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: 0053710

Facility Name: SYMPHONY AT ARIA

Address: 4600 Frontage Road (Number) Hillside (City) 60162 (Zip Code)

County: Cook

Telephone Number: (708) 544-9933 **Fax #** (708) 544-9966

HFS ID Number:

Date of Initial License for Current Owners: 9/28/2012

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 ARIA # 0053710 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	198	Skilled (SNF)	198	72,270	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	198	TOTALS	198	72,270	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			9,181	9,181	8
9	SNF/PED					9
10	ICF	41,539	2,982	8,103	52,624	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,539	2,982	17,284	61,805	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.52%

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)
N/A

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 09/28/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/28/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 198 and days of care provided 9,181

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 ARIA # 0053710 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	421,529	93,000	37,909	552,438		552,438		552,438			1
2	Food Purchase		347,110		347,110		347,110	(166)	346,944			2
3	Housekeeping	329,138		56,044	385,182		385,182		385,182			3
4	Laundry	45,009	23,239		68,248		68,248		68,248			4
5	Heat and Other Utilities			301,336	301,336		301,336	(8,112)	293,224			5
6	Maintenance	75,988		173,090	249,078		249,078	26,611	275,689			6
7	Other (specify):*							3,179	3,179			7
8	**TOTAL General Services**	871,664	463,349	568,379	1,903,392		1,903,392	21,511	1,924,903			8
	B. Health Care and Programs											
9	Medical Director			63,775	63,775		63,775		63,775			9
10	Nursing and Medical Records	4,162,773	355,232	103,449	4,621,454		4,621,454	132,614	4,754,068			10
10a	Therapy			26,447	26,447		26,447		26,447			10a
11	Activities	225,183		1,540	226,723		226,723		226,723			11
12	Social Services	234,504			234,504		234,504		234,504			12
13	CNA Training											13
14	Program Transportation			39,283	39,283		39,283	(4,143)	35,140			14
15	Other (specify):*							20,779	20,779			15
16	**TOTAL Health Care and Programs**	4,622,460	355,232	234,494	5,212,186		5,212,186	149,250	5,361,436			16
	C. General Administration											
17	Administrative	160,970		692,515	853,485		853,485	(628,845)	224,640			17
18	Directors Fees											18
19	Professional Services			374,728	374,728		374,728	(1,632)	373,096			19
20	Dues, Fees, Subscriptions & Promotions			43,863	43,863		43,863	(8,154)	35,709			20
21	Clerical & General Office Expenses	299,569	4,968	1,064,316	1,368,853		1,368,853	(674,702)	694,151			21
22	Employee Benefits & Payroll Taxes			985,695	985,695		985,695		985,695			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,173	1,173		1,173	1,280	2,453			24
25	Other Admin. Staff Transportation			3,852	3,852		3,852	7,606	11,458			25
26	Insurance-Prop.Liab.Malpractice			397,369	397,369		397,369	2,882	400,251			26
27	Other (specify):*							47,553	47,553			27
28	**TOTAL General Administration**	460,539	4,968	3,563,511	4,029,018		4,029,018	(1,254,012)	2,775,006			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,954,663	823,549	4,366,384	11,144,596		11,144,596	(1,083,251)	10,061,345			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 ARIA #0053710 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			42,183	42,183		42,183	500,588	542,771			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,814	150,814		150,814	(7,789)	143,025			32
33	Real Estate Taxes			804,623	804,623		804,623	(92,926)	711,697			33
34	Rent-Facility & Grounds			2,493,753	2,493,753		2,493,753	(2,487,119)	6,634			34
35	Rent-Equipment & Vehicles			58,070	58,070		58,070	3,969	62,039			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,549,443	3,549,443		3,549,443	(2,083,277)	1,466,166			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		609,856	2,168,960	2,778,816		2,778,816	(16,633)	2,762,183			39
40	Barber and Beauty Shops			1,168	1,168		1,168		1,168			40
41	Coffee and Gift Shops			1,108	1,108		1,108		1,108			41
42	Provider Participation Fee			428,307	428,307		428,307		428,307			42
43	Other (specify):*			87,336	87,336		87,336	(87,336)				43
44	**TOTAL Special Cost Centers**		609,856	2,686,879	3,296,735		3,296,735	(103,969)	3,192,766			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,954,663	1,433,405	10,602,706	17,990,774		17,990,774	(3,270,497)	14,720,277			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 ARIA # 0053710 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	(10,089)	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	531,321	30		9
10	Interest and Other Investment Income	(20,880)	32		10
11	Discounts, Allowances, Rebates & Refunds	(54)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(166)	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	(17,648)	21		18
19	Entertainment				19
20	Contributions	(3,100)	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	(656,039)	21		24
25	Fund Raising, Advertising and Promotional	(467)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,968,999)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,146,121)		$	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)	(124,376)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (124,376)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,270,497)		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 ARIA

ID# 0053710

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (952)	21	1
2	Sequestration	(184,856)	21	2
3	Director of Customer Experience	(46,671)	21	3
4	Bank Charges	(5,665)	21	4
5	Marketing Consultant	(72,293)	43	5
6	Marketing Materials	(15,043)	43	6
7	Damage Loss	(98)	21	7
8	Patient Needs	(1,219)	10	8
9	Sales Tax	(2,644)	21	9
10	Additional R&M	7,696	06	10
11	Main Street Sale/Leaseback Arragement	(2,492,655)	34	11
12	Non-Allowable Legal	(8,293)	19	12
13	PAC Dues	(10,710)	20	13
14	Day Care Real Estate Allocation	(96,415)	33	14
15	Day Care Depreciation Allocation	(36,181)	30	15
16	Capitalized R&M	(3,000)	06	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**	(2,968,999)		49

SYMPHONY AT ARIA

ID# 0053710

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 ARIA # 0053710 **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	(166)											(166)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(10,089)		1,977									(8,112)	5
6	Maintenance	4,696		21,915									26,611	6
7	Other (specify):*			3,179									3,179	7
8	**TOTAL General Services**	(5,559)		27,070									21,511	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,219)		133,833									132,614	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(4,143)							(4,143)	14
15	Other (specify):*			20,779									20,779	15
16	**TOTAL Health Care and Programs**	(1,219)		154,612		(4,143)							149,250	16
	C. General Administration													
17	Administrative			(628,845)									(628,845)	17
18	Directors Fees													18
19	Professional Services	(8,293)		6,661									(1,632)	19
20	Fees, Subscriptions & Promotions	(14,277)		6,123									(8,154)	20
21	Clerical & General Office Expenses	(914,627)		239,925									(674,702)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,280									1,280	24
25	Other Admin. Staff Transportation			7,606									7,606	25
26	Insurance-Prop.Liab.Malpractice			2,882									2,882	26
27	Other (specify):*			47,553									47,553	27
28	**TOTAL General Administration**	(937,197)		(316,815)									(1,254,012)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(943,975)		(135,133)		(4,143)							(1,083,251)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SYMPHONY AT ARIA **#** 0053710 **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	495,140		5,448									500,588	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(20,880)		13,091									(7,789)	32
33	Real Estate Taxes	(96,415)		3,489									(92,926)	33
34	Rent-Facility & Grounds	(2,492,655)		5,536									(2,487,119)	34
35	Rent-Equipment & Vehicles			3,969									3,969	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(2,114,810)		31,533									(2,083,277)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(16,633)								(16,633)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(87,336)											(87,336)	43
44	**TOTAL Special Cost Centers**	(87,336)			(16,633)								(103,969)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,146,121)		(103,600)	(16,633)	(4,143)							(3,270,497)	45

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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 ARIA # 0053710 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%	$ 1,977	$ 1,977	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	17,531	17,531	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	4,383	4,383	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,179	3,179	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	113,880	113,880	19
20	V	10	CONTRACT NURSING		MAESTRO CONSULTING SERVICES LLC	100.00%	19,953	19,953	20
21	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	20,779	20,779	21
22	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	63,670	63,670	22
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	6,661	6,661	23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	6,123	6,123	24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	205,226	205,226	25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	34,699	34,699	26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,280	1,280	27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	7,606	7,606	28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,882	2,882	29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	47,553	47,553	30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	5,448	5,448	31
32	V	32	INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	13,091	13,091	32
33	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	3,489	3,489	33
34	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	5,536	5,536	34
35	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	922	922	35
36	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,047	3,047	36
37	V								37
38	V	17	MANAGEMENT FEE	692,515	MAESTRO CONSULTING SERVICES LLC	100.00%		(692,515)	38
39	Total			$ 692,515			$ 588,915	$ * (103,600)	39

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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 Supplies	$ 78,197	Integra Healthcare Equipment LLC		$ 61,564	$ (16,633)	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			$ 78,197			$ 61,564	$ * (16,633)	39

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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	$ 37,461	Lifeline Ambulance LLC		$ 33,318	$ (4,143)	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			$ 37,461			$ 33,318	$ * (4,143)	39

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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	$ 157,252	Maple Leaf Insurance	100.00%	$ 157,252	$	15
16	V	26	Liability Insurance	427,805	Maple Leaf Insurance	100.00%	427,805		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			$ 585,057			$ 585,057	$ *	39

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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	Symcare Healthcare LLC	99.00%	CALIFORNIA GARDENS	CHICAGO	MAESTRO CONSULTING SERVI	LINCOLNWOOD	MANAGEMENT	1
2	Symcare HMG LLC	1.00%	MAPLECREST CARE CENTRE	BELVIDERE	7257 N. LINCOLN AVENUE	LINCOLNWOOD	BUILDING RENTAL	2
3			MCKINLEY COURT	DECATUR	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY/WORK COMP IN	3
4			MONROE PAVILION	CHICAGO	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	4
5			NORTHWOODS CARE CENTRE	BELVIDERE	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERVICES	5
6			SYCAMORE VILLAGE	SWANSEA	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	6
7			SYMPHONY AT 87TH STREET	CHICAGO				7
8			SYMPHONY AT MIDWAY	CHICAGO				8
9			SYMPHONY AT THE TILLERS	OSWEGO				9
10			SYMPHONY OF BRONZEVILLE	CHICAGO				10
11			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				11
12			SYMPHONY OF CHESTERTON	CHESTERTON, IN				12
13			SYMPHONY OF CHICAGO WEST	CHICAGO				13
14			SYMPHONY OF CRESTWOOD	CRESTWOOD				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, IN				15
16			SYMPHONY OF DECATUR	DECATUR				16
17			SYMPHONY OF DYER	DYER, IN				17
18			SYMPHONY OF EVANSTON	EVANSTON				18
19			SYMPHONY OF GLENDALE	GLENDALE, WI				19
20			SYMPHONY OF HANOVER PARK	HANOVER PARK				20
21			SYMPHONY OF JOLIET	JOLIET				21
22			SYMPHONY OF LINCOLN	LINCOLN				22
23			SYMPHONY OF LINCOLN PARK	CHICAGO				23
24			SYMPHONY OF MORGAN PARK	CHICAGO				24
25			SYMPHONY OF ORCHARD VALLEY	AURORA				25
26			SYMPHONY OF SOUTH SHORE	CHICAGO				26
27			SYMPHONY RESIDENCES OF LINCOLN PARK	CHICAGO				27
28								28
29								29
30								30

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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	$	72,468	$ 1,977	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	444,128	444,128	72,468	17,531	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,835,856	28	111,048		72,468	4,383	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,835,856	28	80,529		72,468	3,179	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	2,884,957	2,884,957	72,468	113,880	5
6	10	CONTRACT NURSING	AVAIL. CENSUS DAYS	1,835,856	28	505,476		72,468	19,953	6
7	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,835,856	28	526,402		72,468	20,779	7
8	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	1,612,976	1,612,976	72,468	63,670	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,835,856	28	168,752		72,468	6,661	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,835,856	28	155,112		72,468	6,123	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,835,856	28	5,199,066	5,199,066	72,468	205,226	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,835,856	28	879,035		72,468	34,699	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,835,856	28	32,418		72,468	1,280	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,835,856	28	192,674		72,468	7,606	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,835,856	28	73,017		72,468	2,882	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,835,856	28	1,204,673		72,468	47,553	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,835,856	28	138,011		72,468	5,448	17
18	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,835,856	28	331,638		72,468	13,091	18
19	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,835,856	28	88,385		72,468	3,489	19
20	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	140,244		72,468	5,536	20
21	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	23,351		72,468	922	21
22	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,835,856	28	77,202		72,468	3,047	22
23										23
24										24
25	TOTALS					$ 14,919,170	$ 10,141,128		$ 588,915	25

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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 LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME & Medical Supplies	Direct Allocation			$	$		$ 61,564	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					$	$		$ 61,564	25

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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. Wabash Avenue
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 Allocation			$	$		$ 33,318	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					$	$		$ 33,318	25

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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			$	$		$ 157,252	1
2	26	Liability Insurance	Direct						427,805	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					$	$		$ 585,057	25

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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 ARIA # 0053710 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	Omnicare		X	Note Payable				73,666				6
7	The Private Bank		X	Line of Credit							150,814	7
8	See Supplemental Schedule							524,737				8
9	TOTAL Facility Related						$	$ 598,403			$ 150,814	9
	B. Non-Facility Related*											
10	Interest Income		X								(20,880)	10
11	Allocated From Maestro		X								13,091	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,789)	14
15	TOTALS (line 9+line14)						$	$ 598,403			$ 143,025	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 ARIA # 0053710 **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.**	$	834,435	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.)	$	710,534	2
3. Under or (over) accrual (line 2 minus line 1).	$	(123,901)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	835,597	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.	$	711,696	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	611,161	8
	2013	561,720	9
	2014	666,841	10
	2015	684,950	11
	2016	707,045	12

2017 Accrual = $803,461 X 1.04 = $835,597 (Rounded)

Allocated from Maestro Consulting: $3,489

	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 ARIA COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053710

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.	15-17-101-014-0000	Long Term Care Property	$ 803,460.64	$ 707,045.36
2.	10-27-319-028-0000	Home Office Allocation	$ 88,384.90	$ 3,488.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 891,845.54	$ 710,534.24

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 ARIA COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053710

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 ARIA # 0053710 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,306 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [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).

Hillside Montessori School - Child Day Care

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		2012	$ 1,200,000	1
2	Allocated From Maestro-7257 Lincoln		2004	6,316	2
3	TOTALS			$ 1,206,316	3

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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	198		2012	1997	$ 9,076,289	$	35	$ 259,323	$ 259,323	$ 1,318,502	4
5	Day Care Allocation					(36,181)			36,181		5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2012	36,080		20	1,503	1,503	8,590	9
10	Various			2013	827,751		20	36,351	36,351	194,379	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 ARIA # 0053710 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)								67
68	Related Party Allocations (Pages 12H & 12I)		94,968	1,803		3,562	1,759	42,469	68
69	Financial Statement Depreciation			42,183			(42,183)		69
70	TOTAL (lines 4 thru 69)		$ 10,035,088	$ 7,805		$ 300,739	$ 292,934	$ 1,563,940	70

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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		$ 10,035,088	$ 7,805		$ 300,739	$ 292,934	$ 1,563,940	1
2	Coffee Station & Dining Room Bistro	2014	9,300		20	388	388	1,628	2
3	2 Boiler Pump Replacements	2014	4,084		20	170	170	715	3
4	Stained Concrete Sidewalk Installation	2014	4,760		20	264	264	978	4
5	Trane Chiller	2014	12,249		20	510	510	1,786	5
6	Card Reader Replacement Panel	2014	3,325		20	139	139	513	6
7	Electrical Work - Fire Alarm System	2014	5,250		20	219	219	722	7
8	Doors, Frames And Sideliters	2015	2,622		20	11	11	33	8
9	Install 2 Fans On Boiler	2015	3,485		20	581	581	1,742	9
10	Chiler - Leak Repair	2015	7,420		20	371	371	371	10
11	Cubicle Curtains	2016	7,562		20	378	378	756	11
12	Install 2 Pit Ladder In Elevator	2016	4,562		20	228	228	456	12
13	Chiller Repair	2016	5,049		20	252	252	504	13
14	Chiller Replacement	2016	110,000		20	5,500	5,500	11,000	14
15	Install 15 Sprinkler System	2016	6,823		20	341	341	682	15
16	Repair Heating Pallet In 2Nd Floor Pt. Replace Thermostat, Comp	2016	2,793		20	140	140	280	16
17	Furnish & Install New Submersible Motor For Elevator 1/Contact	2016	2,500		20	125	125	250	17
18	Concrete Ramp On Back Patio Replacement	2017	4,300		20	215	215	215	18
19	Elevator Repair- 2 New Panels	2017	3,000		20	150	150	150	19
20	Phone System Upgrade	2017	42,966		20	2,148	2,148	2,148	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)		$ 10,277,138	$ 7,805		$ 312,869	$ 305,064	$ 1,588,870	34

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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		$ 10,277,138	$ 7,805		$ 312,869	$ 305,064	$ 1,588,870	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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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)		$ 10,277,138	$ 7,805		$ 312,869	$ 305,064	$ 1,588,870	34

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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		$ 10,277,138	$ 7,805		$ 312,869	$ 305,064	$ 1,588,870	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)		$ 10,277,138	$ 7,805		$ 312,869	$ 305,064	$ 1,588,870	34

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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		$ 10,277,138	$ 7,805		$ 312,869	$ 305,064	$ 1,588,870	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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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)		$ 10,277,138	$ 7,805		$ 312,869	$ 305,064	$ 1,588,870	34

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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		$	$		$	$	$	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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	56,842	1,457	35	1,624	167	22,940	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Maestro	2003	462		20	23	23	326	9
10	Allocated From Maestro	2004	9,387		20	468	468	6,442	10
11	Allocated From Maestro	2005	557		20	28	28	358	11
12	Allocated From Maestro	2006	755		20	38	38	429	12
13	Allocated From Maestro	2008	795		20	40	40	368	13
14	Allocated From Maestro	2009	12,806		20	640	640	5,513	14
15	Allocated From Maestro	2010	1,968		20	98	98	739	15
16	Allocated From Maestro	2011	106		20	5	5	37	16
17	Allocated From Maestro	2012	118		20	6	6	34	17
18	Allocated From Maestro	2014	1,480		20	74	74	267	18
19	Allocated From Maestro	2015	416		20	21	21	49	19
20	Allocated From Maestro	2016	1,824	233	20	182	(51)	253	20
21	Allocated From Maestro	2017	244		20	12	12	12	21
22									22
23	Allocated From Maestro-7257 Lincoln	2015	896	77	20	60	(17)	139	23
24	Allocated From Maestro-7257 Lincoln	2005	5,182	36	20	186	150	3,800	24
25	Allocated From Maestro-7257 Lincoln	2004	1,130		20	57	57	763	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 94,968	$ 1,803		$ 3,562	$ 1,759	$ 42,469	34

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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		$ 94,968	$ 1,803		$ 3,562	$ 1,759	$ 42,469	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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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)		$ 94,968	$ 1,803		$ 3,562	$ 1,759	$ 42,469	34

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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	$ 454,238	$ 556	$ 59,157	$ 58,601	10	$ 288,878	71
72	Current Year Purchases	72,909	3,088	5,050	1,962	10	5,050	72
73	Fully Depreciated Assets	1,119,663		163,736	163,736	10	1,119,662	73
74								74
75	TOTALS	$ 1,646,809	$ 3,644	$ 227,944	$ 224,300		$ 1,413,590	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		Ford E350	2015	$ 9,783	$	$ 1,957	$ 1,957	5	$ 5,870	76
77		Allocated From Maestro	2017	350				5	350	77
78										78
79										79
80	TOTALS			$ 10,133	$	$ 1,957	$ 1,957		$ 6,220	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)	$ 13,140,396	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,449	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 542,770	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 531,321	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,008,680	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		$	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 ARIA # 0053710 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:		198		$ 2,492,655			3
4	Additions				(2,492,655)			4
5	Storage Unit				1,098			5
6	Allocated From Maestro				5,536			6
7	TOTAL		198		$ 6,634 **			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: $ 44,663 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford Bus	$ 1,199	$ 14,328	17
18	Allocated From Maestro			3,047	18
19					19
20					20
21	TOTAL		$ 1,199	$ 17,375	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 ARIA # 0053710 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 ARIA

STATE OF ILLINOIS
0053710 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	$		$ 699,041	$		$ 699,041	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			367,708			367,708	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			939,891			939,891	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				430,182		430,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					162,320	179,674		341,994	13
14	TOTAL			$		$ 2,168,960	$ 609,856		$ 2,778,816	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 ARIA **#** 0053710 **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	$ 27,653	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,124,637		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	144,524		6
7	Other Prepaid Expenses	53,514		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,350,328	$	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	16,875		15
16	Equipment, at Historical Cost	287,214		16
17	Accumulated Depreciation (book methods)	(61,654)		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	556,235		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 798,670	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,148,998	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,028,332	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,653		28
29	Short-Term Notes Payable	598,403		29
30	Accrued Salaries Payable	632,176		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,175		31
32	Accrued Real Estate Taxes(Sch.IX-B)	835,597		32
33	Accrued Interest Payable	848		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,750,495		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,898,679	$	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	5,323		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,323	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,904,002	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,755,004)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,148,998	$	48

***(See instructions.)**

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 **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**	$ (664,710)	1
2	Restatements (describe):		2
3	**Prior Year Journal Entries**	(15,909)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (680,619)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,074,385)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,074,385)	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)**	$ (1,755,004)	24 *

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

Facility Name & ID Number SYMPHONY AT ARIA # 0053710 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	$ 15,644,858	1
2	Discounts and Allowances for all Levels	(4,708)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,640,150	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,054,944	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,054,944	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	199,409	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 199,409	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,880	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,880	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,006	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,006	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,916,389	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,903,392	31
32	Health Care	5,212,186	32
33	General Administration	4,029,018	33
	B. Capital Expense		
34	Ownership	3,549,443	34
	C. Ancillary Expense		
35	Special Cost Centers	2,868,428	35
36	Provider Participation Fee	428,307	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,990,774	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,074,385)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,074,385)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,228,710	44
45	Private Pay - Net Inpatient Revenue	626,042	45
46	Medicare - Net Inpatient Revenue	5,307,620	46
47	Other-(specify) Hospice	604,244	47
48	Other-(specify) Managed Care/MAIP	1,873,534	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,640,150	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 ARIA # 0053710 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	1,797	2,127	$ 114,963	$ 54.05	1
2	Assistant Director of Nursing	1,965	2,089	104,076	49.82	2
3	Registered Nurses	29,493	32,376	1,127,135	34.81	3
4	Licensed Practical Nurses	46,353	51,195	1,391,197	27.17	4
5	CNAs & Orderlies	90,273	99,203	1,371,728	13.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,857	2,082	45,967	22.08	9
10	Activity Assistants	14,587	16,053	179,216	11.16	10
11	Social Service Workers	7,740	8,343	234,504	28.11	11
12	Dietician					12
13	Food Service Supervisor	1,941	2,085	65,167	31.26	13
14	Head Cook	5,424	6,100	87,304	14.31	14
15	Cook Helpers/Assistants	22,926	24,953	269,058	10.78	15
16	Dishwashers					16
17	Maintenance Workers	3,576	4,150	75,988	18.31	17
18	Housekeepers	23,555	26,683	329,138	12.34	18
19	Laundry	3,182	3,793	45,009	11.87	19
20	Administrator	1,917	2,102	160,970	76.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,947	15,090	252,898	16.76	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	1,898	2,086	53,674	25.73	31
32	Other Health Care(specify)					32
33	Other(specify)	1,736	1,963	46,671	23.78	33
34	TOTAL (lines 1 - 33)	273,167	302,473	$ 5,954,663 *	$ 19.69	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	Monthly	$ 37,909	01-03	35
36	Medical Director	Monthly	63,775	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	77,899	10-03	38
39	Pharmacist Consultant	Monthly	19,506	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	26,447	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,540	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	6,044	10-03	47
48					48
49	TOTAL (lines 35 - 48)	28	$ 233,120		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 ARIA # 0053710 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marty Aukstuolis	Administrator	0.00%	$ 160,970
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 160,970

B. Administrative - Other

Description	Amount
Management Fees - Maestro Consulting Services	$ 692,515
TOTAL (agree to Schedule V, line 17, col. 3)	$ 692,515
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 15,150
HRM Consultants	Regulatory Consulting	945
Achieve Accreditation	Accreditation	9,226
Maestro	Professional Services	88,089
Ability Network	Data Processing	5,611
Creative Technology Solutions	Data Processing	16,944
HDSI	Data Processing	6,064
Point Click Care	Data Processing	35,093
Matrix Care	Data Processing	5,508
Market Metrix	Data Processing	397
Dart Chart	Data Processing	1,973
See Supplemental Schedule		189,728
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 374,728

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,476
Unemployment Compensation Insurance	86,728
FICA Taxes	442,252
Employee Health Insurance	223,657
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contributions	45,805
Other Employee Benefits	21,102
Employee Physicals	3,675
TOTAL (agree to Schedule V, line 22, col.8)	$ 985,695

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	$ 1,990
Advertising: Employee Recruitment	440
Health Care Worker Background Check	
(Indicate # of checks performed 221)	2,208
Patient Background Checks 574	5,740
Dues & Subscriptions	11,291
Licenses & Fees	7,917
Allocated From Maestro	6,123
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,173
Allocated From Maestro	1,280
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,453

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SYMPHONY AT ARIA **#** 0053710 **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 LTC $21,419**

(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. $ **None** Line **N/A**

(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.
Aria Post Acute Care #52019

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **428,307**
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? **Yes** 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. $ 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