FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0053728

Facility Name: SYMPHONY AT 87TH STREET

Address: 2940 West 87Th Street (Number) Chicago (City) 60652 (Zip Code)

County: Cook

Telephone Number: (773) 434-8787 **Fax #** (773) 434-8717

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,650	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	210	TOTALS	210	76,650	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			21,495	21,495	8
9	SNF/PED					9
10	ICF	38,233	2,048	4,275	44,556	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,233	2,048	25,770	66,051	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.17%

D. How many bed reserve days during this year were paid by the Department?
None (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/1999

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date New Construction NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 210 and days of care provided 12,696

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	377,236	107,775	38,946	523,957		523,957		523,957			1
2	Food Purchase		408,314		408,314	(37,540)	370,774	(127)	370,647			2
3	Housekeeping			410,629	410,629		410,629		410,629			3
4	Laundry		248,515		248,515		248,515		248,515			4
5	Heat and Other Utilities			240,807	240,807		240,807	(10,349)	230,458			5
6	Maintenance	103,758		160,025	263,783		263,783	26,789	290,572			6
7	Other (specify):*							3,371	3,371			7
8	**TOTAL General Services**	480,994	764,604	850,407	2,096,005	(37,540)	2,058,465	19,685	2,078,150			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	5,174,068	326,959	166,863	5,667,890		5,667,890	140,209	5,808,099			10
10a	Therapy			10,980	10,980		10,980		10,980			10a
11	Activities	189,222		1,595	190,817		190,817		190,817			11
12	Social Services	315,324			315,324		315,324		315,324			12
13	CNA Training											13
14	Program Transportation			47,578	47,578		47,578	(5,028)	42,550			14
15	Other (specify):*							22,038	22,038			15
16	**TOTAL Health Care and Programs**	5,678,614	326,959	245,016	6,250,589		6,250,589	157,219	6,407,808			16
	C. General Administration											
17	Administrative	142,155		872,922	1,015,077		1,015,077	(805,393)	209,684			17
18	Directors Fees											18
19	Professional Services			349,663	349,663		349,663	2,123	351,786			19
20	Dues, Fees, Subscriptions & Promotions			65,058	65,058		65,058	(14,252)	50,806			20
21	Clerical & General Office Expenses	322,914	3,816	1,789,070	2,115,800		2,115,800	(1,414,324)	701,476			21
22	Employee Benefits & Payroll Taxes			954,184	954,184	37,540	991,724		991,724			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,827	7,827		7,827	1,357	9,184			24
25	Other Admin. Staff Transportation			352	352		352	8,066	8,418			25
26	Insurance-Prop.Liab.Malpractice			403,079	403,079		403,079	3,057	406,136			26
27	Other (specify):*							50,435	50,435			27
28	**TOTAL General Administration**	465,069	3,816	4,442,155	4,911,040	37,540	4,948,580	(2,168,931)	2,779,650			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,624,677	1,095,379	5,537,578	13,257,634		13,257,634	(1,992,026)	11,265,608			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 AT 87TH STREET #0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			15,174	15,174		15,174	345,191	360,365			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			147,780	147,780		147,780	1,983	149,763			32
33	Real Estate Taxes			557,882	557,882		557,882	3,700	561,582			33
34	Rent-Facility & Grounds			2,647,579	2,647,579		2,647,579	(2,641,708)	5,871			34
35	Rent-Equipment & Vehicles			69,356	69,356		69,356	4,210	73,566			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,437,771	3,437,771		3,437,771	(2,286,623)	1,151,148			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		848,983	2,581,956	3,430,939		3,430,939	(27,670)	3,403,269			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			438,563	438,563		438,563		438,563			42
43	Other (specify):*			81,700	81,700		81,700	(81,700)				43
44	**TOTAL Special Cost Centers**		848,983	3,102,219	3,951,202		3,951,202	(109,370)	3,841,832			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,624,677	1,944,362	12,077,568	20,646,607		20,646,607	(4,388,020)	16,258,587			45

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,445)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	339,413	30		9
10	Interest and Other Investment Income	(11,901)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(127)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(28,862)	21		18
19	Entertainment				19
20	Contributions	(10,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,403,500)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,979,084)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,107,006)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(281,014)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (281,014)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (4,388,020)		37

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

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

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

SYMPHONY AT 87TH STREET

ID# 0053728

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (1,181)	21	1
2	Sequestration	(185,994)	21	2
3	Director of Customer Experience	(47,878)	21	3
4	Bank Charges	(182)	21	4
5	Marketing Consultant	(58,786)	43	5
6	Marketing Materials	(22,914)	43	6
7	Damages Loss	(65)	21	7
8	Patient Needs	(1,735)	10	8
9	Sales Tax	(1,128)	21	9
10	Sale/Leaseback	(2,647,579)	34	10
11	Additional R&M	6,836	06	11
12	PAC Dues	(10,246)	20	12
13	Non-Allowable Legal	(4,942)	19	13
14	Capitalized R&M	(3,290)	06	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**	(2,979,084)		49

SYMPHONY AT 87TH STREET

ID# 0053728

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(127)											(127)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,445)		2,096									(10,349)	5
6	Maintenance	3,546		23,243									26,789	6
7	Other (specify):*			3,371									3,371	7
8	**TOTAL General Services**	(9,026)		28,711									19,685	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,735)		141,944									140,209	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(5,028)							(5,028)	14
15	Other (specify):*			22,038									22,038	15
16	**TOTAL Health Care and Programs**	(1,735)		163,982		(5,028)							157,219	16
	C. General Administration													
17	Administrative			(805,393)									(805,393)	17
18	Directors Fees													18
19	Professional Services	(4,942)		7,065									2,123	19
20	Fees, Subscriptions & Promotions	(20,746)		6,494									(14,252)	20
21	Clerical & General Office Expenses	(1,668,790)		254,466									(1,414,324)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,357									1,357	24
25	Other Admin. Staff Transportation			8,066									8,066	25
26	Insurance-Prop.Liab.Malpractice			3,057									3,057	26
27	Other (specify):*			50,435									50,435	27
28	**TOTAL General Administration**	(1,694,478)		(474,453)									(2,168,931)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,705,239)		(281,759)		(5,028)							(1,992,026)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	339,413		5,778									345,191	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(11,901)		13,884									1,983	32
33	Real Estate Taxes			3,700									3,700	33
34	Rent-Facility & Grounds	(2,647,579)		5,871									(2,641,708)	34
35	Rent-Equipment & Vehicles			4,210									4,210	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(2,320,067)		33,444									(2,286,623)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(27,670)								(27,670)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(81,700)											(81,700)	43
44	**TOTAL Special Cost Centers**	(81,700)			(27,670)								(109,370)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,107,006)		(248,316)	(27,670)	(5,028)							(4,388,020)	45

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 [X] NO

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

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

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAESTRO CONSULTING SERVICES LLC	100.00%	$ 2,096	$ 2,096	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	18,594	18,594	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	4,649	4,649	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,371	3,371	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	120,782	120,782	19
20	V	10	CONTRACT NURSING		MAESTRO CONSULTING SERVICES LLC	100.00%	21,162	21,162	20
21	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	22,038	22,038	21
22	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	67,529	67,529	22
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	7,065	7,065	23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	6,494	6,494	24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	217,664	217,664	25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	36,802	36,802	26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,357	1,357	27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	8,066	8,066	28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,057	3,057	29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	50,435	50,435	30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	5,778	5,778	31
32	V	32	INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	13,884	13,884	32
33	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	3,700	3,700	33
34	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	5,871	5,871	34
35	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	978	978	35
36	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,232	3,232	36
37	V								37
38	V	17	MANAGEMENT FEE	872,922	MAESTRO CONSULTING SERVICES LLC	100.00%		(872,922)	38
39	Total			$ 872,922			$ 624,606	$ * (248,316)	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & Medical Equipment	$ 130,089	Integra Healthcare Equipment		$ 102,419	$ (27,670)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 130,089			$ 102,419	$ * (27,670)	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	Transportation	$ 45,460	Lifeline Ambulance		$ 40,432	$ (5,028)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 45,460			$ 40,432	$ * (5,028)	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	$ 171,519	Maple Leaf Insurance	100.00%	$ 171,519	$	15
16	V	26	Liability Insurance	453,732	Maple Leaf Insurance	100.00%	453,732		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			$ 625,251			$ 625,251	$ *	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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	SymcareHealthcare, LLC	99.9900%	SYMPHONY OF DECATUR	DECATUR	MAESTRO CONSULTING SERVI	LINCOLNWOOD	BOOKKEEPING	1
2	Symcare HMG, LLC	0.0100%	SYMPHONY OF DEERBROOK	DEERBROOK	7257 N. LINCOLN AVENUE	LINCOLNWOOD	BUILDING RENTAL	2
3			SYMPHONY OF COUNTRYSIDE	AURORA	MAPLELEAF INSURANCE	GRAND CAYMAN	INSURANCE	3
4			SYMPHONY OF CRESTWOOD	CRESTWOOD	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	4
5			SYMPHONY OF MAPLE CREST	BELVIDERE	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERV.	5
6			SYMPHONY OF LINCOLN	LINCOLN	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	6
7			SYMPHONY OF MCKINLEY	DECATUR				7
8			SYMPHONY OF NORTHWOODS	BELVIDERE				8
9			SYMPHONY OF SYCAMORE	QUINCY				9
10			SYMPHONY AT THE TILLERS	OSWEGO				10
11			SYMPHONY OF EVANSTON	EVANSTON				11
12			SEVEN OAKS	GLENDALE, WISC				12
13			SYMPHONY OF DYER	DYER, IN				13
14			SYMPHONY OF CHESTERTON	CHESTERTON, IN				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, IN				15
16			SYMPHONY ARIA	HILLSIDE				16
17			SYMPHONY BRONZEVILLE PARK	CHICAGO				17
18			SYMPHONY BUFFALO GROVE	BUFFALO GROVE				18
19			SYMPHONY IVY	CHICAGO				19
20			SYMPHONY JACKSON SQUARE	CHICAGO				20
21			SYMPHONY LINCOLN PARK	CHICAGO				21
22			SYMPHONY MIDWAY	CHICAGO				22
23			SYMPHONY PARK SOUTH	CHICAGO				23
24			SYMPHONY SOUTH SHORE	CHICAGO				24
25			CLAREMONT HANOVER PARK	HANOVER PARK				25
26			CALIFORNIA GARDENS	CHICAGO				26
27			MONROE CORP	CHICAGO				27
28								28
29								29
30								30

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 [X]

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 [X] NO [ ]

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

Name of Related Organization: MAESTRO CONSULTING SERVICES LLC
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,835,856	28	$ 50,076	$	76,860	$ 2,096	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	444,128	444,128	76,860	18,594	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,835,856	28	111,048		76,860	4,649	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,835,856	28	80,529		76,860	3,371	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	2,884,957	2,884,957	76,860	120,782	5
6	10	CONTRACT NURSING	AVAIL. CENSUS DAYS	1,835,856	28	505,476		76,860	21,162	6
7	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,835,856	28	526,402		76,860	22,038	7
8	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	1,612,976	1,612,976	76,860	67,529	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,835,856	28	168,752		76,860	7,065	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,835,856	28	155,112		76,860	6,494	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,835,856	28	5,199,066	5,199,066	76,860	217,664	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,835,856	28	879,035		76,860	36,802	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,835,856	28	32,418		76,860	1,357	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,835,856	28	192,674		76,860	8,066	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,835,856	28	73,017		76,860	3,057	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,835,856	28	1,204,673		76,860	50,435	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,835,856	28	138,011		76,860	5,778	17
18	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,835,856	28	331,638		76,860	13,884	18
19	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,835,856	28	88,385		76,860	3,700	19
20	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	140,244		76,860	5,871	20
21	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	23,351		76,860	978	21
22	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,835,856	28	77,202		76,860	3,232	22
23										23
24										24
25	TOTALS					$ 14,919,170	$ 10,141,128		$ 624,606	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME & Medical Equipment	Direct			$	$		$ 102,419	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 102,419	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	Transportation	Direct			$	$		$ 40,432	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 40,432	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 [X] 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	Workers Compensation	Direct			$	$		$ 171,519	1
2	26	Liability Insurance	Direct						453,732	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					$	$		$ 625,251	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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
Street Address
City / State / Zip Code
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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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
Street Address
City / State / Zip Code
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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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
Street Address
City / State / Zip Code
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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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
Street Address
City / State / Zip Code
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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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
Street Address
City / State / Zip Code
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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Symcare		X	Line of Credit							146,298	6
7	Omnicare / Lifemed Pharmacy		X					207,545			1,482	7
8												8
9	TOTAL Facility Related						$	$ 207,545			$ 147,780	9
	B. Non-Facility Related*											
10	Interest Income		X								(11,901)	10
11	Allocated From Maestro		X								13,884	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,983	14
15	TOTALS (line 9+line14)						$	$ 207,545			$ 149,763	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 460,158	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.)		$ 501,995	2
3. Under or (over) accrual (line 2 minus line 1).		$ 41,837	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 519,745	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.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 561,582	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	446,442	8
	2013	424,905	9
	2014	433,464	10
	2015	455,895	11
	2016	498,295	12

2017 Accrual = $498,295 X 1.04 = $519,745 (Rounded)

Beginning Accrual Adjusted

Allocated from Maestro Consulting = $3,700

	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 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SYMPHONY AT 87TH STREET COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053728

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-36-322-011-0000	Long Term Care Property	$ 69,640.53	$ 69,640.53
2.	19-36-322-012-0000	Long Term Care Property	$ 88,140.65	$ 88,140.65
3.	19-36-322-013-0000	Long Term Care Property	$ 135,673.33	$ 135,673.33
4.	19-36-322-014-0000	Long Term Care Property	$ 97,647.14	$ 97,647.14
5.	19-36-322-015-0000	Long Term Care Property	$ 88,140.65	$ 88,140.65
6.	19-36-322-016-0000	Long Term Care Property	$ 12,903.01	$ 12,903.01
7.	19-36-322-017-0000	Long Term Care Property	$ 3,176.95	$ 3,176.95
8.	19-36-322-018-0000	Long Term Care Property	$ 2,972.89	$ 2,972.89
9.	10-27-319-028-0000	Allocated-7257 N. Lincoln	$ 88,384.90	$ 3,700.32
10.			$	$
		TOTALS	$ 586,680.05	$ 501,995.47

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SYMPHONY AT 87TH STREET COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053728

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,911 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	51,162	1994	$ 143,613	1
2	Allocated From Maestro- 7257 Lincoln		2004	6,699	2
3	TOTALS	51,162		$ 150,312	3

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	210			1999	$ 8,930,998	$	39	$ 223,306	$ 223,306	$ 4,172,654	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	89,068		20	4,434	4,434	81,681	9
10	Various			2000	45,130		20	1,174	1,174	20,532	10
11	Various			2001	40,213		20	2,011	2,011	32,907	11
12	Various			2002	12,014		20	344	344	10,516	12
13	Various			2003	20,012		20	795	795	15,693	13
14	Various			2004	27,005		20	244	244	26,639	14
15	Various			2005	16,125		20	75	75	15,538	15
16	Various			2006	109,609		20			109,608	16
17	Various			2010	320,346		20	29,837	29,837	232,542	17
18	Various			2011	169,484		20	14,484	14,484	117,454	18
19	Various			2012	43,995		20	3,686	3,686	35,089	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		783,631			39,182	39,182	354,050	67
68	Related Party Allocations (Pages 12H & 12I)		100,725	1,914		3,777	1,863	45,039	68
69	Financial Statement Depreciation			15,174			(15,174)		69
70	TOTAL (lines 4 thru 69)		$ 10,708,355	$ 17,088		$ 323,348	$ 306,260	$ 5,269,943	70

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,708,355	$ 17,088		$ 323,348	$ 306,260	$ 5,269,943	1
2	Installed 4" And 6" Check Valves And Cast Iron Pipe For Pump S	2015	12,450		20	623	623	1,868	2
3	Patched Cracks On Roof	2015	3,500		20	175	175	525	3
4	Custom Built Backsplash For 2Nd And 3Rd Floor Dinning Room	2015	2,982		20	149	149	447	4
5	Doors & Window(1) Replacement	2016	3,799		20	190	190	269	5
6	Roof Repair	2016	20,210		20	1,011	1,011	1,263	6
7	Hvac Repair	2016	4,227		20	211	211	299	7
8	Fan Coil Motor	2016	2,526		20	126	126	189	8
9	Architectural Services-Upgrade Of Mechanical Room	2016	29,415		20	1,471	1,471	1,471	9
10	Plumbing - Piping Replacement In Kitchen	2017	7,240		20	362	362	362	10
11	Plumbing - Repairs In Kitchen Piping- Floor Drains	2017	7,640		20	382	382	382	11
12	Coupling/Risers On Pumps-Cooling System-3Rd Floor Rooms	2017	3,290		20	164	164	164	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)		$ 10,805,634	$ 17,088		$ 328,212	$ 311,124	$ 5,277,183	34

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,805,634	$ 17,088		$ 328,212	$ 311,124	$ 5,277,183	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 10,805,634	$ 17,088		$ 328,212	$ 311,124	$ 5,277,183	34

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,805,634	$ 17,088		$ 328,212	$ 311,124	$ 5,277,183	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,805,634	$ 17,088		$ 328,212	$ 311,124	$ 5,277,183	34

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,805,634	$ 17,088		$ 328,212	$ 311,124	$ 5,277,183	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,805,634	$ 17,088		$ 328,212	$ 311,124	$ 5,277,183	34

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2005	96,496		20	4,825	4,825	87,853	9
10	Built In Kitchen Unit/Cabinet/Table Legs And Sink	2007	10,200		20	510	510	6,460	10
11	Replace Built-In Cabinets And Credenza Unit	2007	9,800		20	490	490	6,125	11
12	2Nd Floor - Sink	2007	4,800		20	240	240	3,000	12
13	3Rd Floor - Assisted Bathing Area	2007	5,200		20	260	260	3,250	13
14	150 Yds Tranquility Dandelion - Wall Covering	2007	2,546		20	127	127	2,077	14
15	2Nd Floor Dinning Room - Electrical	2007	3,500		20	175	175	2,188	15
16	3Rd Floor Dinning Room - Electrical	2007	3,500		20	175	175	2,188	16
17	Basement Corridor	2007	2,750		20	138	138	1,723	17
18	Lobby/Large Main Office - Carpeting	2007	8,578		20	429	429	5,801	18
19	Door Upgrades & R&M	2007	4,301		20	215	215	2,688	19
20	Replace Ejector Pumps For Flood Control System	2007	3,700		20	185	185	2,189	20
21	Vct Tiles For Bathroom	2008	4,656		20	233	233	2,330	21
22	Upholestered Cornice And Roller Shades; Remove Existing Windo	2008	8,647		20	432	432	4,321	22
23	Material & Labor For Power Supply & Switch For Airconditiong	2008	5,726		20	286	286	2,861	23
24	Installation: Sprinkler, Ddc Valve, Expansion Tank & Anitfreeze	2008	7,665		20	383	383	3,831	24
25	Replacement Motor & Compressor And Refrigerant Of Freezer	2008	5,368		20	268	268	2,681	25
26	Telephone System Tadrian	2008	23,739		20	1,187	1,187	11,870	26
27	Motor Conversion	2008	2,965		20	148	148	1,481	27
28	130 Ft Of Sdr35 Drain Tile	2008	8,910		20	446	446	4,459	28
29	Asphalt Repair Work Sealing And Striping	2008	7,600		20	380	380	3,780	29
30	Prime And Paint Outside Railings, Repair Walls, Paint Payroll Of	2008	3,220		20	161	161	1,610	30
31	Painting - 2Nd Floor Doorframes And Dining Room	2008	2,970		20	149	149	1,489	31
32	Plaster, Prime, And Paint 3Rd Floor Dining Rm Walls, Window S	2008	10,600		20	530	530	5,300	32
33	Part & Labor to repair Fire Sprinkler System	2009	4,224		20	211	211	1,899	33
34	TOTAL (lines 1 thru 33)		$ 251,661	$		$ 12,583	$ 12,583	$ 173,454	34

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 251,661	$		$ 12,583	$	$ 173,454	1
2	Core Glosswhite Tile	2009	2,753		20	138	138	1,242	2
3	Paint & Remodeling of 7 Shower Rooms	2009	17,363		20	868	868	7,812	3
4	Flooring	2011	194,042		20	9,702	9,702	67,914	4
5	Casework/Countertops	2011	68,125		20	3,406	3,406	23,842	5
6	Demolition/Carpentry	2011	74,500		20	3,725	3,725	26,075	6
7	Buildout	2011	65,045		20	3,252	3,252	22,764	7
8	Wallpaper/Paint	2011	59,430		20	2,972	2,972	20,804	8
9	VCT Tile Removal & Installation-Resident Rooms 1st,2nd & 3rd F	2014	44,000		20	2,200	2,200	8,800	9
10	Install New Vinyl Base in Resident Rooms with New Tiles-1,2&3rd	2014	3,900		20	195	195	780	10
11	2nd Floor - Replaced Wood Door and Window	2014	2,812		20	141	141	563	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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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)		$ 783,631	$		$ 39,182	$ 26,599	$ 354,050	34

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Maestro- 7257 Lincoln	2004	60,287	1,546	35	1,722	176	24,330	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Maestro	2003	490		20	25	25	346	9
10	Allocated From Maestro	2004	9,956		20	497	497	6,832	10
11	Allocated From Maestro	2005	590		20	30	30	379	11
12	Allocated From Maestro	2006	800		20	40	40	455	12
13	Allocated From Maestro	2008	844		20	42	42	390	13
14	Allocated From Maestro	2009	13,582		20	679	679	5,847	14
15	Allocated From Maestro	2010	2,087		20	104	104	783	15
16	Allocated From Maestro	2011	113		20	6	6	39	16
17	Allocated From Maestro	2012	126		20	6	6	36	17
18	Allocated From Maestro	2014	1,570		20	78	78	283	18
19	Allocated From Maestro	2015	442		20	22	22	51	19
20	Allocated From Maestro	2016	1,935	248	20	193	(55)	268	20
21	Allocated From Maestro	2017	259		20	13	13	13	21
22									22
23	Allocated From Maestro- 7257 Lincoln	2015	950	81	20	63	(18)	148	23
24	Allocated From Maestro- 7257 Lincoln	2005	5,496	39	20	197	158	4,030	24
25	Allocated From Maestro- 7257 Lincoln	2004	1,198		20	60	60	809	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 100,725	$ 1,914		$ 3,777	$ 1,863	$ 45,039	34

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 100,725	$ 1,914		$ 3,777	$ 1,863	$ 45,039	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 100,725	$ 1,914		$ 3,777	$ 1,863	$ 45,039	34

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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	$ 401,011	$ 590	$ 26,766	$ 26,176	10	$ 297,008	71
72	Current Year Purchases	49,788	3,275	4,979	1,704	10	4,979	72
73	Fully Depreciated Assets	1,966,788		410	410	10	1,966,787	73
74								74
75	TOTALS	$ 2,417,587	$ 3,865	$ 32,154	$ 28,289		$ 2,268,773	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From Maestro	2017	$ 371	$	$	$	5	$ 371	76
77										77
78										78
79										79
80	TOTALS			$ 371	$	$	$		$ 371	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)	$ 13,373,904	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 20,953	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 360,366	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 339,413	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,546,327	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Furniture, Computers	$ 144,200	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 & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		210		$ 2,647,579			3
4	Additions				(2,647,579)			4
5								5
6	Allocated From Maestro				5,871			6
7	TOTAL		210		$ 5,871 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 70,334 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated From Maestro		$	$ 3,232	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,232	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 & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 1,145,930	$		$ 1,145,930	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			143,911			143,911	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,143,134			1,143,134	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				639,611		639,611	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					148,981	209,372		358,353	13
14	TOTAL			$		$ 2,581,956	$ 848,983		$ 3,430,939	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.

STATE OF ILLINOIS

Facility Name & ID Number SYMPHONY AT 87TH STREET **#** 0053728 **Report Period Beginning:** 01/01/17 **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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 35,911	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	9,504,863		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	187,081		6
7	Other Prepaid Expenses	189,145		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,917,000	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	70,615		15
16	Equipment, at Historical Cost	68,624		16
17	Accumulated Depreciation (book methods)	(19,699)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	466,957		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 586,497	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,503,497	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,303,999	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,911		28
29	Short-Term Notes Payable	207,545		29
30	Accrued Salaries Payable	506,908		30
31	Accrued Taxes Payable (excluding real estate taxes)	85,520		31
32	Accrued Real Estate Taxes(Sch.IX-B)	519,745		32
33	Accrued Interest Payable	1,483		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	729,105		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,388,216	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	3,580,826		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,580,826	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,969,042	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,534,455	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,503,497	$	48

***(See instructions.)**

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 907,980	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)**	$ 907,981	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	626,474	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)**	$ 626,474	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)**	$ 1,534,455	24 *

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 20,547,570	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 20,547,570	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	709,159	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 709,159	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	1,410	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	372	19
20	Radiology and X-Ray	69	20
21	Other Medical Services	1,419	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,270	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,901	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,901	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,181	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,181	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 21,273,081	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,096,005	31
32	Health Care	6,250,589	32
33	General Administration	4,911,040	33
	B. Capital Expense		
34	Ownership	3,437,771	34
	C. Ancillary Expense		
35	Special Cost Centers	3,512,639	35
36	Provider Participation Fee	438,563	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,646,607	40
41	**Income before Income Taxes (line 30 minus line 40)****	626,474	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 626,474	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,624,052	44
45	Private Pay - Net Inpatient Revenue	468,667	45
46	Medicare - Net Inpatient Revenue	7,883,209	46
47	Other-(specify) Hospice	889,676	47
48	Other-(specify) Managed Care / MAIP	6,681,966	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 20,547,570	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

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

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,956	2,166	$ 118,397	$ 54.66	1
2	Assistant Director of Nursing	1,937	2,126	93,861	44.15	2
3	Registered Nurses	23,907	25,920	924,402	35.66	3
4	Licensed Practical Nurses	70,579	75,132	2,199,151	29.27	4
5	CNAs & Orderlies	122,881	132,874	1,770,104	13.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,813	4,171	93,840	22.50	9
10	Activity Assistants	6,629	7,309	95,382	13.05	10
11	Social Service Workers	10,995	12,213	315,324	25.82	11
12	Dietician					12
13	Food Service Supervisor	1,986	2,094	67,619	32.29	13
14	Head Cook	6,289	6,814	90,683	13.31	14
15	Cook Helpers/Assistants	17,140	18,502	218,934	11.83	15
16	Dishwashers					16
17	Maintenance Workers	3,997	4,415	103,758	23.50	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,988	2,086	142,155	68.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,808	16,033	275,036	17.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,851	2,134	32,899	15.42	31
32	Other Health Care(specify)					32
33	Other(specify)	3,603	4,014	83,132	20.71	33
34	TOTAL (lines 1 - 33)	294,359	318,003	$ 6,624,677 *	$ 20.83	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	823	$ 38,946	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,469	80,461	10-03	38
39	Pharmacist Consultant	Monthly	21,007	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	10,980	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	1,595	11-03	44
45	Social Service Consultant				45
46	Other(specify) Psychiatric	Monthly	30,780	10-03	46
47	Dental Consultant	Monthly	10,615	10-03	47
48	Orthopedic Consultant	Monthly	24,000	10-03	48
49	TOTAL (lines 35 - 48)	2,321	$ 236,384		49

C. CONTRACT NURSES

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

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Johnson	Administrator	0.00%	$ 142,155
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,155

B. Administrative - Other

Description	Amount
Management Fees- Maestro	$ 872,922
TOTAL (agree to Schedule V, line 17, col. 3)	$ 872,922
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Achieve Accreditation	Accreditation	$ 11,723
Corporation Service	State Filings	481
See Attached	Legal	52,931
Language Line Service	Interpretation	28
LTC Consulting Service	Billing Consulting	24,273
Medical Business Office	Managed Care Consulting	26,441
Michigan Peer Review	Conflict Resolution	818
MTS Consulting	Tax Consulting	3,239
National Datacare Corp	Data Processing	1,313
Personnel Planners	Unemployment Consulting	2,763
Resolute Healthcare	Healthcare Consulting	32,384
See Supplemental Schedules		193,269
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 349,663

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 177,180
Unemployment Compensation Insurance	91,149
FICA Taxes	494,276
Employee Health Insurance	125,383
Employee Meals	37,540
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	11,016
Pension Contributions	39,975
Other Employee Benefits	15,205
TOTAL (agree to Schedule V, line 22, col.8)	$ 991,724

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 994
Advertising: Employee Recruitment	190
Health Care Worker Background Check	5,464
(Indicate # of checks performed 546)	
Patient Background Checks 533	5,330
Dues & Subscriptions	23,352
Licenses & Permits	8,982
Allocated From Maestro	6,494
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,806

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,827
Allocated From Maestro	1,357
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,184

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SYMPHONY AT 87TH STREET # 0053728 Report Period Beginning: 01/01/17 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? **Yes**
If YES, give association name and amount. **Illinois Council on LTC: $20,491**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **427** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **Yes**
If YES, give effective date of lease. **11/1/2015**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Renaissance at 87th St., IDPH 0042093, Date 11/01/15

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **438,563**
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. $ **37,540** 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? **100 % Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees