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: 0053678

Facility Name: SYMPHONY AT MIDWAY

Address: 4437 South Cicero (Number) Chicago (City) 60632 (Zip Code)

County: Cook

Telephone Number: (773) 884-0484 **Fax #** (773) 884- 0485

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

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

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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	249	Skilled (SNF)	249	90,885	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	249	TOTALS	249	90,885	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			4,529	4,529	8
9	SNF/PED					9
10	ICF	57,545	1,216	18,021	76,782	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,545	1,216	22,550	81,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.47%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 06/05/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/05/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 249 and days of care provided 4,529

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 MIDWAY # 0053678 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	369,765	148,094	47,642	565,501		565,501		565,501			1
2	Food Purchase		407,681		407,681	(28,288)	379,394	(61)	379,333			2
3	Housekeeping			415,187	415,187		415,187		415,187			3
4	Laundry		289,596		289,596		289,596		289,596			4
5	Heat and Other Utilities			243,676	243,676		243,676	(12,913)	230,763			5
6	Maintenance	70,535		250,109	320,644		320,644	23,641	344,285			6
7	Other (specify):*							3,998	3,998			7
8	TOTAL General Services	440,300	845,371	956,614	2,242,285	(28,288)	2,213,998	14,664	2,228,661			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	4,481,585	470,088	135,670	5,087,343		5,087,343	167,210	5,254,553			10
10a	Therapy			2,943	2,943		2,943		2,943			10a
11	Activities	232,440		2,420	234,860		234,860		234,860			11
12	Social Services	199,056			199,056		199,056		199,056			12
13	CNA Training											13
14	Program Transportation			40,551	40,551		40,551	(4,025)	36,526			14
15	Other (specify):*							26,131	26,131			15
16	TOTAL Health Care and Programs	4,913,081	470,088	198,384	5,581,553		5,581,553	189,316	5,770,869			16
	C. General Administration											
17	Administrative	134,389		753,509	887,898		887,898	(673,439)	214,459			17
18	Directors Fees											18
19	Professional Services			392,633	392,633		392,633	(12,681)	379,952			19
20	Dues, Fees, Subscriptions & Promotions			49,957	49,957		49,957	(10,794)	39,163			20
21	Clerical & General Office Expenses	265,748	1,201	1,073,358	1,340,307		1,340,307	(694,232)	646,075			21
22	Employee Benefits & Payroll Taxes			915,041	915,041	28,288	943,329		943,329			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,191	1,191		1,191	1,609	2,800			24
25	Other Admin. Staff Transportation			835	835		835	9,565	10,400			25
26	Insurance-Prop.Liab.Malpractice			454,699	454,699		454,699	3,625	458,324			26
27	Other (specify):*							59,801	59,801			27
28	TOTAL General Administration	400,137	1,201	3,641,223	4,042,561	28,288	4,070,849	(1,316,546)	2,754,303			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,753,518	1,316,660	4,796,221	11,866,399		11,866,399	(1,112,566)	10,753,833			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 MIDWAY #0053678 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			21,511	21,511		21,511	414,969	436,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			180,956	180,956		180,956	(11,611)	169,345			32
33	Real Estate Taxes			673,468	673,468		673,468	(4,740)	668,728			33
34	Rent-Facility & Grounds			2,897,157	2,897,157		2,897,157	(2,890,196)	6,961			34
35	Rent-Equipment & Vehicles			54,277	54,277		54,277	4,992	59,269			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,827,369	3,827,369		3,827,369	(2,486,586)	1,340,783			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		479,793	1,864,222	2,344,015		2,344,015	(42,162)	2,301,853			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			744	744		744		744			41
42	Provider Participation Fee			602,395	602,395		602,395		602,395			42
43	Other (specify):*			104,276	104,276		104,276	(104,276)				43
44	**TOTAL Special Cost Centers**		479,793	2,571,637	3,051,430		3,051,430	(146,438)	2,904,992			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,753,518	1,796,453	11,195,227	18,745,198		18,745,198	(3,745,590)	14,999,608			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 MIDWAY # 0053678 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	(15,399)	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	408,118	30		9
10	Interest and Other Investment Income	(28,074)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(61)	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	(3,068)	21		18
19	Entertainment	(100)	21		19
20	Contributions	(5,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(782,398)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,260,016)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,686,498)		$	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)	(59,091)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (59,091)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,745,589)		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 MIDWAY

ID# 0053678

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (2,577)	21	1
2	Sequestration Expense	(124,134)	21	2
3	Director of Customer Experience	(55,199)	21	3
4	Bank Charges	(27,331)	21	4
5	Marketing Expenses	(104,276)	43	5
6	Patient Needs	(1,095)	10	6
7	Sales Tax-Administrative	(1,149)	21	7
8	Additional R&M	4,595	06	8
9	Main Street Sale/Leaseback Arrangement	(2,897,157)	34	9
10	PAC Dues	(12,994)	20	10
11	Non Allowable Legal Fees	(21,058)	19	11
12	RE Tax Late Fees	(9,127)	33	12
13	Capitalized R&M	(8,514)	06	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,260,016)		49

SYMPHONY AT MIDWAY

ID# 0053678

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 MIDWAY # 0053678 **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	(61)											(61)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(15,399)		2,486									(12,913)	5
6	Maintenance	(3,919)		27,560									23,641	6
7	Other (specify):*			3,998									3,998	7
8	**TOTAL General Services**	(19,379)		34,043									14,664	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,095)		168,305									167,210	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(4,025)							(4,025)	14
15	Other (specify):*			26,131									26,131	15
16	**TOTAL Health Care and Programs**	(1,095)		194,436		(4,025)							189,316	16
	C. General Administration													
17	Administrative			(673,439)									(673,439)	17
18	Directors Fees													18
19	Professional Services	(21,058)		8,377									(12,681)	19
20	Fees, Subscriptions & Promotions	(18,494)		7,700									(10,794)	20
21	Clerical & General Office Expenses	(995,956)		301,724									(694,232)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,609									1,609	24
25	Other Admin. Staff Transportation			9,565									9,565	25
26	Insurance-Prop.Liab.Malpractice			3,625									3,625	26
27	Other (specify):*			59,801									59,801	27
28	**TOTAL General Administration**	(1,035,508)		(281,038)									(1,316,546)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,055,981)		(52,559)		(4,025)							(1,112,566)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SYMPHONY AT MIDWAY **#** 0053678 **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	**408,118**		**6,851**									**414,969**	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	**(28,074)**		**16,463**									**(11,611)**	32
33	Real Estate Taxes	**(9,127)**		**4,388**									**(4,740)**	33
34	Rent-Facility & Grounds	**(2,897,157)**		**6,962**									**(2,890,196)**	34
35	Rent-Equipment & Vehicles			**4,992**									**4,992**	35
36	Other (specify):*													36
37	**TOTAL Ownership**	**(2,526,241)**		**39,655**									**(2,486,586)**	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				**(42,162)**								**(42,162)**	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	**(104,276)**											**(104,276)**	43
44	**TOTAL Special Cost Centers**	**(104,276)**			**(42,162)**								**(146,438)**	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(3,686,498)**		**(12,904)**	**(42,162)**	**(4,025)**							**(3,745,590)**	45

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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 MIDWAY # 0053678 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAESTRO CONSULTING SERVICES LLC	100.00%	$ 2,486	$ 2,486	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	22,047	22,047	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	5,513	5,513	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,998	3,998	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	143,213	143,213	19
20	V	10	CONTRACT NURSING		MAESTRO CONSULTING SERVICES LLC	100.00%	25,092	25,092	20
21	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	26,131	26,131	21
22	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	80,070	80,070	22
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	8,377	8,377	23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	7,700	7,700	24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	258,088	258,088	25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	43,636	43,636	26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,609	1,609	27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	9,565	9,565	28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,625	3,625	29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	59,801	59,801	30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	6,851	6,851	31
32	V	32	INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	16,463	16,463	32
33	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	4,388	4,388	33
34	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	6,962	6,962	34
35	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	1,159	1,159	35
36	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,832	3,832	36
37	V								37
38	V	17	MANAGEMENT FEE	753,509	MAESTRO CONSULTING SERVICES LLC	100.00%		(753,509)	38
39	Total			$ 753,509			$ 740,605	$ * (12,904)	39

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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	$ 198,223	Integra Healthcare Equipment, LLC		$ 156,061	$ (42,162)	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			$ 198,223			$ 156,061	$ * (42,162)	39

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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	$ 36,399	Lifeline Ambulance		$ 32,374	$ (4,025)	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			$ 36,399			$ 32,374	$ * (4,025)	39

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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	$ 168,022	Maple Leaf Insurance	100.00%	$ 168,022	$	15
16	V	26	Liability Insurance	483,217	Maple Leaf Insurance	100.00%	483,217		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			$ 651,239			$ 651,239	$ *	39

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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 MIDWAY # 0053678 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 MIDWAY # 0053678 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 MIDWAY # 0053678 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 MIDWAY # 0053678 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 MIDWAY # 0053678 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	99.99%	CALIFORNIA GARDENS	CHICAGO	MAESTRO CONSULTING SERVI	LINCOLNWOOD	MANAGEMENT	1
2	SYMCARE HMG LLC	0.01%	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 ARIA	HILLSIDE				7
8			SYMPHONY AT 87TH STREET	CHICAGO				8
9			SYMPHONY AT MIDWAY	CHICAGO				9
10			SYMPHONY AT THE TILLERS	OSWEGO				10
11			SYMPHONY OF BRONZEVILLE	CHICAGO				11
12			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				12
13			SYMPHONY OF CHESTERTON	CHESTERTON, IN				13
14			SYMPHONY OF CHICAGO WEST	CHICAGO				14
15			SYMPHONY OF CRESTWOOD	CRESTWOOD				15
16			SYMPHONY OF CROWN POINT	CROWN POINT, IN				16
17			SYMPHONY OF DECATUR	DECATUR				17
18			SYMPHONY OF DYER	DYER, IN				18
19			SYMPHONY OF EVANSTON	EVANSTON				19
20			SYMPHONY OF GLENDALE	GLENDALE, WI				20
21			SYMPHONY OF HANOVER PARK	HANOVER PARK				21
22			SYMPHONY OF JOLIET	JOLIET				22
23			SYMPHONY OF LINCOLN	LINCOLN				23
24			SYMPHONY OF LINCOLN PARK	CHICAGO				24
25			SYMPHONY OF MORGAN PARK	CHICAGO				25
26			SYMPHONY OF ORCHARD VALLEY	AURORA				26
27			SYMPHONY OF SOUTH SHORE	CHICAGO				27
28			SYMPHONY RESIDENCES OF LINCOLN PARK	CHICAGO				28
29								29
30								30

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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 MIDWAY # 0053678 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											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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 MIDWAY # 0053678 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	$	91,134	$ 2,486	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	444,128	444,128	91,134	22,047	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,835,856	28	111,048		91,134	5,513	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,835,856	28	80,529		91,134	3,998	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	2,884,957	2,884,957	91,134	143,213	5
6	10	CONTRACT NURSING	AVAIL. CENSUS DAYS	1,835,856	28	505,476		91,134	25,092	6
7	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,835,856	28	526,402		91,134	26,131	7
8	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	1,612,976	1,612,976	91,134	80,070	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,835,856	28	168,752		91,134	8,377	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,835,856	28	155,112		91,134	7,700	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,835,856	28	5,199,066	5,199,066	91,134	258,088	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,835,856	28	879,035		91,134	43,636	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,835,856	28	32,418		91,134	1,609	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,835,856	28	192,674		91,134	9,565	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,835,856	28	73,017		91,134	3,625	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,835,856	28	1,204,673		91,134	59,801	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,835,856	28	138,011		91,134	6,851	17
18	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,835,856	28	331,638		91,134	16,463	18
19	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,835,856	28	88,385		91,134	4,388	19
20	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	140,244		91,134	6,962	20
21	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	23,351		91,134	1,159	21
22	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,835,856	28	77,202		91,134	3,832	22
23										23
24										24
25	TOTALS					$ 14,919,170	$ 10,141,128		$ 740,605	25

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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			$	$		$ 156,061	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					$	$		$ 156,061	25

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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			$	$		$ 32,374	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					$	$		$ 32,374	25

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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			$	$		$ 168,022	1
2	26	Liability Insurance	Direct						483,217	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					$	$		$ 651,239	25

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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 MIDWAY # 0053678 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 MIDWAY # 0053678 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 MIDWAY # 0053678 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 MIDWAY # 0053678 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 MIDWAY # 0053678 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	The Private Bank		X	Line of Credit				323,959			180,956	6
7												7
8												8
9	TOTAL Facility Related						$	$ 323,959			$ 180,956	9
	B. Non-Facility Related*											
10	Interest Income		X								(28,074)	10
11	Allocated from Maestro Consul	X									16,463	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,611)	14
15	TOTALS (line 9+line14)						$	$ 323,959			$ 169,345	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 MIDWAY # 0053678 **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.**	$	607,950	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.)	$	632,294	2
3. Under or (over) accrual (line 2 minus line 1).	$	24,344	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	644,384	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.	$	668,728	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	614,037	8
	2013	539,614	9
	2014	550,484	10
	2015	574,477	11
	2016	627,906	12

2017 Accrual = $627,906 x 1.02 = $644,384 (Rounded)

Allocated from Maestro Consulting Services $4,388

	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 MIDWAY COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053678

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-03-304-004-0000	Long Term Care Property	$ 2,034.32	$ 2,034.32
2.	19-03-304-005-0000	Long Term Care Property	$ 2,812.84	$ 2,812.84
3.	19-03-304-006-0000	Long Term Care Property	$ 8,755.84	$ 8,755.84
4.	19-03-304-007-0000	Long Term Care Property	$ 153,991.11	$ 153,991.11
5.	19-03-304-008-0000	Long Term Care Property	$ 269,523.83	$ 269,523.83
6.	19-03-304-009-0000	Long Term Care Property	$ 180,429.04	$ 180,429.04
7.	19-03-304-023-0000	Long Term Care Property	$ 10,359.32	$ 10,359.32
8.	10-27-319-028-0000	Home Office	$ 88,384.90	$ 4,387.53
9.			$	$
10.			$	$
		TOTALS	$ 716,291.20	$ 632,293.83

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 MIDWAY COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053678

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 MIDWAY # 0053678 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,903 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	48,972		$ 155,000	1
2	Allocated from Maestro 7257 Lincoln			7,943	2
3	TOTALS	48,972		$ 162,943	3

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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	249			2000	$ 9,032,497	$	35	$ 260,214	$ 260,214	$ 4,575,430	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2000	186,297		20	9,284	9,284	162,603	9
10	Various			2001	47,574		20	2,379	2,379	39,464	10
11	Various			2002	15,861		20			15,861	11
12	Various			2003	126,758		20	5,399	5,399	123,055	12
13	Various			2004	42,166		20	1,280	1,280	40,886	13
14	Various			2005	29,048		20	497	497	28,283	14
15	Various			2006	172,462		20	2,519	2,519	162,414	15
16	Various			2007	3,200		20			3,200	16
17	Various			2009	23,132		20	148	148	21,374	17
18	Various			2010	254,899		20	22,416	22,416	178,459	18
19	Various			2011	261,021		20	21,016	21,016	141,244	19
20	Various			2012	32,175		20	3,422	3,422	26,091	20
21	Various			2013	5,760		20	288	288	1,325	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 MIDWAY # 0053678 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)		568,779			28,427	28,427	253,478	67
68	Related Party Allocations (Pages 12H & 12I)		119,431	2,269		4,478	2,209	53,407	68
69	Financial Statement Depreciation			21,511			(21,511)		69
70	TOTAL (lines 4 thru 69)		$ 10,921,060	$ 23,780		$ 361,766	$ 337,986	$ 5,826,573	70

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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		$ 10,921,060	$ 23,780		$ 361,766	$ 337,986	$ 5,826,573	1
2	Install New Vinyl Base In All Residents Rooms With New Tiles	2014	5,500		20	275	275	1,031	2
3	Shower Room Demolition & Repair - 2Nd & 3Rd Floor	2014	36,600		20	1,830	1,830	6,253	3
4	Install 18 Window Sills For Dining Rm On 1St,2Nd,3Rd,4Th Floor	2014	4,500		20	225	225	788	4
5	On Floor/Walls, Remove Drywall By Shower	2014	19,200		20	960	960	3,040	5
6	Repaired Sewer Storm Lines	2015	6,500		20	325	325	975	6
7	Install Electrical Sub-Panel & Circuit Breaker In Basement	2015	5,215		20	261	261	782	7
8	Scrape Iron Fence & Replace Railing	2015	8,500		20	425	425	1,275	8
9	66X Cubicle Curtains In Golden Color	2016	4,281		20	214	214	428	9
10	Room Entry Door Refacing With P1.Lam Both Sides	2016	2,750		20	138	138	275	10
11	Solid Core Birch 20 Min Smoke Label Doors In Rooms	2016	7,634		20	382	382	763	11
12	Walkin Freezer-New Pressure Switch, New Filter Drier With Torc	2016	2,726		20	136	136	273	12
13	Plumbing Service To Repair Leak On Hot Water Main At Tank	2016	5,885		20	294	294	589	13
14	Electrical-New Junction Box & Extend 100 Amp 3 Phace To Top C	2016	2,670		20	134	134	267	14
15	Kitchen Floor And Wall Repairs	2017	3,055		20	153	153	153	15
16	Replace Kitchen Cooler Condens	2017	5,972		20	299	299	299	16
17	Fence Repairs	2017	4,800		20	240	240	240	17
18	Plumbing Install Bypass For Domestic Hot Water Feeding Tmv	2017	5,895		20	295	295	295	18
19	Doors For Rms 325,403, 413	2017	2,619		20	131	131	131	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)		$ 11,055,361	$ 23,780		$ 368,481	$ 344,701	$ 5,844,429	34

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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		$ 11,055,361	$ 23,780		$ 368,481	$ 344,701	$ 5,844,429	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)		$ 11,055,361	$ 23,780		$ 368,481	$ 344,701	$ 5,844,429	34

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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		$ 11,055,361	$ 23,780		$ 368,481	$ 344,701	$ 5,844,429	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,055,361	$ 23,780		$ 368,481	$ 344,701	$ 5,844,429	34

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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		$ 11,055,361	$ 23,780		$ 368,481	$ 344,701	$ 5,844,429	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 11,055,361	$ 23,780		$ 368,481	$ 344,701	$ 5,844,429	34

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2005	45,177		20	2,259	2,259	29,366	9
10	Repair Door Closures	2006	5,062		20	253	253	2,783	10
11	Repair Door Holders	2006	7,201		20	360	360	3,960	11
12	Tv Lounge/Stairway	2007	5,000		20	250	250	2,750	12
13	Flooring 4Th Floor Corridor	2007	41,150		20	2,058	2,058	22,636	13
14	Install - Card Swipe And Door Strike	2007	3,501		20	175	175	1,925	14
15	2 Tormax Ttx Ii Low Engergy Operator	2007	3,470		20	174	174	1,912	15
16	10 Fantagraph Pleated Shades, Window Fashions	2007	5,394		20	270	270	2,968	16
17	Fire Sprinkler Work	2007	4,929		20	246	246	2,708	17
18	Admission/Hallway Lobby/Reception Area	2007	6,560		20	328	328	3,608	18
19	6 Track System For Cubicle Curtain	2007	3,310		20	166	166	1,824	19
20	1St Floor 22 Resident Washrooms	2007	4,620		20	231	231	2,541	20
21	14 Pleated Shades/Blinds Window Fashion	2007	8,154		20	408	408	4,486	21
22	1 Tormax Ttx Ii Low Engergy Operator	2007	4,968		20	248	248	2,730	22
23	Door Closer/Holders	2007	4,045		20	202	202	2,224	23
24	Generator Upgrade	2007	5,793		20	290	290	3,188	24
25	Flooring 22 Residents Washrooms	2007	4,920		20	246	246	2,706	25
26	Flooring Admission Hallway/Lobby/Reception Area	2007	6,560		20	328	328	3,608	26
27	1St Floor Reface 34 Doors	2007	2,295		20	115	115	1,265	27
28	1St Floor Reface 34 Doors	2007	2,295		20	115	115	1,265	28
29	Door Locks	2007	2,832		20	142	142	1,560	29
30	Construct Patient Room	2007	5,000		20	250	250	2,750	30
31	Ventilation Work For Generator	2007	26,978		20	1,349	1,349	14,839	31
32	Window Coverings	2007	23,163		20	1,158	1,158	12,738	32
33	Construct Closets	2007	6,000		20	300	300	3,300	33
34	TOTAL (lines 1 thru 33)		$ 238,377	$		$ 11,921	$ 11,921	$ 135,640	34

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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		$ 238,377	$		$ 11,921	$	$ 135,640	1
2	Flooring	2007	3,890		20	195	195	2,143	2
3	Drapery	2007	5,169		20	258	258	2,840	3
4	Painted 33 Rooms; Holes Patching & Repairing	2008	6,930		20	347	347	3,757	4
5	Armstrong Wide Material - Connection Corlon Stone Harbor - Floorin	2008	4,471		20	224	224	2,425	5
6	Replaced Door Closures & Holders For Rooms	2008	10,865		20	543	543	5,975	6
7	Reface Doors & Metal Door Kickplates	2008	8,050		20	403	403	4,431	7
8	Routing And Cracksealing Of Parking Lot; Concrete Removal & Repl	2008	6,909		20	345	345	3,336	8
9	Sign Lightbox And Banner	2008	5,726		20	286	286	2,670	9
10	Landscape Irrigation System	2008	6,500		20	325	325	2,925	10
11	Painting Walls in 31 Rooms	2009	8,725		20	436	436	3,926	11
12	Landscape retaining Walls, Plants, Perennials, and Mulch	2009	9,000		20	450	450	4,050	12
13	Chair Rail - Oak Color	2009	4,410		20	221	221	1,987	13
14	2nd and 3rd Flr Dining Rm- Tiles, Window Treatments, Chair Rails	2009	59,648		20	2,968	2,968	26,712	14
15	Outside Security System - Monitors, Strobe Lights, Indoor and Outdoc	2009	21,603		20	1,080	1,080	9,720	15
16	Painting 30 Rooms	2009	12,305		20	615	615	5,537	16
17	Landscaping, Rocks, Boulders, Plants, and Mulch	2009	9,000		20	450	450	4,050	17
18	Chair Rails for 3rd Floor	2009	2,482		20	124	124	1,116	18
19	5 Indoor Cameras; 1 Outdoor Camera; 6 Boxes of Wire	2009	3,465		20	173	173	1,559	19
20	Wifi Cable Wiring	2013	5,500		20	275	275	1,375	20
21	Solid-State Starter	2013	3,047		20	152	152	760	21
22	1 Crv Heat Exchanger Cb 1796 Ch1801H	2013	4,910		20	246	246	984	22
23	Sand down and satin 250 doors, laminate and reinstalled doors	2014	22,500		20	1,125	1,125	4,500	23
24	Removed and installed floor tiling-resident rooms on 1,2,3 & 4th FL	2014	62,000		20	3,100	3,100	12,400	24
25	1st, 2nd, 3rd, and 4th Floor Dining Room - Wallcoverings	2014	38,297		20	1,915	1,915	7,660	25
26	8 Fire doors	2014	5,000		20	250	250	1,000	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 568,779	$		$ 28,427	$ 16,506	$ 253,478	34

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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	71,483	1,833	35	2,042	209	28,849	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Maestro Consulting Services	2003	581		20	29	29	411	9
10	Allocated from Maestro Consulting Services	2004	11,805		20	589	589	8,101	10
11	Allocated from Maestro Consulting Services	2005	700		20	35	35	450	11
12	Allocated from Maestro Consulting Services	2006	949		20	47	47	539	12
13	Allocated from Maestro Consulting Services	2008	1,000		20	50	50	463	13
14	Allocated from Maestro Consulting Services	2009	16,105		20	805	805	6,933	14
15	Allocated from Maestro Consulting Services	2010	2,475		20	124	124	929	15
16	Allocated from Maestro Consulting Services	2011	134		20	7	7	46	16
17	Allocated from Maestro Consulting Services	2012	149		20	7	7	43	17
18	Allocated from Maestro Consulting Services	2014	1,861		20	93	93	336	18
19	Allocated from Maestro Consulting Services	2015	524		20	26	26	61	19
20	Allocated from Maestro Consulting Services	2016	2,294	294	20	229	(65)	318	20
21	Allocated from Maestro Consulting Services	2017	307		20	15	15	15	21
22									22
23	Allocated from Maestro/7257 Lincoln	2015	1,127	96	20	75	(21)	175	23
24	Allocated from Maestro/7257 Lincoln	2005	6,516	46	20	234	188	4,779	24
25	Allocated from Maestro/7257 Lincoln	2004	1,421		20	71	71	959	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 119,431	$ 2,269		$ 4,478	$ 2,209	$ 53,407	34

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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		$ 119,431	$ 2,269		$ 4,478	$ 2,209	$ 53,407	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
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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)		$ 119,431	$ 2,269		$ 4,478	$ 2,209	$ 53,407	34

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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	$ 815,979	$ 699	$ 57,754	$ 57,055	10	$ 575,057	71
72	Current Year Purchases	113,319	3,883	9,759	5,876	10	9,759	72
73	Fully Depreciated Assets	691,202		486	486	10	691,201	73
74								74
75	TOTALS	$ 1,620,501	$ 4,582	$ 67,999	$ 63,417		$ 1,276,017	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Maestro Consulti	2017	$ 440	$	$	$	5	$ 440	76
77										77
78										78
79										79
80	TOTALS			$ 440	$	$	$		$ 440	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)	$ 12,839,245	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,362	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 436,480	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 408,118	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,120,885	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	CIP	$ 20,130	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 MIDWAY # 0053678 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:				$ 2,897,157			3
4	Additions				(2,897,157)			4
5	Allocated from Maestro Consulting				6,962			5
6								6
7	TOTAL				$ 6,962 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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	$

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: $ 55,436 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Maestro Consulting		$	$ 3,832	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,832	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 MIDWAY # 0053678 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 MIDWAY

STATE OF ILLINOIS
0053678 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	$		$ 747,596	$		$ 747,596	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			228,074			228,074	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			767,414			767,414	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				243,702		243,702	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					121,138	236,091		357,229	13
14	TOTAL			$		$ 1,864,222	$ 479,793		$ 2,344,015	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 MIDWAY **#** 0053678 **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	$ 53,445	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,486,350		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	108,475		6
7	Other Prepaid Expenses	354,468		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,002,738	$	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	17,272		15
16	Equipment, at Historical Cost	151,336		16
17	Accumulated Depreciation (book methods)	(26,533)		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	869,939		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,012,014	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,014,752	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,405,198	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,445		28
29	Short-Term Notes Payable	323,959		29
30	Accrued Salaries Payable	543,259		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,836		31
32	Accrued Real Estate Taxes(Sch.IX-B)	644,384		32
33	Accrued Interest Payable	619		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	4,128,825		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,130,525	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,130,525	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (115,773)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,014,752	$	48

***(See instructions.)**

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 **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**	$ 494,276	1
2	Restatements (describe):		2
3	**Rounding**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 494,279	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(610,052)	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)**	$ (610,052)	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)**	$ (115,773)	24 *

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

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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	$ 17,006,730	1
2	Discounts and Allowances for all Levels	(383)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,006,347	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,096,265	6
7	Oxygen	(399)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,095,866	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	647	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,635	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,282	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,074	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,074	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,577	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,577	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,135,146	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,242,285	31
32	Health Care	5,581,553	32
33	General Administration	4,042,561	33
	B. Capital Expense		
34	Ownership	3,827,369	34
	C. Ancillary Expense		
35	Special Cost Centers	2,449,035	35
36	Provider Participation Fee	602,395	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,745,198	40
41	**Income before Income Taxes (line 30 minus line 40)****	(610,052)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (610,052)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,741,720	44
45	Private Pay - Net Inpatient Revenue	324,850	45
46	Medicare - Net Inpatient Revenue	2,616,483	46
47	Other-(specify) MAIP/Hospice	2,184,773	47
48	Other-(specify) Managed Care	3,138,521	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,006,347	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 MIDWAY # 0053678 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	1,877	2,166	$ 142,534	$ 65.81	1
2	Assistant Director of Nursing	2,093	2,271	100,012	44.04	2
3	Registered Nurses	18,332	19,755	777,408	39.35	3
4	Licensed Practical Nurses	62,415	67,110	1,907,172	28.42	4
5	CNAs & Orderlies	103,112	110,618	1,490,571	13.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,915	2,094	36,640	17.50	9
10	Activity Assistants	13,404	14,920	195,800	13.12	10
11	Social Service Workers	7,861	8,316	192,231	23.12	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,122	61,873	29.16	13
14	Head Cook	6,040	6,596	96,479	14.63	14
15	Cook Helpers/Assistants	17,000	18,874	211,413	11.20	15
16	Dishwashers					16
17	Maintenance Workers	3,886	4,200	70,535	16.79	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,988	2,153	134,389	62.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,835	9,864	210,549	21.35	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	1,887	2,132	33,404	15.67	31
32	Other Health Care(specify)					32
33	Other(specify)	4,593	4,909	92,508	18.84	33
34	TOTAL (lines 1 - 33)	257,275	278,100	$ 5,753,518 *	$ 20.69	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	$ 47,642	01-03	35
36	Medical Director	Monthly	16,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	98,064	10-03	38
39	Pharmacist Consultant	Monthly	24,226	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	59	2,943	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,420	11-03	44
45	Social Service Consultant				45
46	Other(specify) Psychiatric Consult	Monthly	9,780	10-03	46
47	Dental Consultant	Monthly	3,600	10-03	47
48					48
49	TOTAL (lines 35 - 48)	103	$ 205,475		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 MIDWAY # 0053678 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mike Hunter	Administrator	0	$ 134,389
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,389

B. Administrative - Other

Description	Amount
Management Fees - Maestro Consulting Services	$ 753,509
TOTAL (agree to Schedule V, line 17, col. 3)	$ 753,509
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 29,667
RSM US LLP	Accounting	9,751
Maestro Consulting Services	Regional Allocated Cost	94,708
See Attached	Legal Fees	28,101
Achieve Accreditation	Accreditation	13,807
Care Cost	Cost Management	1,797
Corporation Service Company	Representation	481
Language Line Services	Translation Services	3,096
LTC Consulting Services	Medical Billing	31,131
McCabe, Ballester, Kirshner	HC Insurance Solutions	4,285
Medical Business Office Services	Medical Coding	31,482
See Supplemental Schedule		144,326
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 392,632

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 171,413
Unemployment Compensation Insurance	87,631
FICA Taxes	434,176
Employee Health Insurance	160,080
Employee Meals	28,288
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contribution	42,008
Employee Physical Exams	6,177
Other Employee Benefits	13,556
TOTAL (agree to Schedule V, line 22, col.8)	$ 943,328

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	1,007
Health Care Worker Background Check	
(Indicate # of checks performed 424)	4,243
Patient Background Checks 440	4,400
Dues & Subscription	14,375
Licenses & Permits	5,448
Allocated from Maestro Consulting Services	7,700
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,162

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,191
Allocated from Maestro Consulting Services	1,609
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,800

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SYMPHONY AT MIDWAY # 0053678 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. **ICLTC $25,987**

(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. $ **131** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Renaissance at Midway #0041749 11/01/2015

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **602,395**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **28,288** 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