal Year End: 12/31/18

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Formation Healthcare Group, LLC	Monthly Subscription Fee	1,016
FYI Systems	Computer IT	420
Health Data Systems Inc	Programming	3,693
Managed Care Group LLC	IT Support	1,466
Market Metrix	Customer and Employee Metrix Subscription	860
Mood Media	Music over the paging system	52
Nexuscomm, LLC	Cable	4,835
PatientPing, Inc.	Care coordination network	4,000
PointClickCare Technologies Inc.	Cloud based software and services	40,942
Prime Care Technologies	PBJ Reporting Module Access Fee	222
Real Time Medical Systems LLC	Clinical and Financial Analytics Service	4,331
Scott Norton	Computer Consulting	382
Snowflake Computing, Inc.	Computer Services	670
Sourcetech	Operator Monthly Support Fee	1,380
Telemedicine Solutions, LLC	Wound Rounds Care	15,012
Wencel Worldwide, Inc	Branding	3,829
RSM US LLP	Accounting	21,086
Accrual	Legal fees	61,911
Chuhak & Tecson, P.C.	Legal fees	13,543
HIPP Law Office	Legal fees	2,248
Lewis & Gellen, LLP	Legal fees	37
Much Shelist	Legal fees	298
Neal, Gerber & Eisenberg, LLP	Legal fees	59
SB2 Inc.	Legal fees	214
Stone, Pogrund & Korey LLC	Legal fees	10
Achieve Accreditation	Accreditation	9,376
Corporation Service Company	Annual Filing	254
Jan Paul Storey	Consulting services	85
Life Safety Resources, LLC	Manufacturing	3,080
LTC Consulting	Collection Agency	117,560
Maestro Consulting Services	Consulting services	57,998
McCabe, Kirshner P.C.	Consulting services	4,516
MTS Consulting, LLC	Tax consulting	5,494
National Datacare Corporation	Trust fund and Medicaid billing services	2,909
Personnel Planners, Inc	Quarterly Unemployment Claims	1,245
Resolute Healthcare	Consulting services	4,023
SB2 Inc.	Professional fees	2,134
The Joint Commission	License accreditation	2,760
	From Pg21	81,110
	Total (agree to Schedule V, line 19, column 3)	475,060
Allocated from Maestro		89,213
Allocated from Management Company	Legal Fees	
Allocated from Management Company	Professional Services	107
	Less: Non-Allowable Legal Fees	(3,794)
	Total (agree to Schedule V, line 19, column 8)	560,586

Facility Name & ID Number Symphony Countryside, LLC D/B/A SYMPHONY OF ORCHARD VAL # 0051763 Report Period Beginning: 1/1/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HC Council of IL - \$33,681
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (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? No 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. \$ 439,518
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.